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CHEROKEE NATION®
Health Services

TELEMEDICINE ACCESS AND EXPANSION REPORT

Evaluating Current Utilization, Barriers, and Opportunities for a World-Class System of Wellness

ABSTRACT

This report examines the state of telemedicine within Cherokee Nation Health Services (CNHS), analyzing usage trends, barriers, and opportunities for expansion.

Work Group on Telemedicine

Dr. Stephen Jones, Chief Executive Officer of Cherokee Nation Health Services, Dr. Corey Bunch, Chief of Staff of the Cherokee Nation, Deputy Secretary of State Canaan Duncan

Report compiled by the Medicare Usage and Access Work Group and published by the Cherokee Nation Office of the Principal Chief.

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Cherokee Nation Contact Information

P. O. Box 948
Tahlequah, OK 74465

https://www.cherokee.org/

Abstract

This report was prepared pursuant to the February 27, 2025 administrative memorandum issued by Principal Chief Chuck Hoskin Jr., which directed a review of Cherokee Nation's telemedicine capabilities and opportunities for expansion. As emphasized in the Anadisgoi news release, Chief Hoskin's directive reflects his administration's focus on building a "world-class system of wellness" by studying gaps in health access and identifying citizen-centered solutions. At-large Councilor Johnny Jack Kidwell requested special consideration of how telemedicine can increase access for citizens living outside the reservation, while Speaker Mike Shambaugh and other leaders noted the importance of ensuring rural citizens benefit from sustainable and innovative health services.

The work group's analysis shows that CNHS telemedicine utilization remains significant but has declined since its peak during the COVID-19 Public Health Emergency. The report highlights both strengths and barriers: strong adoption in behavioral health and specialty care; limited uptake in primary care; and challenges with interstate licensure, reimbursement, and patient readiness. It also outlines potential opportunities for sustainable expansion, including a telemedicine queue system, partnerships with telemedicine companies, integration with SDPI and other programs, and leveraging Cherokee Nation's $80 million broadband expansion project to reduce rural access barriers.

About Cherokee Nation Health Services (CNHS)

Cherokee Nation Health Services (CNHS) is the largest tribally operated health care system in the United States, serving more than 2 million patient visits annually across a network of nine health centers, one employee clinic, and W.W. Hastings Hospital in Tahlequah. CNHS provides comprehensive medical, behavioral, and community health services, while also investing in state-of-the-art facilities such as a new $400 million hospital and an $84 million health center in Salina. With programs ranging from diabetes prevention and cancer care to emergency medical services and behavioral health treatment, CNHS works to ensure no citizen within the reservation lives more than 30 minutes from quality care. Guided by the vision of "Healthy Cherokee people, families, and communities for this and future generations," CNHS reflects the Cherokee Nation's commitment to improving the quality of life for its more than 460,000 citizens, strengthening tribal sovereignty, and building a world-class system of wellness for future generations.

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Executive Summary

Cherokee Nation Health Services (CNHS) provided over **338,000 visits in the past six months**, of which **21,619 (6%) were via telemedicine or telehealth**. While telemedicine use has decreased since the end of the Public Health Emergency, it remains a critical tool for increasing access, particularly in behavioral health, psychiatry, and specialty care.

Key Findings

Utilization Trends

- Psychiatry: up to 72% telemedicine.
- Behavioral health: avg. 25%.
- Neurology: 54%.
- Radiology: 100% telehealth.
- Primary care: 0.3–7.9%.

Geographic Reach

- 18,218 visits on the reservation.
- 3,401 visits elsewhere in Oklahoma.
- 837 visits outside Oklahoma (with Arkansas, Missouri, Kansas, and Texas leading).

Barriers

- **Licensure:** 94% of CNHS providers licensed only in Oklahoma.
- **Policy:** Medicare telehealth flexibilities end September 30, 2025.
- **Infrastructure:** Broadband, equipment access, digital literacy.
- **Billing/Reimbursement:** Fragmented payer rules create denials and delays.
- **Clinical Limitations:** Restricted physical exams, diagnostic studies, and ancillary services.

Opportunities

Short-Term

- Develop a telemedicine queue system to reduce no-shows and expand access.
- Incentivize provider participation with wRVU adjustments.
- Expand telemedicine for dietitian, follow-up care, tobacco cessation, and SDPI metrics.
- Contract with external telemedicine firms to fill gaps.
- Advocate federally for sustained telehealth reimbursement and flexibilities.

Long-Term

- Strategically recruit or contract providers licensed in high-population Cherokee citizen states (e.g., California).
- Expand broadband hubs at community centers for telemedicine access.
- Build partnerships with external health systems (e.g., Mercy) for labs and diagnostics.
- Establish a CNHS nurse hotline for triage and advice.

Conclusion

In alignment with Chief Hoskin's directive and the public framing in Anadisgoi, the report affirms that telemedicine remains essential to Cherokee Nation's vision of a world-class health system. While challenges exist, a deliberate combination of policy advocacy, provider incentives, broadband expansion, and strategic partnerships will allow CNHS to expand telemedicine in a way that sustainably benefits citizens both on the reservation and at-large.

