ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
Administrative Offices 4141 Ambassador Drive
Anchorage, Alaska 99508
Telephone: 907-729-1900
Facsimile: 907-729-1901

Testimony of
Don Kashevaroff
Tribal Self-Governance Advisory Committee Representative
to the IHCIA Reauthorization National Steering Committee
President, Seldovia Village Tribe
President and Chairman, Alaska Native Tribal Health Consortium

Senate Committee on Indian Affairs

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Regarding
Reauthorization of the Indian Health Care Improvement Act
The Effects of HHS Consolidation On Narrowing the AI/AN Health Disparities Gap

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INTRODUCTION

Mr. Chairman and members of the Committee, thank you for the opportunity to testify regarding the reauthorization of the Indian Health Care Improvement Act (IHCIA). I appear here today on behalf of the Tribes participating in the Self-Governance program. At the invitation of the Committee, I will also briefly touch upon the impact that Department of Health & Human Services (HHS) consolidation will have on the Indian Health Service and on tribes operating health programs trying to narrow the American Indian/Alaska Native health disparities gap.

The Tribal Self-Governance Advisory Committee (TSGAC) is a committee of tribal leaders convened by the Indian Health Service to address the health care needs of all eligible American Indian/Alaska Natives (AI/AN), especially those served by tribal health programs operated through Self-Governance compacts authorized by Public Law 93-638, as amended. Self-Governance compacts:

- Have been entered into by or on behalf of 279 Tribes;
- Constitute 27.3% of the IHS budget; and
- Serve 33% of the IHS user population.

My experience proves the versatility of Self-Governance. My own tribe, Seldovia Village Tribe, is relatively small – only 414 members. Since taking over the tiny contract health services program in 1991, we have been able to expand our services to the point that we were able to open a small direct service clinic through which we have expanded culturally appropriate services provided as efficiently and economically as one can for a small population.

I contrast this with my experience as President and Chairman of the Board of the Alaska Native Tribal Health Consortium, which is the largest Self-Governance program in America ANTHC manages over $125 million annually in IHS program and project funds. With another tribal organization we operate the only Level II Trauma Center in Alaska, the Alaska Native Medical Center, the premier tertiary care hospital in the Indian Health system. We also manage all of the statewide functions previously performed by the IHS Alaska Area Office, including construction of sanitation facilities throughout rural Alaska, operation of one of the three statewide Community Health Aide Training Programs, public health research, and a statewide telemedicine program to name just a few.

Since the formation of the Alaska Tribal Health Compact of which Seldovia Village Tribe and ANTHC are both signatories, the Alaska Area Office of the Indian Health Service has downsized from 350 to 40. While the remaining functions of the IHS Area Office are critical to our success, the transition we have experienced in Alaska, represented by these two extreme examples, proves the importance of the Self-Governance and of the Indian Health Care Improvement Act.

Thus we take very seriously both the reauthorization of the Indian Health Care Improvement Act, and also HHS consolidation, because both have a direct and significant impact on our operations.

S. 556, INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION

It has been over 25 years since the original enactment of the Indian Health Care Improvement Act. This latest effort at reauthorization, in which this Committee has taken a leadership role, truly proves how much has been accomplished. In 1999, tribes from around the country sent representatives to participate with the Indian Health Service and national Indian organizations, including representatives of the Urban Indian programs, in the National Steering Committee. Building on the strong base of existing law, these tribal leaders, supported by their staff and consultants, undertook to draft our own reauthorization bill – one that would reflect the changes wrought by self-determination and self-governance and the changes that have come about in health care delivery.

This product of an extraordinary effort in national consensus building was the base for S. 556, the bill you have before you. In the four intervening years, work has continued. We have had time to reflect on the 1999 National Steering Committee draft. We have had time to consider issues raised by this body and concerns expressed by the Administration. The National Steering Committee has met many times since 1999, and while we have not had perfect unanimity, we have maintained nearly complete consensus about how best to address these points of view and remain true to the principles that underlie the tribal draft of the reauthorization.

