DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT
OF
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BEFORE THE
SEANTE COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

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TESTIMONY OF INDIAN HEALTH SERVICE
SENATE COMMITTEE ON INDIAN AFFAIRS OVERSIGHT HEARING
ON
IMPLEMENTATION OF SELF-GOVERNANCE DEMONSTRATION PROJECT

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to discuss the implementation of the Self-Governance Demonstration Project (SGDP) by the Indian Health Service (IHS). I am Michel E. Lincoln, Deputy Director, IHS. I am accompanied by Ms. Luana Reyes, Acting Director of Headquarters Operations, Mr. Reuben Howard, Acting Director, Office of Tribal Self-Governance, and Mr. Douglas Black, Associate Director, Office of Tribal Activities of the IHS.

The spirit and intent of the self-governance law and policy is consistent with the IHS Director's vision that the agency provide for the direct participation of tribes in the development and management of Indian health programs.

The IHS Self-Governance Demonstration Project (SGDP) which provides for the compacting of their health care was authorized in October 1992 pursuant to Public Law 102-573, the Indian Health Amendments of 1992. Last year, P.L. 103-435 extended this authority to 18 years and requires the addition of up to 30 tribes for each fiscal year.

In May 1993, the Agency began its first compact negotiations with tribes under the demonstration authority. Since that time, the Agency has entered into 29 Self-Governance (SG) compacts and 41 annual funding agreements through Fiscal Year (FY) 1995. These compacts transfer approximately $272 million to 197 tribes in Alaska and 28 tribes in the lower 48 states participating in the SGDP. As part of these agreements, we have negotiated the transfer of $248 million in program services and $24 million in IHS administrative funds associated with the transfer of non-residual functions, activities, and services from Area and Headquarters budgets to the tribes to carry out these responsibilities. We are presently beginning the negotiations process for FY 1996.

On April 18, 1995, the Director, IHS, announced three key policy decisions that are critical to the continued implementation of the SGDP in FY 1996. These decisions address important policy questions about residual resources, user population as a factor in resource allocation, and resources allocation methodologies. The Director based his decisions upon the analyses and recommendations made by three Joint Tribal/IHS workgroups, which were established specifically to provide guidance to the Agency in these essential policy areas. These decisions will be refined in FY 1997 and future years.

In summary, the Tribal/IHS Residual Workgroup recommended estimate of $15.56 million as the Headquarters residual, plus the negotiated Area Office Residuals will be used to calculate tribal shares for the FY 1996 compact negotiations. The $15.56 million represents approximately 1 percent of the IHS services budget in FY 1994 dollars.

The Agency plans to use the existing user population definition for the FY 1996 negotiations. While the Tribal/IHS User Population Workgroup recommendation to change the definition to a facilities-based count has merit, the Agency will have to conduct a full analysis of its impact before it could be adopted.

The Tribal Size Adjustment (TSA) methodology recommended by the Joint Allocation Methodology Workgroup has been adopted as the approach that best maintains fairness as a basis for allocating Headquarters General Pool resources. The TSA methodology bases 87 percent of the allocation on population and 13 percent on the total number of tribes. The allocation methods for the remaining categories of funds will be based on longstanding legislative provisions, program experience, and feasibility.

These decisions are critical to the upcoming FY 1996 compact negotiations. They will, of course, also be applicable to the Title I contract negotiations in accordance with Public Law 103-413. The decisions have been communicated to all tribal leaders and the Committee staff was briefed by the Director, IHS, last week. We are prepared to provide additional briefings to the Chairman, members of the Committee, and staff upon request. At this time, we would like to make a copy of the complete packet, including the Director's transmittal letter to tribal leaders sent to the tribes, a part of the record.

The Project is administered by the Office of Tribal Self-Governance (OTSG) in the Office of the Director. Efforts to fill the OTSG Director's position are ongoing. The position was readvertised in March and April of this year after a joint IHS/tribal interview team was unable to reach a consensus on the top three candidates. Upon the interview team's recommendation, the position was re-classified and re-advertised at the SES level. The closing date for the announcement was Friday, April 28, 1995, and, as soon as a panel of qualified applicants is certified, the Agency intends to proceed with the interviews.

Since the inception of the self-governance demonstration project, we have always utilized active tribal consultation and participation in the decision making process in the development of policy. This consultation has occurred through a variety of mechanisms including workgroups, workshops and meetings.

The Agency is committed to implementing the SGDP on a collaborative and proactive basis with tribes. In less than 2 years, we are reaching the point where large transfers of program services and administrative funds are occurring through the compacting process. The Title I amendments made by Public Law 103-413 will accelerate this process as tribes exercise their option to contract for program services and administrative funds on a similar basis to compacting tribes.

We are at a critical juncture in the demonstration project. We must assess the impact of large transfers of funds upon the Agency's ability to carry out its residual functions and to continue providing direct health services to tribes who choose not to contract or compact. The Agency is taking steps to downsize and reorganize in order to free up resources for transfer to tribes but these efforts could be outpaced by the rate of compacting and contracting, given the significant amount of tribal interest.

At this time, the Agency must carefully consider the impact of adding 30 new tribes under the demonstration authority in the coming fiscal year. To assure tribes that the Agency has the ability to make tribal shares readily available to both compacting and contracting tribes, and without causing adverse impact on other tribes, it may be prudent to delay entering new compacts.

The Agency and tribes must also evaluate how the Indian health systems supported by the resources that are being compacted or contracted will be affected. Unintended consequences like the fragmentation of the Indian health program services or reduced access to certain services resulting from the division of limited resources needs to be avoided. We have begun these evaluation efforts by establishing a joint tribal and IHS workgroup that will develop evaluation design requirements for a major independent evaluation study in FY 1997.

The challenge before the Tribes, Indian health programs, the IHS and the Congress is to retain the Indian health programs' applied expertise in core public health functions that are critical to elevating the health status of American Indians/Alaska Natives (AI/ANs) and reducing the disparity in the health status of AI/ANs compared with the general population. We, who are involved in Indian health care, must deal with a changing external environment with new demands, new needs, and new priorities.

The pursuit of increased efficiency, effectiveness, accountability and integrity must be intensified while maintaining our customer focus. As stated in the Director's vision statement for IHS, "Change must be accomplished so that our customer, the American Indian and Alaska Native patient, only notices improved quality of care. The needs of our patients and our communities are always paramount because they honor us when they come to us for care." We must continue to work together in partnership to achieve this goal.

This concludes my prepared statement. We will be pleased to answer any questions that you may have.