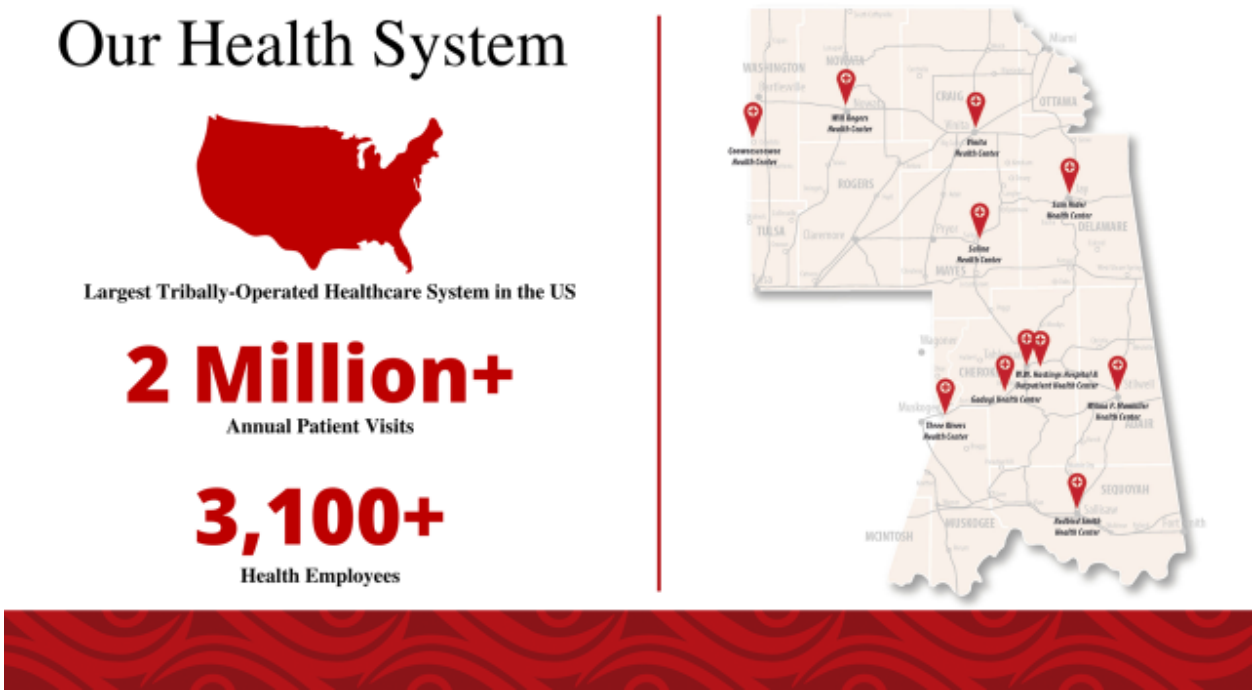
Purpose Statement

This report explores the accessibility and impact of telemedicine services within Cherokee Nation Health Services (CNHS), within the reservation, within the boundaries of the state of Oklahoma, and outside the state of Oklahoma. By examining data on telemedicine usage, patient outcomes, opportunities, barriers, short and long term strategic planning this report provides a comprehensive overview of current telemedicine capabilities and highlights opportunities for future expansion to ensure equitable healthcare access for all.

Cherokee Nation Health Services Overview

- Chief Hoskin set forth a path for CNHS to become a world-class system of wellness.
  - CNHS serves as a role model for other Tribal and "private" health systems.
- One of the things that sets us apart is that we are a Tribal health system and one of the underlying principles to understand is Tribal Sovereignty.
  - Tribal Sovereignty defines the inherent authority of Tribes to govern themselves.
    - This allows Tribes to honor and preserve their cultures and traditional ways of life.
    - Tribal Sovereignty allows us to establish our own government, create and enforce laws, and manage our lands and resources.
  - We see our Tribal health system as another means of exercising Tribal Sovereignty for the benefit of Cherokee citizens.
  - It's important to point out that while we frequently reference what we do for Cherokee citizens, we provide care to any member of a Federally-recognized Tribe.
  - Because CNHS is a part of the Cherokee Nation, we are just one part of the work being done by the Cherokee Nation to engage in economic development in communities that have suffered from multi-generational economic distress.
    - Cherokee Nation works to address a multitude of social determinants of health because we know that health care alone can't fix the problem.
    - Cherokee Nation builds roads and other infrastructure, provides transportation, promotes safe communities, creates jobs, and provides education opportunities in an effort to create an environment where people can be healthy.

- Our Reservation is made up of 14 counties where we operate the largest Tribal health system in the United States.
  - CNHS provided over 2 million patient visits last year across our health system which encompasses
  - W.W. Hastings Hospital in Tahlequah and nine outpatient health centers, including our newest facility which is the Cherokee Nation Outpatient Health Center (CNOHC) on our Tahlequah Health Campus.



- We have an unwavering commitment to provide quality health care to our citizens.
  - Our Vision is: Healthy Cherokee people, families and communities for this and future generations.
  - Our Mission is: To ensure the story of the Cherokee Nation continues, we partner with individuals, families, and communities to improve our health and quality of life.
  - Our Vision, Mission, and Values serve as the Foundation for all we do.

Our Foundation

Vision:
Healthy Cherokee people, families and communities for this and future generations.

Mission:
To ensure the story of the Cherokee Nation continues, we partner with individuals, families, and communities to improve our health and quality of life.

Values:
Cherokee Nation Health Services operates with seven values and guiding principles, which are listed to the right.

Self-Determination
For Cherokees by Cherokees.
Excellence
A legacy of superior quality and selflessness carried through generations.
Respect
Holding each other sacred.
Visible to the Community
Our strength is in our collective collaborations with each other.
Integrity
Doing the right thing and achieving the highest standard in service.
Compassion
Supporting each other with genuine concern and kindness.
Equity
Balancing resources to address greatest needs

- A challenge faced by American Indians in the United States is in part due to the geographical distances to healthcare facilities.
  - To address this disparity, Cherokee Nation's Long Range Health Plan identified a scope of services needed in the reservation to achieve our goals of **seamless healthcare that's close to home**. We want to provide:
    - Seamless health care delivery, where primary and tertiary facilities complement each other,
      - so we can offer state of the art, comprehensive care to our citizens
      - in an efficient and coordinated manner
    - Secondly, we strategically located Health Centers so that from anywhere on the reservation, it's a 30-minute drive, or less, to our health centers.
- Key Initiatives to achieve these goals included
  - Hiring physicians, advanced practice providers, and all manner of appropriate support staff
  - Building new health facilities and upgrading existing ones
- Cherokee Nation has been able to achieve these goals via focus on:
  - Increasing Third Party Revenue,

- Developing our high quality workforce

- Investment of Tribal business revenue directly into our new and expanded health centers.

