

Kennedy testifies before Congress

Tribal chairwoman keys in on improved health care funding

By Dean Rhodes

Smoke Signals editor

Tribal Chairwoman Cheryle A. Kennedy was among 18 Native American representatives who testified on Wednesday, May 4, before the House Appropriations Committee's Subcommittee on Interior, Environment and Related Agencies.

Testimony focused on the need to retain adequate funding for American Indian programs throughout Indian Country in the fiscal year 2012 federal budget.

Kennedy's comments are below:

"My name is Cheryle Kennedy and I am the Chairwoman of the Confederated Tribes of the Grand Ronde Community of Oregon. Mr. Simpson, I had the pleasure of working with all of Idaho's Tribes during my tenure as executive director of the Northwest Portland Area Indian Health Board, which represents health care issues of the 43 federally recognized Tribes in Washington, Oregon and Idaho.

"I also have the honor of serving on Secretary Sebelius' Secretary's Tribal Advisory Committee (STAC), the first Tribal advisory committee established to advise the secretary in the history of the Department of Health and Human Services.

"First, I want to thank the Subcommittee for its leadership in addressing the many issues facing Indian Country. 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 Native people and, more importantly, as someone who personally experienced the immediate injustices of federal Termination of her Tribe 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. Specifically, changing the 2001 CHS Allocation Workgroup formula. This formula is used to allocate increases in Contract Health Service (CHS) funding to Tribes. However, it does not fairly account for the unique situation of CHS Dependent Tribes like Grand Ronde.

"Health care to eligible beneficiaries is provided at the Grand Ronde Health and Wellness Center, a health care facility built, financed and owned by the Tribe on the Grand Ronde Reservation. Like most Tribes, we have struggled to achieve and maintain a high level of health care service, given chronic under-funding, especially of CHS funds.

"The CHS budget is the most important budget item for the Grand Ronde Health and Wellness Center. The Portland area has no IHS hospitals or specialty care facilities. This is significant because these

facilities can provide inpatient and specialty care services that outpatient clinics cannot. Unlike hospital-based areas, which can provide these services directly, Grand Ronde and other Portland area Tribes must purchase all specialty and inpatient care services with CHS resources.

"Moreover, hospital-based Areas can bill Medicare, Medicaid and other third-party payers thereby preserving critical CHS funds. CHS Dependent Areas cannot generate third party reimbursements at the same level as hospital-based areas, thus their need for CHS funds is higher.

"Yet neither the annual distribution of CHS funds nor the 2001 CHS Allocation Workgroup formula give sufficient weight to this fundamental difference. 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.

"Due to the lack of facilities to deliver services, Grand Ronde has no choice but to purchase specialty and inpatient care from the private sector using CHS funds. 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.

"As the former executive director of the Northwest Portland Area Indian Health Board, I am keenly aware of the impact 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 acknowledge that changes to the CHS distribution formula may be warranted. 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 CHS Dependent Areas.

"Last year, 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 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 that Dr. Roubideaux convene a new CHS Workgroup to revisit the



Tribal Chairwoman
Cheryle A. Kennedy

2001 formula and consider the following:

"(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 IHS and Congress in national and internal health reform, otherwise these systems will continue to be plagued with chronic underfunding and may not be able to capitalize on health care coverage expansions that will come with health reform;

"And (5) to address the lack of access to the Catastrophic Health Emergency Fund (CHEF), Congress should consider establishing

an intermediate risk pool for CHS Dependent Areas.

"In sum, the 2001 Workgroup formula does not meet the test of fairness in the way it was developed or the results 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.

"In addition to the recommended changes in the 2001 CHS Allocation Formula, I strongly support the IHS Budget Formulation Workgroup requests for a \$118 million increase to be provided for Contract Health Services. Considering the estimated CHS program needs exceeds \$1 billion, the requested increase would greatly assist the many Indian people without access to key medical services.

"I support the Workgroup's request for an increase of \$145 million to fully fund Contract Support Costs (CSC) in FY2012. The Tribal self-determination and self-governance initiatives have been widely recognized as the single greatest contributor to improved health care in American Indian and Alaska Native communities. Successful operation of Tribal health care systems depends on CSC funding being

available to cover fixed costs.

"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 provided by physicians who are providers 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 underfunding, IHS under-funding and the lack of fairness of the distribution formula has on Tribal health programs and Tribal sovereignty.

"Before I conclude my testimony, I would like to add my voice to those advocating for increased funding to address the law enforcement, infrastructure and education needs of Indian Country. There are huge gaps between Tribes' abilities to fund law enforcement and their law enforcement needs. Grand Ronde is responding to community demands for police services by taking steps to establish its own Police Department. Department start-up cost are high, but so is the cost of fear for Tribal members living in rural areas poorly served by county sheriffs, even where Tribal-county agreements for sheriff patrols in Tribal communities are in place.

"Funding needs are especially acute for restored Tribes such as Grand Ronde. During the 1960s and 1970s, the federal government provided Tribes more training, involvement and influence in the process of managing federal funds through, for example, Tribal Priority Allocations for law enforcement, social services, adult vocational training and natural resources management. As Grand Ronde was not restored until 1983, the Tribe was unable to participate in this federal investment in Indian Country.

"The Tribe is playing catch-up from the years its community was neglected following Termination in 1954. Serious efforts must be made to provide restored Tribes with direct funding to assist them in developing fundamental public safety resources and infrastructure in their communities. Federal funds intended for Tribes are often sent first to the states, which may then distribute these funds to Tribal governments. This is inefficient. Funds for Tribal governments should go directly to them.

"As a mother and grandmother, as well as the Tribal Chairwoman, I implore Congress to continue funding for education programs serving Native students, including funding for the Chemawa Indian School. Education is a fundamental component of the federal trust responsibility. The education we provide our children must keep pace with the rapid pace of technological change.

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

"The CHS budget is the most important budget item for the Grand Ronde Health and Wellness Center."

~ Cheryle A. Kennedy