Kennedy submits written testimony

Tribal chair addresses inequities of Contract Health Services funding

By Dean Rhodes
Smoke Signals editor

Last year, it was in person.

This year, in writing.

But Confederated Tribes of Grand Ronde Chairwoman Cheryle A. Kennedy is ensuring her voice is heard by the House Committee on Appropriations' 14-member Subcommittee on Interior, Environment and Related Agencies.

Although she did not travel to Washington, D.C., for the March 23 Voices From Our Native American Communities hearing, Kennedy submitted three pages of testimony to Chairman James P. Moran (D-Va.) and ranking Republican member Michael K. Simpson of Idaho.

The text read:

"First, I want to thank the Subcommittee for its leadership in addressing the many issues facing Indian Country. Your commitment to increasing funding for health care, economic and infrastructure development, crime and gang prevention, and other Native priorities is very much welcomed and appreciated.

"My testimony today is shaped in part by a 30-year career as a health administrator working to improve the access and quality of health care to Natives and, more importantly, as someone who personally experienced the immediate injustices of Termination and has lived long enough to witness and chronicle its long-term consequences.

"I would like to focus my testimony today on a topic of great importance to me, my Tribe and other Contract Health Dependent Area Tribes — recommended changes of the 2001 CHS Allocation Workgroup formula. This formula is used to distribute federal funds for health care services for patients when the local Tribal facility is unable to provide needed services. These recommendations are supported by the Northwest Portland Area Indian Health Board, which represents 43 federally recognized Tribes in the states of Oregon, Washington and Idaho.

"Notwithstanding the significant increase in funding provided to Contract Health Services in FY10 and President Obama's FY11 budget, there is still much to be done. I come from a restored Tribe. I was a young girl when Congress passed the Western Oregon Indian Termination Act ending federal recognition of all western Oregon Tribes, including Grand Ronde. For most Grand Ronde people, Termination meant a loss of home, identity as a Tribe and services from the federal government. After 30 years of hard work and perseverance by Tribal members, the Grand Ronde people convinced Congress in 1983 to reverse its ill-fated Termination decision and restore Grand Ronde's federal recognition.

"As you would expect, Termination forced the vast majority of Grand Ronde Tribal members to leave the reservation in search of work and sustenance. While today many Tribal members are returning to the reservation, Grand Ronde has Tribal members living across the United States and around the world.

"Health care to eligible beneficiaries who reside in our six-county area is provided out of the Grand Ronde Health and Wellness Center, a health care facility built, financed and owned by the Tribe on the Grand Ronde Reservation. The Tribe first contracted with the Indian Health Service (IHS) in 1986 and began running a CHS program. In 1995, the Tribe and IHS entered into a self-governance agreement under Title V of the Indian Self-Determination and Education Assistance Act. Like most of the other Tribes, we have struggled to achieve and maintain a high level of health care service, despite chronic under-funding, especially of CHS funds. The CHS budget is the most important budget item for the Grand Ronde Health and Wellness Center as there are no hospitals in the Portland area, unlike most other IHS areas. This is significant because IHS inpatient hospitals are able to provide services that outpatient clinics cannot.

"This gap in services is otherwise borne by a Tribe's CHS funds. Due to the lack of facilities to deliver health services, Grand Ronde has no choice but to purchase specialty care from the private sector. It is important to understand that the CHS program does not function as an insurance program with a guaranteed benefit package. When CHS funding is depleted, CHS payments are not authorized. The CHS program only covers those services provided to patients who meet CHS eligibility and regulatory requirements, and only when funds are available. Past allocations have missed the most important aspect of the funding formula disparity, which is the fact that IHS areas that have hospitals have a tremendous allocation of H&C funding, plus millions in revenue generated from hospital services that are not included in the CHS formula distribution. By not including these figures in CHS allocations, the IHS has shortchanged non-hospital areas like Portland, California, etc., for years, creating such a burden on CHS funding that quality outcomes are nonexistent.

"The Portland area has been working for many years to address the inadequacies the distribution methodology used by IHS to allocate CHS resources has had on Contract Health Services Dependent Areas. Unlike hospital-based areas that can provide specialty care services, CHS Dependent Areas must purchase all specialty care utilizing CHS resources. IHS hospital-level care can substitute for CHS-purchased services in some areas, but not in others. Yet the annual distribution of CHS funds does not consider this fundamental exchange.