Achieving Our Long-Term Goals

Seamless Health Care Delivery

30-Minute Maximum Drive to Reach a Health Center

Hiring Additional Health Employees

Building & Renovating Health Facilities

Increasing Third-Party Revenue

- Oklahoma and, in particular, rural Oklahoma where so many Tribal citizens live, faces some of the worst health challenges anywhere in the United States.
    - We rank 46th in the number of primary care doctors per capita.
    - As a State, we perpetually come in last in almost any metric used for measuring health.
        - In the most recent State of the State's Health report, the only measure we received an A for was for the number of seniors receiving the flu vaccine.
        - While this is an important measure that saves a lot of lives, our performance in every other measure such as heart disease, smoking, obesity, and infant mortality overshadow the single A on our state's report card.
- Because of these challenges, Tribes began to lead the way in solving rural health problems.
    - **There's a recognition that no one is coming, it's up to us.**

Quality Management System

Strategic Planning

Quality Management System

External/Internal Review

Continuous Improvement Culture

- Our health system is accredited by DNV and our quality management system is ISO 9001 certified to assure safe, high quality care with a focus on **continual improvement.**

Accreditation and ISO Certification

Definitions

- Traditional telemedicine: Patient is in the health facility and the Practitioner is not.
- Nontraditional telemedicine: Patient may be outside the health facility.
- Telemedicine: Telemedicine involves the use of audio and video for real-time, interactive communication between a patient and medical Practitioner for health delivery, diagnosis, consultation, and treatment, including the transfer of medical data.
- Telehealth: "Telehealth" refers to delivering healthcare services through audio-only communication via information and communication technologies, facilitating diagnosis, consultation, treatment, education, care management, and self-management at a distance from healthcare Practitioners.

Analysis

Trends

A. Nationally in 2022, according to the American Medical Association (AMA):
    1. Telemedicine/telehealth use tends to rise with age.
        a. 18-29 29.4%
        b. 30-44 35.3%
        c. 45-64 38.9%
        d. > 64 43.3%
    2. Women are more likely to use telehealth:
        a. Women 42%
        b. Men 31.7%
    3. Ethnic variation:
        a. American Indian/Alaska Natives (AI/AN) are high adopters at 40.6%
        b. Whites 39.2%
        c. Hispanics 32.8%
        d. Blacks 33.1%
        e. Asians 33%
    4. Use varies with education:
        a. College degree or higher 43.2%

b. Some college 39%
c. High School (HS) diploma 30.3%
d. Less than a HS diploma 28.7%

5. More urban = more telemedicine
    a. Large metropolitan areas 40.3%
    b. Large fringe metropolitan areas 40.2%
    c. Medium metropolitan areas 35.4%
    d. Small metropolitan areas 32.4%
    e. Micropolitan areas 30.5%
    f. “noncore areas” 27.5%
6. Regional variation
    a. Western US 42.4%
    b. Northeastern 40%
    c. South 34.3%
    d. Midwest 33.3%

B. Medicare Telemedicine/telehealth trends from 1/1/2020-9/30/2024; reported 1/9/2025
    1. Percentage of Medicare users with a telehealth service:
        a. 2020 48%
        b. 2021 34%
        c. 2022 29%
        d. 2023 25%

Current State of Telemedicine in CNHS

A. The implementation of telemedicine was touched off in 2020, early during the COVID-19 pandemic and the declaration of a Public Health Emergency (PHE) status. Its adoption and use escalated rapidly and has waned since the end of the pandemic.

B. Service lines utilizing telemedicine and usage data for the past 6 months:
    1. Primary Care
        a. Facility range: 0.3% - 7.9%
        b. Practitioner range: 0 - 21.33%
    2. Pediatrics (very small percentage of services provided)

a. Facility range 0% - 4%
b. Practitioner range: 0% - 12%

3. Psychiatry (largely variable service percentages)
    a. Facility range 15.8% - 72%
    b. Practitioner range: 0% - 100%
        i. RSHC APRN works from home 80% of the time and does 72% telemedicine.
4. Behavioral Health
    a. Facility range: 0% - 100%
        i. Average of 25% for CNHS facilities
    b. Practitioner range: 0% - 97%
5. Tribal Health Connection (THC) contracted telemedicine only company
    a. 100% telemedicine (7% of the system's BH visits in 2024).
6. Specialty Care
    a. Neurology
        i. 54% telemedicine
        ii. Range 4% to 69%).
    b. Cardiology
        i. 0% telemedicine
        ii. They do provide remote device interrogation (e.g. pacemakers, defibrillators, etc.) via telehealth.
    c. Pulmonology
        i. 24% telemedicine
    d. Women's Health at CNOHC
        i. 2% telemedicine
    e. Infectious Disease
        i. 25% telemedicine
        ii. Range 18%-29%
    f. Dietitians Very small percentage
        i. <1% telemedicine
    g. Radiology

i. 100% *telehealth*.

C. CNHS overall; past 6 months:

1. 338,268 total visits
    a. 94% in person
    b. 6% telemedicine/telehealth
2. 21,619 telemedicine/telehealth visits
    a. 18,218 on the reservation
    b. 3,401 off the reservation, within Oklahoma
    c. 837 outside the state of Oklahoma (States with at least 15 visits; in order of total visits)
        i. Arkansas
        ii. Missouri
        iii. Kansas
        iv. Texas
        v. New York
        vi. Alabama
        vii. Other states with < 15 visits: Arizona, California, Colorado, Florida, Iowa, Indiana, North Carolina, Tennessee, Virginia, Vermont.

D. **Summary**:

1. Telemedicine and/or telehealth are used in nearly all areas of CNHS healthcare delivery. Usage varies widely from 0% to 100% depending on specialty, Practitioner, patient preference, and specific situations.
2. Telemedicine use expanded rapidly during the pandemic and has waned since the pandemic ended.
3. A benefit to having telemedicine capability is the ability to quickly shift to telemedicine during events like inclement weather. For example, in February of 2025 WRHC usage rose from an average of 5.1% to 14.39% and CHC rose from 2.58% to 11.7%.

4. Another potential benefit is that in-person no-showed appointments can be converted to telemedicine or telehealth (if the Practitioner is able to connect with the patient), allowing care to continue with minimal disruption.
5. Patient uptake is variable and often lower than expected.
    a. Patients tend to prefer telehealth (audio only) over telemedicine (audio and video) visits.

Current state of telemedicine within the State of Oklahoma

A. Before the PHE, Medicare only covered traditional telemedicine (i.e. patient onsite).
B. Currently the PHE status, which has been extended through 9/30/2025, allows Medicare patients to receive telemedicine services (professional portion) from "anywhere," meaning that the patient does not need to be in the health facility.
C. This flexibility will likely end after September.
    1. If it does, patients will have to be onsite to receive telemedicine services, reverting to traditional telemedicine requirements.
    2. This will result in lengthy travel for patients outside the reservation to participate in telemedicine services.
D. Currently telemedicine visits are coded and billed using the Evaluation and Management (E&M) system that allows for equitable work Relative Value Units (wRVUs) for telemedicine visits and in person visits. This is a significant difference from pre PHE coding and billing, at which time telemedicine visits were coded and billed at significantly lower levels.
    1. wRVUs are used to measure and monitor medical Practitioner productivity and determine salaries and productivity bonuses.
    2. If/when the PHE status ends, the pre PHE coding will likely be reinstated which will be a significant disincentive for our medical Practitioners to utilize telemedicine.

