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HEARING: The President's Fiscal Year 2005 Budget for the Indian Health Service

WITNESS: Don Kashevaroff, Chairman/President, Alaska Native Tribal Health Consortium

BEFORE: The Senate Committee on Indian Affairs
February 11, 2004, 9:30 AM
Russell Senate Office Building, Room 485

SUMMARY

1. **The President's proposed FY2005 budget for the Indian Health Service is not adequate to make meaningful progress towards achieving the President's goal of narrowing the American Indian/Alaska Native health disparities gap.**

2. **The President's proposed FY 2005 budget for Indian Health Service, by significantly under funding contract support costs for both existing and new and expanded tribal health programs, has created a major disincentive for Tribes to compact IHS programs pursuant to the President's policy goal that, "we don't want the federal government running health care" (Washington Post, Jan 29, 2004).**

INTRODUCTION

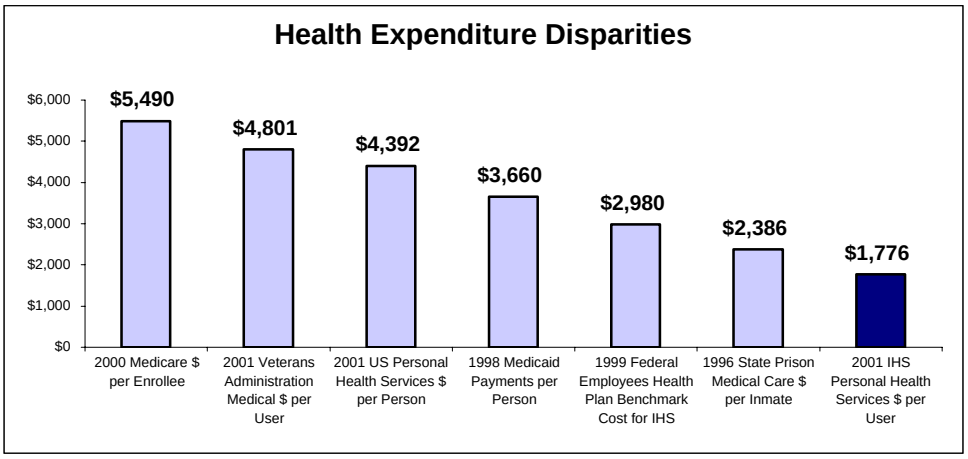
Chairman Campbell and members of the Committee, thank you for the opportunity to testify on the President's 2005 Budget for the Indian Health Service.

By way of introduction, the Alaska Native Tribal Health Consortium is the largest privately managed Indian Health Service program in America, managing over $125 million annually in IHS program and project funds. Our services encompass the Alaska Native Medical Center (ANMC), a 150-bed acute care hospital, as well as the Division of Environmental Health and Engineering (DEHE), which constructs most of the health facility and sanitation systems in rural Alaska.

We employ over 1600 staff in Anchorage and in rural Alaska, including over 600 Indian Health Service employees assigned under Intergovernmental Personnel Agreements and over 100 Commissioned Officers assigned under Memoranda of Agreement. Our vision is *"a unified Native health system, working with our people, achieving the highest health status in the world."*

In short, we are the front line in carrying out the President's mandate to narrow the health disparities gap between Alaska Natives and the general population. It is not an easy task—Alaska Natives have significant health disparities in areas such as cancer rates, respiratory diseases, communicable diseases, alcoholism, diabetes and diseases associated with a lack of basic sanitation systems.

Thus, IHS funding critically impacts our ability to provide adequate primary and tertiary care health services; adequate maintenance and construction funding for village clinics and other facilities; and construction and maintenance of the most basic water and sewer systems in Alaska Native villages.



I've included a graph taken from the recent IHS Business Plan that shows the per capita expenditures of various groups. As you can see, IHS personal health services fall way behind the rest of the population, including expenditures for prisoners.

FUNDING FOR ALASKA TRIBAL HEALTH FALLS FAR SHORT OF THE NEED

Throughout Indian Country, the need for funding to make any sort of significant progress in closing the health disparities gap continues to be a great challenge. At ANMC, for example, we have been challenged with over 10 percent annual growth in patient encounters; nearly 10 percent annual increases in costs; and a fast-growing overall service population, while at the same time, FY 2001 through FY 2004 IHS funding has only increased at levels of 1.96 percent, 3.20 percent, 2.41 percent, and 1.21 percent respectively.

Now compare IHS's small funding increases to other healthcare cost indexes. According to the newly released report by Katie Levit, Director of National Health Statistics Group, CMS, (published in *Health Affairs* -Volume 23, Number 1), Medicare funding grew at 8.5 percent in 2001 and 9.3 percent in 2002. Medicaid expenditures grew by over 10 percent those two years. In addition, drug expenditure growth was over 15 percent in the same years.

This variance between actual costs of operations and actual funding levels has created significant problems for our health care delivery system in Alaska. At ANMC, we suffer from chronic budget shortfalls, recurrent staffing challenges, and severe clinic space shortages. In particular:

- STAFFING COSTS are rising by over $2 million per year. For Fiscal Year 2004, the mandatory Federal employee pay increase was for 4.1 percent, which we had to give to all of our employees, including our hundreds of Federal officers and employees. This cost us $2.3 million. However, our IHS funding for all personnel costs only rose a little more than

$600,000 in that same year. This created a $1.7 million shortfall, which we had no choice but to pay for out of funds that otherwise would have been used for patient care.

- PHARMACEUTICAL COSTS have risen by double digits in each of the last five years, and are now costing us nearly $15 million per year. Because we received only nominal IHS funding increases to help pay for these costs, we have had no choice but to pay for the vast majority of these costs out of funds that otherwise would have been used for patient care.