We have had the good fortune to have the opportunity to work closely with staff of both houses, with the support of the House Office of Legislative Counsel, to try to improve upon our initial efforts to produce the best legislation possible. We expect to have a clean draft bill reflecting our latest work available in early April and hope this Committee will consider substituting it for the pending bill. In the meantime, we appreciate the Senate's leadership in conducting hearings on this critical legislation.

While there have been great achievements in improving the health status of American Indians and Alaska Natives, it is the disparities that still are most prominent. Prime among our considerations, is that it is no longer acceptable that the objectives for improvement be lower for American Indians and Alaska Natives than those for the rest of the nation. Thus, we have incorporated the *Healthy People 2010* objectives as our own. They set the benchmark for us, as they do for the nation.

We considered other principles as well. We recognized that while tribal health programs have the good fortune to be part of a national Indian health system, they also have increasingly assumed control of their own health delivery systems and been able to focus more specifically on local needs and demands. They prove the value of local control. Thus, we worked to ensure that tribal autonomy is respected in the bill.

We also approached this bill as the authorization bill that it is, not as an appropriation bill. The Indian health system is desperately under funded. While we deplore that fact, and urge that it be remedied, we cannot as tribal leaders sit back and wait for that day. Thus, we are frustrated by what we consider to be an inflated calculation of the cost of the legislation and are angered by suggestions that it must be pared down. We have never been fully funded and no matter how much we pare down the bill, we will not be fully funded.

For tribes to have the opportunity "to do the best that we can with what we have," however we cannot limit the authority to develop a model system to a few demonstration project sites. We must authorize a modern health care system and strive to achieve it. The experiences in one location will provide the base for improvements in another. Thus, we make the best use of our individual accomplishments and strengths and the entire system improves.

Among the criticisms we have heard is that we have been too aggressive in our pursuit of recovery from the Medicaid and Medicare programs. We have a somewhat different view. The Indian health system did not choose to be reliant on these funding sources. We believe American Indians and Alaska Natives have an absolute right to health care services paid for with the lives and lands of our ancestors. However, the payments have not been made through direct appropriations. Instead, the Congress chose to make us dependent on these other Federal programs to supplement the limited direct appropriations made available. We now merely seek the opportunity to maximize this recovery.

Our goals here have been three. First, that if there is a payment advantage or reimbursable activity available to any other provider, it should be equally available to the Indian health system. Secondly,

the cost of recovery should be limited as much as possible so that limited resources are conserved for direct delivery of health care programs. And, finally, "managed care" and other innovations in delivery and payment models must not interfere with the right of American Indians and Alaska Natives to continue to receive care in the culturally competent health care programs operated by the Indian Health Service and by tribes and tribal organizations. To achieve these goals, we have worked to form a closer relationship with the Centers for Medicare and Medicaid Services. However, in the end, new legislation is needed. It is embodied in our reauthorization proposals.

We have compromised though. Since the initial draft, the National Steering Committee has recentralized certain activities that we initially proposed for area allocation. We have scaled back our effort to authorize a unique Medicare and Medicaid provider type – the Qualified Indian Health Program, which still appears in S. 556 but which, in the updated proposal on which we are working, is reduced to a study of reimbursement in our new proposal.

Now, we need your support. We need your commitment to substitute our new bill as soon as it is available in April, to hold the necessary hearings, and to enact reauthorization this year. We appreciate the challenges facing the Administration and this Congress. We know that your work in support of our troops in Iraq and Afghanistan must take priority. American Indians and Alaska Natives have been disproportionately represented in every military conflict faced by this nation in the last century and this one.

The families of those fighting men and women belong to our communities; the veterans of past service are part of our communities; and these service people will come home, God willing, to our communities. They are fighting to ensure that the American way is preserved. That means progress on front lines other than those in Iraq cannot stop while they are gone. That means that important legislation reflecting America's commitment to its original residents cannot be shelved.

Self-Governance Tribes and the National Steering Committee look forward to working closely with this Committee this year to achieve enactment into law of the Indian Health Care Improvement Act Reauthorization.

THE EFFECTS OF HHS CONSOLIDATION ON THE INDIAN HEALTH SYSTEM

I also appreciate the opportunity to comment briefly on the proposed reorganization of the Department of Health and Human Services and the effects it will have on the Indian health system.