Current state of telemedicine outside the State of Oklahoma

A. Approximately 35% of CN citizens live outside the state of Oklahoma.
B. Practitioners can only provide telemedicine services to out-of-state patients if the Practitioner is licensed in the state in which the patient is physically located.

1. Currently CNHS employs a total of 182 Physicians and Advanced Practice Practitioners (APPs) combined, 171 of whom are licensed ONLY in Oklahoma.
    a. Of the 11 dually licensed Practitioners employed by CNHS the additional states of licensure are Texas, Arkansas, and Missouri.

C. There is a difference in billing and licensure that has to be understood:
    1. CNHS can bill for telemedicine services for Oklahoma Medicaid patients, even if the patient is located in another state.
    2. However, the Practitioner must still be licensed in the state where the patient is physically located to legally provide the service.
    3. Companies like LifeMD, BetterHealth, and our own BC/BS provide telemedicine services to patients who are in other states by hiring multiple Practitioners who are licensed in various states. Most who practice in this manner are licensed in multiple states for the express reason of practicing telemedicine.
        a. How do they arrange for lab, x-ray, etc.?
            i. LifeMD refers patients to Labcorp and Quest for lab services.
                - Lab services are the patient's financial responsibility. i.e. LifeMD does not have a contract with LabCorp or Quest to cover the cost of the lab services for the patients.
    4. CNHS can now provide and bill for telemedicine services for Arkansas Medicaid patients under two conditions:
        a. The patient is physically in Oklahoma and the Practitioner is licensed in Oklahoma.
        b. The patient is in Arkansas and the Practitioner is licensed in Arkansas.
        c. This is a relatively new development that took > 2 years to implement.

Current state of telemedicine for At-Large Cherokee Nation Citizens

A. Any CN citizen patient who has an active chart (i.e. who has previously established care in person (for Medicare)) and is physically in Oklahoma at the time of the telemedicine visit can receive telemedicine services.
    1. Most commercial insurances follow Medicare's lead, meaning they may revert to traditional telemedicine (patient must be in the health facility) after the PHE ends.
B. If/when the Public Health Emergency status ends, there will likely be more barriers for patients who are outside the reservation (whether inside or outside the state of Oklahoma).
    1. i.e. reverting to traditional telemedicine will require the patient to be onsite in a CNHS health facility to participate in a telemedicine visit.
C. Doing the paperwork to establish a chart either onsite or remotely can be a challenge/barrier for some. See below.
D. Attending initial and subsequent periodic in-person visits (both of which are necessary) can be difficult for those who live far from CNHS facilities.

- **Summary**:
    A. Patients must have an established chart, created through an in-person "establish care" visit.
    B. The PHE has provided some specific leniencies for Medicare and other insured patients, which will likely soon go away.
    C. Legal's advice has been, and continues to be: *Our CNHS Practitioners, including Behavioral Health personnel, who are licensed only in Oklahoma may legally do telemedicine visits only with patients who are physically within the borders of the state of Oklahoma at the time of the visit.*
        1. 94% of our currently employed Practitioners are licensed **only** in Oklahoma.
    D. Licensure rules and billing rules are not always the same.
        1. For example Oklahoma Medicaid allows billing for telemedicine services provided to Oklahoma Medicaid patients who are outside the state of Oklahoma, but Oklahoma Medical Licensure Board does not allow (only) Oklahoma licensed Practitioners to legally provide the service.

Opportunities for Expanding Telemedicine Access

Within the reservation/Oklahoma

- **Telemedicine Queue System**

  Develop a telemedicine/telehealth queue where patients who have requested a virtual visit, either by phone or online, are placed in line to be seen by the next available Provider. The Provider may be scheduled for telemedicine/telehealth that day or week or may have available patient care time.

- **Dietitian Services**

  Explore options for providing dietitian services via telemedicine/telehealth, as reimbursement is very low regardless of the service delivery method.

- **Follow-Up Visit Format**

  Telemedicine is well-suited for follow-up visits (e.g., hypertension and/or depression following medication adjustments). It is not an optimal format for "establish care" type appointments for new patients.

- **Inclement Weather Solutions**

  Telemedicine/telehealth offers a rapid transition option during inclement weather, but it should be for established patients only. There is a need to develop strategies to improve patient uptake when a shift to telemedicine is indicated or necessary.

- **Provider Absence Contingency**

  Telemedicine can be utilized when a Provider is unable to come to the Health Center.

- **Specialist Access**

  Use telemedicine/telehealth to connect patients with specialists who are not physically present, but may be located at another health facility, or even outside the system. This could help reduce PRC costs.

- **Tobacco Cessation Counseling**

  Telemedicine/telehealth can be used to deliver tobacco cessation counseling, increasing accessibility for patients.
- **Support for Special Diabetes Program for Indians (SDPI) Metrics**

  Possibly addressing other unmet SDPI metrics.
- **Broadband and Telephone Access**

  Improving broadband availability/telephone service in rural areas.
- **Digital Literacy Improvement**

  Promote digital literacy among tribal members to ensure more people can effectively access and use telehealth services.
- Use of more telemedicine could serve to ease financial burdens for patients who experience difficulty traveling to the current CNHS outpatient facilities.