- FACILITY UPKEEP COSTS must also be made to keep up with our ever-increasing patient encounter volumes. ANMC had to invest over $4 million in facility upgrades the last two years, again, with no IHS funding increase to pay for it, and again, out of funds that otherwise would have been used for direct patient care.

- HEALTH INFORMATION TECHNOLOGY COSTS also continue to rise. Quality patient care, quality medical records systems, effective compliance systems, and effective billing and collections systems require a first rate health information system. ANMC has had to invest over $6 million in information system upgrades, above and beyond the ordinary recurring costs of maintaining our information systems, and will continue to invest heavily in these systems on an ongoing basis in the future. Because we received only nominal IHS funding increases to help pay for these costs, and because paying these costs are critical to narrowing the health disparities gap, we have had no choice but to pay for the vast majority of these costs out of funds that otherwise would have been used for patient care.

The Indian Health Service Business Plan recognized this problem last year when it calculated the number of patients that would not get treatment if IHS did not receive an adequate budget increase. I do not know if anyone has recalculated the figures, but since the last year's budget was quite flat, I suspect that the graph will still be accurate for FY05.

	FY 2003	No Increase	2.2% Increase ($63.4M)	3.75% Increase ($108.1M)	3.75% Plus $80M Increase	6.9% Increase ($199M)
Inpatient Admissions	61,200	55,500 (-9.3%)	56,800 (-7.1%)	57,600 (-5.8%)	58,000 (-5.2%)	61,200
Outpatient Visits	8,293,000	7,671,000 (-7.5%)	7,845,700 (-5.3%)	7,962,000 (-3.9%)	8,012,000 (-3.3%)	8,293,000
Dental Services	2,536,000	2,331,500 (-8.0%)	2,423,000 (-4.4%)	2,451,700 (-3.3%)	2,451,700 (-3.3%)	2,536,000
CHS Outpt. Visits	492,700	484,025 (-1.7%)	484,025 (-1.7%)	487,800 (-0.9%)	500,000 (+1.4%)	492,7000

("Services Projection Summary" shows the relative increases/decreases in performance that might be expected under various budget projections.)

Basically IHS needed $199 million last year to have the same "output level". This was essentially the amount needed to keep from losing ground and serving less Indians than the year before. IHS ended up with a 1.21 percent increase for FY2004. If IHS's assumptions hold true, in FY 04, IHS will have decreased its "output level" by about 4,500 inpatient admissions, 485,000 outpatient visits, 141,000 dental visits and 8,000 CHS visits. Since the Administrations FY2005 budget is near the 2.2 percent increase column, how much more "output" will IHS lose next year?

At our health facility and sanitation division, DEHE, we have determined that statewide, Alaska Native communities have prioritized unmet needs in sanitation facilities that exceed $650 million, and prioritized unmet needs in health facilities that exceed $570 million. While I applaud the Administration adding $10 million to the Sanitation line, the reduction of $37 million from the overall Facility category will not help us bridge the health disparities gap.

Mr. Steve Weaver, Director, DEHE, of the Alaska Native Tribal Health Consortium previously testified to this Committee regarding the details of Alaska's sanitation and health facilities needs from both a numbers perspective and a human perspective. We would refer you to Mr. Weaver's testimony last year as evidence that the President's current proposed funding for facilities and sanitation programs falls far short of what will be needed to make any meaningful impact in the health disparities gap.

I would like to thank the Administration for increasing the Community Health Aides/Practitioners and Contract Health budgets. But the increases while welcome, still fall short of the great need in both areas.

FUNDING FOR CONTRACT SUPPORT COSTS IS INADEQUATE

The Alaska Native Tribal Health Consortium is under funded by over $8 million per year in contract support funding, calculated on the basis of a statutorily-authorized, negotiated contract support cost rate. These chronic underpayments severely undermine our ability to provide services to Alaska Natives.

Although we have been able to cut our administrative overhead to the bare minimum, due in part to excellent management practices, the fact is, allowable contract support costs are very legitimate and very real, as is documented on OMB Cost Principle Circulars A-87 and A-122.

My testimony to you today is that ANTHC is under funded many millions of dollars per year in legitimate contract support costs, and that because we have already cut our actual, OMB-allowable contract support costs to the bare minimum, the amounts that we are under funded do not have the effect of improving our efficiency (which is already optimized), but rather, has the effect of reducing the amounts available for direct health services.

If I may put it more directly: When the government outsources or otherwise enters into a contract with a private firm, it negotiates the best deal it can. As a part of that negotiation, the government and the contractor agree on the total amount, including allowable administrative costs. The government then pays these agreed upon amounts as the private firm carries out the contract.

When the government enters into a contract or compact with a Tribe or tribal organization, it enters into a similar type of negotiation or agreement, including a negotiated allowable amount for contract support costs. However, with Tribes and tribal organizations, the government chronically breaks its agreement on the negotiated contract or compact amount after the fact by significantly under funding contract support costs in the budgeting and appropriations process. Why are Tribal contractors treated worse than private contractors with regard to administration costs?

Taking the President at his word, if it is truly a national policy goal that "the best health care system is that health care system generated in the private markets," and that "we don't want the federal government running health care," I would recommend that this Administration, at all levels, consider reconciling this policy goal with actual contract support cost budgeting and funding processes, which is clearly a disincentive Tribes and tribal organizations from contracting or compacting with the Indian Health Service to carry out the statutory policy purposes of tribal self-determination.

Thank you again for the opportunity to testify before you this morning. I welcome any questions.