"The funding disparity impacts the ability of Tribes such as Grand Ronde to offer services such as radiology, specialty diagnostics, laboratory and pharmacy services, which tend to be associated with hospital-based facilities. As a former executive director of the Northwest Portland Area Indian Health Board, I am keenly aware of the impacts the 2001 CHS Workgroup formula has had on the ability of Tribes to provide quality health care to their members. The formula is simply not fair.

"I appreciate Dr. Roubideaux's outreach to Indian Country to solicit recommendations on how best to improve the efficiency and effectiveness of the CHS program and acknowledging that changes to the CHS distribution formula may be warranted.

"On March 11, 2010, the Northwest Portland Area Indian Health Board held a listening session with Dr. Roubideaux to discuss recommended programmatic and CHS distribution formula changes specific to CHS Dependent Area Tribes. It is the position of the Portland-area Tribes that the proposed formula developed by the 2001 CHS Workgroup has not been officially adopted by the IHS and that the agency should continue to consult with Tribes over its continued use. It was also recommended Dr. Roubideaux should convene a new CHS Workgroup to revisit the 2001 formula and consider the following recommendations: 1) Alternate resources (Medicaid, Medicare, private insurance and changes under health reform) when making CHS distributions; 2) CHS Dependency; 3) Use of actual medical inflation when allocating CHS funding; 4) The unique circumstances of CHS Dependent Areas must be addressed by the IHS and Congress in national and internal health reform, otherwise these systems will continue to be plagued with chronic under-funding and may be not able to capitalize on health care coverage expansions that will come with health reform; and 5) To address the lack of access to the CHEF, it is recommended that Congress consider establishing an intermediate risk pool for CHS Dependent Areas.

"When Grand Ronde took over the delivery of health care services, our goal was simple: to provide the best possible health care to our people. We wanted to provide a continuum of care to our patients that would include as many possible health services in one location as possible so that the care is provided by physicians who are providers that could be integrated and coordinated. The challenge Grand Ronde has faced in providing health services to its members is an illustration of the impact that CHS under-funding, IHS under-funding and the lack of fairness of the distribution formula has on Tribal health programs and Tribal sovereignty.

"Since Restoration, the Grand Ronde Tribe has worked diligently to develop the foundation necessary to sustain a viable community. We have invested in excess of $100 million to date toward this effort. However, to accomplish our ultimate objective requires an additional investment of hundreds of millions of dollars in areas such as health care, land acquisition, physical infrastructure, government institutional systems, support services and other resources which promote a sustainable community and provide a reasonable opportunity for our people to realize social and economic stability and progress.

"The last two years and the President's proposed FY2011 budget mark positive changes for Indian health funding. All Tribes share in that success if increases in federal funding are distributed fairly. The 2001 Workgroup formula does not meet the test of fairness in the way it was developed or the results that it produces. Grand Ronde, along with the Northwest Portland Area Indian Health Board, is ready, willing and able to work on a new formula that will meet the needs of all Tribes.

"Your attentions to the outlined concerns are greatly appreciated." ■

Kennedy appointed to state Health Improvement Plan Committee

By Dean Rhodes
Smoke Signals editor

Grand Ronde Tribal Chairwoman Cheryle A. Kennedy's decades of experience in health care are being put to use by the state of Oregon.

Tribal Chairwoman Cheryle A. Kennedy

Kennedy was appointed out of 110 applicants to the Oregon Health Improvement Plan Committee by the Oregon Health Policy Board.

The 27-member committee, chaired by Dr. Tammy Bray, dean of the College of Health and Human Sciences and a professor of Nutrition and Medical Biochemistry at Oregon State University, is charged with promoting and supporting lifestyle changes to prevent and manage chronic diseases in Oregon.

The committee's plan will incorporate policy, systems and environmental approaches that promote population health.

Kennedy was selected for her years of experience and expertise in Indian health care, as well as her participation in many statewide health initiatives and her strong interest in improving health among Native Americans. She has worked for 30 years as a health administrator for Tribes, including serving as Grand Ronde health director for almost 15 years.

The Oregon Health Authority launched a strategic planning process in January to create a statewide Health Improvement Plan that will focus on population health and create ways to improve the health of all Oregonians with the goal of reducing health care costs.

The committee will be looking at ways to prevent and reduce tobacco use and obesity, early detection and management of chronic diseases, and addressing other underlying conditions.

Other members of the committee represent a wide variety of health care interests, from the American Diabetes Association to the Oregon Academy of Family Physicians to the Bicycle Transportation Alliance. ■