Opportunities for Expanding Telemedicine Access Outside the state of Oklahoma

A. Very limited currently based on current staffing and current guidance from legal counsel.
    1. CNHS would need to hire or contract with medical Practitioners who are licensed in other states in which the Cherokee Nation tribal citizens reside.
B. Contracting with a telemedicine company (e.g. LifeMD) to provide the service is a potential, and likely the most pragmatic opportunity.
    1. CN employees have access to telemedicine through our BC/BS.
C. States with a large population of CN citizens may be a target for expansion of telemedicine access. Keeping up with licensure and state medical board requirements/regulations for Practitioners licensed in *one specific state* other than Oklahoma, or contracting with a locum company who manages the Practitioners' licensure, may make this a manageable project.
    1. The state other than OK with the largest CN citizen population is California
        a. Consider detailing the licensure requirements for:
            i. Physicians
            ii. Advance Practice Registered Nurses
            iii. Physician Assistants

iv. Pharmacists

v. Outline the:

- regulations,
- barriers,
- possibilities

Barriers to Expanding Telemedicine Access

A. **Within the Reservation**

1. Technological or other infrastructure-related barriers
   a. Broadband availability/telephone service in rural areas.
   b. Patient access to appropriate equipment.
   c. Adoption of technology by citizens.
   d. Digital literacy, likely more prevalent among the elderly.
2. Legal and regulatory barriers:
   a. Public Health Emergency status may be rescinded soon. Sunsetting of the PHE 9/30/2025 could have significant consequences on the current use of telemedicine and on the future expansion of telemedicine use.
   b. May have to return to traditional telemedicine rules.
      i. If so then will need to have Practitioners licensed in multiple states or have contracts in place with telemedicine companies such as LifeMD, MD Live, BetterHelp (BH services).
3. Insurance and coding/billing:
   a. Evaluation and Management (E/M) codes were originally developed to document in-person clinical encounters, capturing both assessment and treatment of patient conditions. Before the 2020 Public Health Emergency (PHE), telehealth primarily referred to visits where the patient was on-site, and the provider delivered care remotely via audio/video. E/M codes were utilized for all payers with the use of a modifier to indicate the service was performed by a provider who was off-site and a patient who was on-site.
   b. The PHE redefined telemedicine across federal and commercial payers to include multiple care configurations—whether both patient and provider were off-site,

one on-site and the other remote, or both on-site. This broadened view was pivotal in expanding access but introduced complexity in billing. In response, the AMA released new telemedicine-specific CPT codes in 2025. However, CMS and many commercial insurers declined to adopt these changes, instead continuing to require traditional E/M codes with telehealth-specific modifiers. The result is a fragmented billing landscape where coding requirements and reimbursement eligibility vary widely by payer. In the absence of clear payer guidance, claims are often submitted using CMS standards as the default—but this can result in denials when commercial payer requirements differ. Given the volume and variability of commercial plans we bill, it is not feasible to identify and align with each payer's specific billing protocols in real time. This inconsistency drives claim denials, rework, and administrative burden—hindering efficiency and delaying revenue capture.

4. There is a perception that Practitioners across the system were encouraged to use less telemedicine/telehealth after the pandemic subsided.
5. Privacy concerns – sharing sensitive protected health information (PHI) via telemedicine/telehealth systems demands robust cybersecurity.
    a. To address these concerns CNHS IT has implemented industry leading tools and practices to ensure all Protected Health Information (PHI) and sensitive data within our environment is protected at rest and in transit.
        i. Other internal controls beyond our Health IT team are in place such as cybersecurity partnerships with Fortified Security (3rd party reviews and risk reviews), Cisco (external/internal penetration testing), and various CNHS controls such as Data Governance Committee, CNHS Compliance, etc.
        ii. CNHS IT is also actively implementing the M365 solution that will include several security tool enhancements over the current environment, including data loss prevention, email encryption, expanded multifactor authentication, and device management.
        iii. All of these measures enhance our overall privacy, security, and response efforts.

6. Restricted access to diagnostic studies – e.g. lab, radiology, etc.:
    a. Patient would have to come to a Health Center for diagnostic lab, radiology, etc.
7. Physical exams via telemedicine are extremely limited.
    a. It is difficult to perform a thorough physical exam via a video call. While some components of the physical exam can be accomplished via telemedicine, e.g. patients can weigh themselves, check their own pulse and blood pressure, demonstrate range of motion of the extremities and even palpate their own abdomens and report pain, some simply cannot. E.g. auscultation of the heart and lungs (requires a stethoscope), examination of the eardrums (requires an otoscope), pelvic and/or rectal exams, evaluation of weakness, etc.

B. **Within the State of Oklahoma**
1. Same as Within the Reservation
2. It is not an acceptable format for "establish care" type appointments for new patients who live far away.
    a. They would still have to be seen at a CNHS health facility to establish care.
    b. Periodic follow-up in-person visits/exams are necessary

C. **Outside the State of Oklahoma**
1. All of the same issues/barriers noted above apply here as well. Our Practitioners who are licensed only in Oklahoma may legally only participate in telemedicine visits with patients who are physically within the borders of the state of Oklahoma at the time of the visit.
    a. We would have to have Practitioners licensed in the state in which the patient(s) live/are located to provide telemedicine/telehealth services to those patients or contract with telemedicine companies that employ Practitioners who are licensed in all states.

2. Continuity of care would be difficult for out-of-Oklahoma patients, as we would have to have Practitioners licensed in the patients' states to provide telemedicine/telehealth services to them.
    a. As Practitioners who were licensed in states outside of Oklahoma left the system, they would have to be replaced with similarly licensed (same state(s))

and specialized (same specialty) Practitioners to provide continuity of care to the out-of-Oklahoma patients

b. Decreased continuity of care increases the number of Emergency Room (ER) and Urgent Care (UC) visits and decreases the efficiency of workups.

3. Lack of legal knowledge of other states' medical and pharmacy laws.
   a. We would have to be knowledgeable of other state's medical and pharmacy laws. They are very variable from state to state.
4. Cost
   a. Pharmacy
      i. May not get reimbursed for Medicaid prescriptions and some commercial insurance prescriptions.
      ii. Contracting to be allowed to bill for Medicaid patients from states other than Oklahoma is a convoluted process. It took > 2 years to work it out with AR and it is going very slowly with Kansas.
      iii. A key logistical challenge is ensuring reimbursement for prescriptions from patients with out-of-state insurance coverage. This would obligate each of our pharmacies to enter into and annually renew individual contracts with numerous state Medicaid agencies and commercial insurance providers, creating a substantial and resource-intensive contract management burden. Additionally, based on state contract restrictions, some 3rd party plans may also require the prescriber to be licensed by that state and enrolled in that state's Medicaid program.
5. Mailed prescriptions
   a. Cannot mail refrigerated medications (e.g. insulin, eye drops, etc.).
   c. Increased workload on Centralized Refill Center (CRC).
   d. USPS mail errors/delays are a big concern.
6. Getting appropriate lab and radiology studies performed for appropriate diagnostic workups
   a. CNHS would have to develop unique partnerships, each with its own contract, with vendors who provide these services in the areas of the patients.