There is little question that the sprawling Department of Health & Human Services is an organizational challenge; nor is there question about the stated objective – "One HHS." I applaud the Secretary for working to improve service, reduce waste and create efficiencies in the Department, similar to what Self Governance Tribes have undertaken since "compacting."

However, as much as we trust the Secretary's intentions, we have some concerns about the potential impact of several elements of the consolidation, that in actuality will not improve service or create efficiencies, including:

(1) IHS Information Technology funding consolidation into the HHS;

(2) IHS Legislative Affairs office consolidation into the HHS;

(3) IHS Human Resource office consolidation into the HHS; and

(4) IHS direct operation and tribal operation budget cuts for managerial reform.

I briefly outline each of these concerns below in the order listed:

1. IHS HUMAN RESOURCE OFFICE CONSOLIDATION INTO HHS

While we believe that the concept of consolidation of Human Resources functions for some HHS operating divisions is sound at the macro-level, we believe the Department needs to acknowledge the unique status and functions of the Indian Health Service, and make exceptions to the consolidation plan in the case of the Indian Health Service because of this status.

Unlike the other HHS operating divisions, the operations of the Indian Health Service are widely-dispersed throughout the United States, primary in small communities and remote, isolated, rural areas. The IHS is unique within HHS in that it must provide direct medical care services and community-based health initiatives. The Indian Health Service is unique in its duty to exercise Indian Preference in hiring and contracting, and to ensure compliance with such legislation as the Indian Child Protection and Family Violence Act. The Indian Health Service is unique in its substantial relationships with tribes and tribal health organizations providing health care to Indian Health Service beneficiaries under self-determination and self-governance agreements.

ANTHC believes that centralizing all of the Indian Health Service Human Resources staffing from all twelve of its area offices and service units to one location in the Washington D.C. area will seriously compromise its ability to fulfill its mission nationwide. We do not believe that a Beltway-based Human Resources office will be able to comprehend, let alone respond adequately to the unique personnel requirements of federal offices and medical facilities located in places like Kotzebue, Alaska or on the Pine Ridge Reservation in South Dakota.

In Alaska, specifically, there are ten Human Resources staff remaining in the Alaska Area Office in Anchorage who will be displaced because of this initiative. Today these individuals work in the same building we do, giving us the opportunity to interact with them daily in the recruiting and support of the federal employees assigned to us and to the other tribal health organizations in Alaska. It is inconceivable that ANTHC would get the same level of service from a Washington-based office as we currently get from this office. E-mail and telephone encounters cannot replace what we have.

Furthermore, resolution of Human Resources issues often involves interaction with the Area Director, the Area Finance office, and other locally-based entities and individuals. Such interaction will be made unnecessarily complicated and ineffective by the proposed consolidation.

Many of these Area Human Resource staff are American Indians and Alaska Natives who are knowledgeable of the unique situations that exist in our state; we believe that the proposed consolidation will result in the loss of this valuable expertise when these employees elect not to relocate and instead seek employment with other federal agencies here in Anchorage. We are certain that the voice on the other end of the phone will not be that of an American Indian or Alaska Native.

Finally, in the negotiation of the Alaska Tribal Health Compact, the unique self-governance agreement between the Indian Health Service and Alaska Native tribes and tribal organizations, we negotiated a written agreement that committed the Indian Health Service to maintain a specific level of such services at the Area Office here in Alaska. This agreement is one of the underpinnings of the overall Compact. The proposed consolidation will violate the fundamental understandings around which this agreement was negotiated.

Consequently, ANTHC believes that the Indian Health Service should be exempted from the proposed national consolidation of HHS Human Resources functions.

2. IHS INFORMATION TECHNOLOGY FUNDING CONSOLIDATION INTO HHS

With regard to information technology needs, IHS and IHS-funded facilities such as those in Alaska are unique within HHS because, unlike other agencies, we provide direct patient care, which requires unique patient data, billing, facility, provider, and management information systems. These are mission critical software systems not only for administrative systems, but for patient care systems which is unique in HHS.

So for IHS-funded Self-Governance Tribes, our ability to build and maintain sufficient IT infrastructure is a critical component to narrowing the health disparities gap. The IT infrastructure is required to help us record individual patient care, measure our health status, plan and manage services, and generate third party revenues to support vital health programs.