7. Grants (e.g. SDPI diabetes grant that supplies about 7 million dollars/year to the health system) that require certain metrics (e.g. specific labs, annual foot exam, etc.) would be difficult to maintain without periodic in-person visits.
8. Increased Practitioner/CNHS liability due to lack of ancillary services limiting appropriate diagnostic workups.
9. Lack of other ancillary services (e.g. PT, OT, SLP, etc.) availability for the patients.
10. Would not be able to provide other services that patients within the reservation have access to (e.g. Dental, Optometry, etc.).
11. Would have to be contracted with the individual state's Medicaid to bill for services for Medicaid patients in that state:
    a. As noted we are contracted with Arkansas for Medicaid services. It took > 2 years to get the contract in place. CN is the first Oklahoma tribe to contract with Arkansas Medicaid.
    b. Working on a Medicaid contract with Kansas. Kansas has a "50 mile rule" – they will not pay for medical services outside the state if the patient has a medical facility within 50 miles of where they live.
        i. We currently do not have any employed CNHS Practitioners who are licensed in Kansas.
12. Having a first "in-person" visit, and periodic in-person visits, will definitely be required after the end of the Public Health Emergency.
    a. BH may be excluded.
13. Doing registration "paperwork" electronically:
    b. Not everyone is currently willing to use and/or capable of utilizing DocuSign or other electronic formats that allow remote paperwork completion and digital signatures.

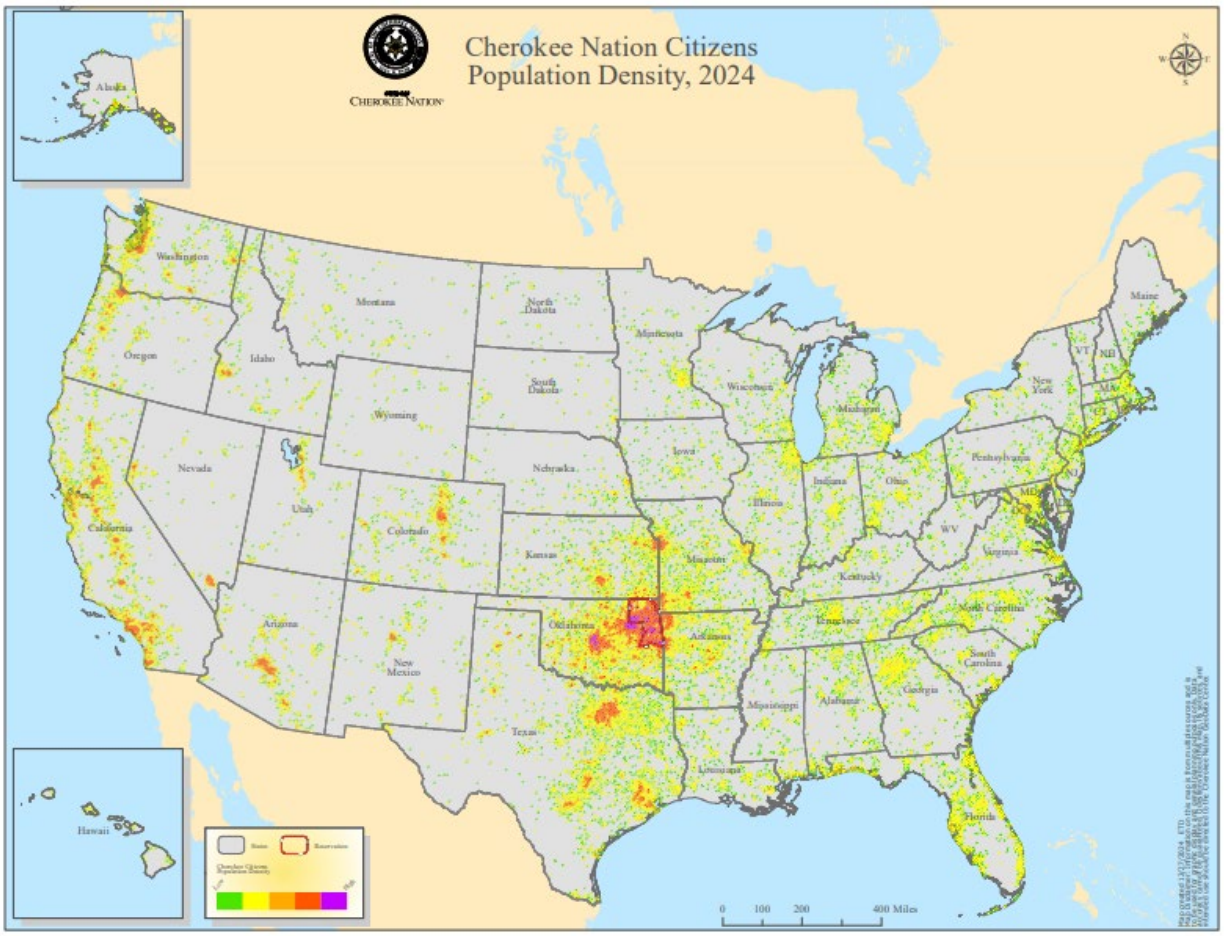
Strategic Plan for expansion of CNHS telemedicine

A. Short term

1. Evaluate opportunities for "low hanging fruit" and for the most impactful strategies to increase utilization of telemedicine to increase access to appropriate healthcare for CN citizens.
    e. Ideas include
        i. Designating medical Practitioners to rotate using a "telemedicine schedule".
        ii. Developing a queue in which patients can be placed until a medical Practitioner is available to attend to the call.
            - Making the queue available to appropriate medical Practitioners to access in case of no-shows, late cancellations, etc.
            - Consider extended hours for the queue; similar to an after-hours UC.
        iii. Incentivizing telemedicine visits through wRVU multiplier, especially if the wRVU rates return to the pre PHE rates.
2. Continue development and implementation of online scheduling.
    a. Utilize online scheduling capability to develop methods for increasing telemedicine capacity.
        i. This will require input from Health Leadership to determine the most impactful and efficient methods for utilizing telemedicine.
3. Consider contracting with "telemedicine companies" such as LifeMD to provide services to CN citizens/patients.
4. Engage CN's Government Relations team to address with the federal government the pitfalls for CN citizens of returning to pre-PHE telemedicine rules.
5. Evaluate barriers and work to overcome all that are deemed surmountable.

B. Long term

6. Expand the use of contracted telemedicine companies to provide telemedicine services to at large and/or out of state CN citizens.
7. Expand knowledge of medical and pharmacy laws (legal) and Medicaid and insurance rules (billing) in states (e.g. California) that are heavily populated with CN citizen patients and/or states that neighbor Oklahoma.


Cherokee Nation Citizens
Population Density, 2024
Cherokee Nation
Alaska
Hawaii
Washington
Oregon
California
Nevada
Idaho
Montana
Wyoming
Utah
Arizona
Colorado
New Mexico
North Dakota
South Dakota
Nebraska
Kansas
Oklahoma
Texas
Minnesota
Iowa
Missouri
Arkansas
Louisiana
Wisconsin
Illinois
Michigan
Indiana
Ohio
Kentucky
Tennessee
Mississippi
Alabama
Georgia
Florida
South Carolina
North Carolina
Virginia
WV
Pennsylvania
New York
Maine
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RI
NJ
MD
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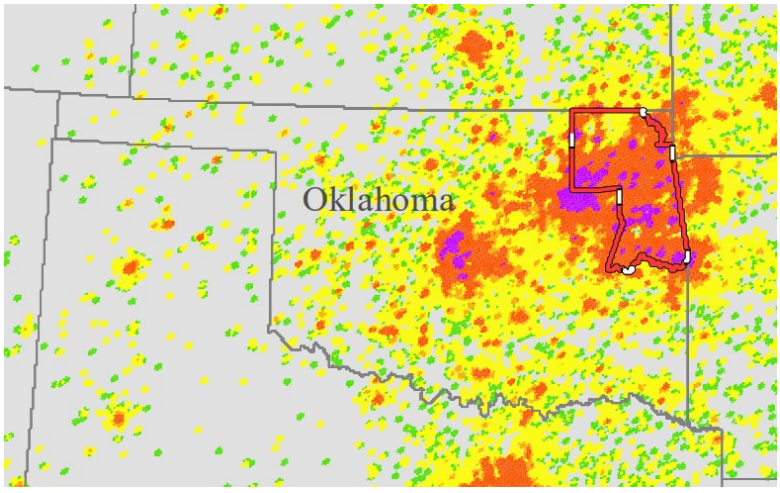
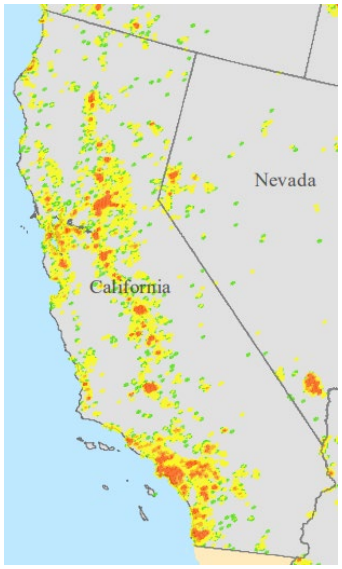
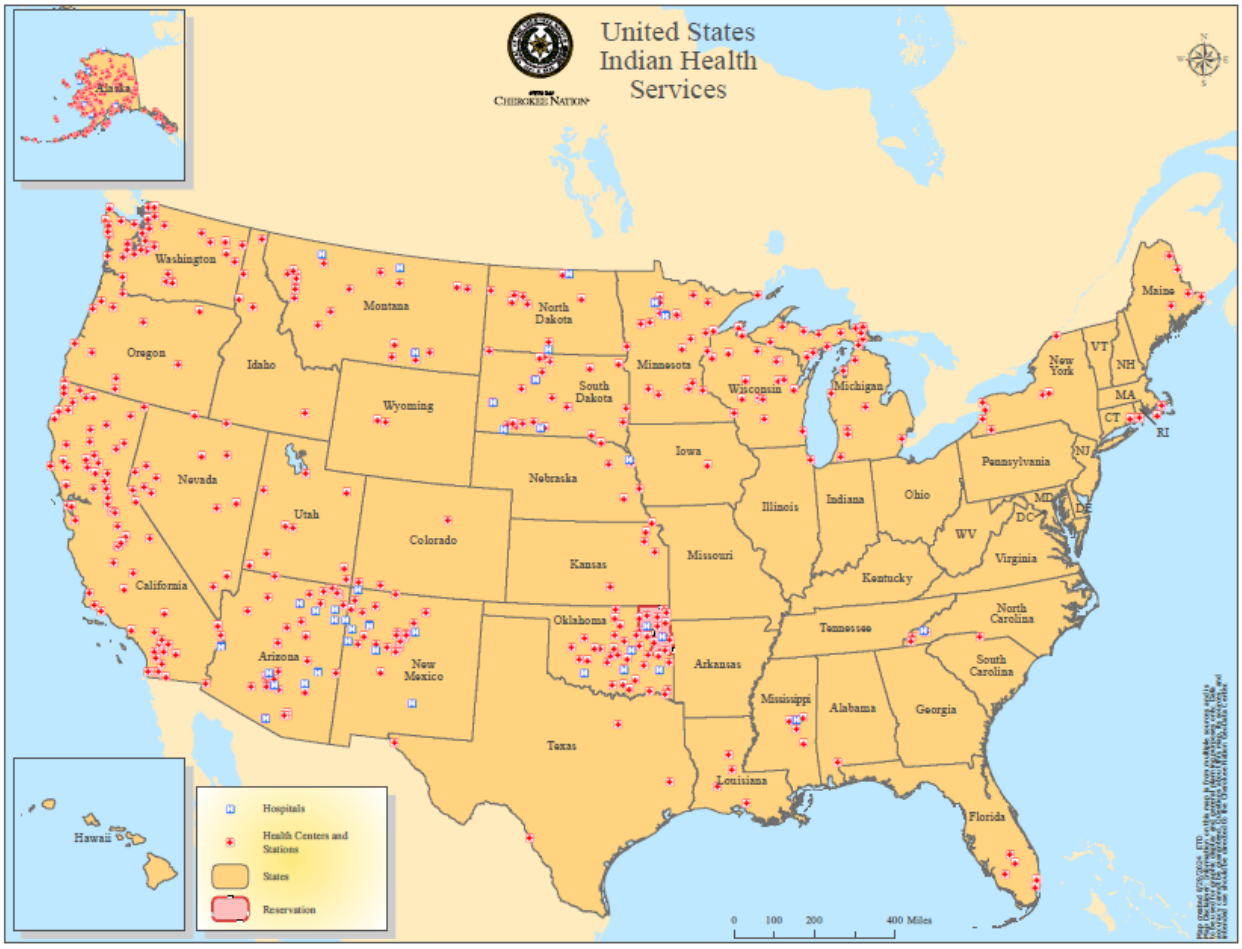