However, despite its unique and significant IT needs, IHS grossly under-invests in IT—IT constitutes only about 2% of its annual budget. By comparison, equivalent private sector IT investment typically constitutes 4-5% of a company's annual budget and that is independent of trying to maintain a truly integrated national health information system like RPMS.

Unfortunately, HHS consolidation efforts appear to be only compounding the effects of the IHS's chronic under-investment in IT. In the FY 2004 budget, the HHS reduced the IT budgets of all HHS agencies, including the IHS, expecting consolidation and "economy of scales" to cover the IT need. Although IHS information systems appear to be similar, it is sufficiently unique that consolidation will cost more than any realized savings.

The result: an IHS Information Technology budget in FY 2004 that is $9 million (16%) less than in FY 2003. For Self-Governance Tribes, this leaves us with two options: (1) continue to let the lack of basic health care IT infrastructure hurt the quantity and quality of care we provide to our people; or (2), build and support the IT infrastructure that we need in the long-run by paying for it out of money we need in the short-term for direct patient care, which in turn will still result in a reduction in the quantity and quality of health care that we can provide to our people.

Our conclusion based on the day-to-day reality of running a health program, is that when it comes to the information technology needs of direct-service hospitals and clinics (including those of the IHS, Tribes and Urban Indian organizations), one size does not fit all.

We would strongly urge the Committee to ask HHS to exempt the IHS from HHS IT budget consolidation activities, because further "consolidating" the IHS IT budget would do great harm to our efforts to narrow the AI/AN health disparities gap.

3. IHS LEGISLATIVE AFFAIRS CONSOLIDATION INTO HHS

In its Report on the Fiscal Year 2003 Omnibus Appropriations Act (C.R. S585), The Senate Committee on Appropriations expressed its views on the Administration's proposal to consolidate the IHS Legislative Affairs Office in a most erudite fashion:

> …(T)he (Appropriations) Committee does not agree to the proposed transfer of $838,000 for consolidation of the Legislative Affairs Office at IHS with that of the U.S. Department of Health and Human Services (DHHS). The complexity and variety of issues that surround the provision of health services to Native Americans and Alaska Natives demand an unusual degree of expertise and experience. It is the Committee's view that Native American health issues merit greater emphasis and attention than would be gained in a consolidation at the Department's headquarters level.

Self-Governance Tribes concur with this assessment, and urge the Committee to ask HHS, for the reasons stated by the Senate Committee on Appropriations, to exempt the IHS from HHS' Legislative Affairs Office consolidation efforts. We note the same could be said about the other two consolidation efforts discussed above.

4. IHS DIRECT OPERATION AND TRIBAL OPERATION BUDGET CUTS FOR MANAGERIAL REFORM

In its Report on the Fiscal Year 2003 Omnibus Appropriations Act (C.R. S585), The Senate Committee on Appropriations expressed its views on the Administration's proposal for administrative reductions or transfers in IHS direct operations and tribal operations budgets for managerial reform in a most erudite fashion:

> …(T)he (Appropriations) Committee does not agree to the proposed reductions … from tribal operations and … from direct operations for managerial reforms. The budget estimate indicates that these reductions are to be taken from administrative positions and costs associated with travel, training, copying, and similar activities. In the time period from 1993-2001, the FTE levels at IHS headquarters were reduced by 60 percent. Regional program staffing levels were reduced by 58%. Given these statistics, as well as the vast need for improved services, the Committee cannot support these proposals."

Self-Governance Tribes concur with this assessment, and urge the Committee to ask HHS, for reasons stated by the Senate Committee on Appropriations, to permanently abandon this proposed IHS budget consolidation proposal.

CONCLUSION

In conclusion, I thank Chairman Campbell and the Committee members for this opportunity to share our experiences from the "front lines," and to have a say in legislative and agency policy-making that impacts our operations. I welcome your questions.

For more information, contact:
Don Kashevaroff, President & Chairman
Alaska Native Tribal Health Consortium
4141 Ambassador Drive
Anchorage, Alaska 99508
907-729-1900