Oklahoma


Nevada
California

8. CN is investing 80 million dollars working on broadband expansion
    - One aspect of that is a possibility is to have broadband available at community buildings/centers and set aside space and equipment in that space to allow citizens to accomplish telemedicine visits.
9. Expand the healthcare footprint of CNHS into other states for Cherokee citizens.
    a. Consider states that are heavily populated with CN citizen patients and/or neighboring states.
    b. Strategically employ medical Practitioners who are licensed in other states, or
    c. Develop partnerships with locums companies that can consistently provide medical Practitioners with whom to contract who are licensed in the target states.



10. Develop partnerships with other health systems throughout the state and potentially in other states (e.g. Mercy) that would allow CN citizen patients in remote parts of the state or in other states to access ancillary services (e.g.

laboratory and radiology services) to augment the healthcare provided via telemedicine.

11. Establish a “Nurse Hotline” that can be utilized by CN citizens to provide Nursing advice and/or triage by telephone.

D. **Summary:**

1. We have ideas for short and long term strategies to implement increased telemedicine utilization.
2. It is difficult to, and may be imprudent to deploy significant time and/or resources toward any definitive plans until at least a couple of things are known:
    a. When the PHE will end.
    b. What the status of telemedicine allowances and leniencies or lack thereof, in regard to coding and billing will be at that time.

Multidisciplinary Workgroup Members

- Dr. Corey Bunch, CN Chief of Staff
- Canaan Duncan, CN Deputy Secretary of State
- Dr. Stephen Jones, CNHS Executive Director
- Todd Gourd – CNHS Executive Chief Information Officer
- Aaron Arterberry – CNHS Chief Technology Officer Executive IT
- Lewanda Teehee – CNHS Director of Medical Records
- Jason Loepp – CNHS Senior Director Health Business Operations
- Darylin Doublehead – CNHS Advanced Practice Registered Nurse, Informatics
- Kaleb Chamberlain – CNHS Pharmacy Supervisor Sam Hider Health Center
- Kathleen Imhoff – CNHS Ambulatory Care Nursing Director WW Hastings Hospital
- Skylar Glass – CNHS Health Administrative Coordinator
- Brett Gray, MD – CNHS Deputy Executive Medical Director
- Ad hoc – Elizabeth Odell – CN Senior Assistant Attorney General

Appendices

1. Transcription of original *Administration Memorandum Directing a Review of the Current State of Telemedicine and Opportunities for Expansion Inside and Outside the Cherokee Nation Reservation by the Telemedicine Work Group*

February 27, 2025

TO: Dr. Stephen Jones, Chief Executive Officer of Cherokee Nation Health Services
FR: Chuck Hoskin, Jr. Principal Chief
CC: Cabinet, Dr. Corey Bunch, Chief of Staff, Sub-Cabinet, Mike Shambaugh, Speaker of the Council of the Cherokee Nation

Administration Memorandum Directing a Review of the Current State of Telemedicine and Opportunities for Expansion Inside and Outside the Cherokee Nation Reservation by the Telemedicine Work Group

The purpose of this memorandum is to initiate a review of current telemedicine access for patients in the Cherokee Nation Health System. Additionally it aims to assess opportunities for telemedicine access, as well as identify potential barriers to extending these services both within and beyond the Cherokee Nation Reservation.

Overview: Cherokee Nation is a Leader in Telemedicine

Cherokee Nation's health system, the largest in Indian Country, is a leader in telemedicine in Indian Country delivering essential healthcare services across our reservation. Each year thousands of patients benefit from the convenience and accessibility of Cherokee Nation's telemedicine, reinforcing its position as a key provider of innovative healthcare solutions. Elected Leadership can better support continued telemedicine expansion by gaining a deeper understanding of the current accessibility to telemedicine for patients along with identifying opportunities, and barriers for future growth.

Cherokee Nation's commitment to excellence in health care requires a broad understanding of our growing and increasingly complex health system by not only health care staff and leadership but also by-elected and appointed leadership outside of our health system. Cherokee Nation leadership is deeply invested in the success of our health system, and every leader has the opportunity to support and strengthen it. Additionally,

citizens look to Cherokee Nation leadership to have sufficient depth of knowledge of the health system to answer questions and understand concerns.

Citizens' interest in accessing telemedicine through Cherokee Nation Health seems to be growing, and this interest is naturally shared by Cherokee Nation leadership. The rapid expansion of Cherokee Nation Health Services, including increased access to telemedicine, presents challenges for leaders outside the health system, as well as for citizens, in staying informed about current telemedicine services and understanding the opportunities and barriers to further expanding access.

To effectively support the continued growth of our Health System's telemedicine services, leadership needs an overview of the current state of telemedicine, as well as the opportunities and barriers to its future expansion.

III. Telemedicine Work Group

On the basis of the foregoing, I am directing a Work Group on Telemedicine. The Work Group is composed of:

- Health leadership and staff as designated by Dr. Jones
- Chief of Staff Corey Bunch or Designee
- Deputy Secretary of State Canaan Duncan

The Work Group shall draft and submit to the Principal Chief a brief report which outlines telemedicine related subjects as determined by Dr. Jones, but which should address these issues:

- What is the current state of telemedicine access to for our patients, by type of health service?
- What is the current state of telemedicine access for at-large Cherokee Nation citizens?
- What opportunities are on the horizon for expanding access to telemedicine?
- What barriers exist to expanding access to telemedicine? Analysis of barriers would include:
    - Technological or other infrastructure-related barriers.
    - Legal and regulatory barriers.
    - Unique barriers to Cherokee Nation citizens living at-large.

The Work Group described herein is not a public body within the meaning of Cherokee Nation FOIA, but the report or a summary thereof will be disclosed to members of the Council of the Cherokee Nation and to the general public as the Principal Chief directs. The report should be submitted by July 1, 2025, or by an approved deadline extension.

Signed.
Chuck Hoskin, Jr.
Principal Chief of the Cherokee Nation