

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

WITNESSES

Principal Witness:

Michel E. Lincoln, Deputy Director, Indian Health Service

Accompanied by:

Paula K. Williams, Office of Tribal Self-Governance

Gary J. Hartz, P.E., Assistant Surgeon General, Director, Facilities and Environmental
Engineering

DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATEMENT OF
MICHEL E. LINCOLN, DEPUTY DIRECTOR
INDIAN HEALTH SERVICE
BEFORE THE
COMMITTEE ON RESOURCES
OF THE UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON

H.R. 1833, Tribal Self-Governance Amendments of 1997

March 17, 1998

OPENING STATEMENT
MICHEL E. LINCOLN, DEPUTY DIRECTOR

Mr. Chairman and Members of the Committee:

Good morning. I am Michel E. Lincoln, Deputy Director of the Indian Health Service (IHS).

Accompanying me today are Ms. Paula K. Williams, Director, Office of Tribal Self-Governance and Mr. Gary J. Hartz, Director, Facilities and Environmental Engineering. We are pleased to be here today to discuss H.R. 1833, the "Tribal Self-Governance Amendments of 1997."

The IHS goal is to raise the health status of American Indians and Alaska Natives (AI/ANs) to the highest possible level. The mission is to provide a comprehensive health services delivery system for AI/ANs with opportunity for maximum Tribal involvement in developing and managing programs to meet their health needs. The provision of Federal health services to American Indians and Alaska Natives (AI/ANs) is based upon a special government-to-government relationship between Indian tribes and the United States, which has been reaffirmed throughout the history of this Nation. This relationship has been repeatedly reaffirmed by all three branches of this Nation's government. In 1994, the President issued an Executive Memorandum directing all Federal Departments and Agencies to implement policies and procedures for consulting with Indian Tribes on matters that effect Indian people.

The Self-Governance Demonstration Project has been a success. The tribes participating in this project constitute 45 percent of the federally recognized tribes and they collectively serve over 27 percent of the total IHS users. We anticipate that participation in the Self-Governance Project will continue to grow by approximately 30 tribes per year. This project has provided Tribal Governments the needed local control of their health programs to allow Tribal leadership to implement aggressive and successful health promotion and disease prevention initiatives which are truly responsive to the health needs of their service population. Local control has also provided more ownership by local leadership which has resulted in significant improvements in the quality and quantity of health services. Tribes have been able to increase the number of physicians and clinic sites to make health care more accessible to the people. Others have implemented special services to address the unique needs of the elderly. And, most impressive, tribally operated health facilities are scoring higher in their accreditation reviews than they did under Agency administration. For example, the Chippewa Cree Health Center and laboratory each scored a perfect 100 points and their Chemical Dependency Center Scored 98 points in the accreditation review conducted by the Joint Commission on Accreditation of Health Care Organizations.

The IHS Self-Governance Demonstration Project (SGDP) was authorized in October 1992 pursuant to Public Law 102-573, the Indian Health Amendments of 1992. In May 1993, the Agency began its first compact negotiations with tribes under the demonstration authority. Since that time, the Agency has entered into 39 Self-Governance (SG) Compacts and 55 Annual Funding Agreements (AFA) through Fiscal Year (FY) 1998. These compacts transfer approximately \$410 million to 211 tribes in Alaska and 38 tribes in the lower 48 states participating in the SGDP.

The Administration supports the spirit and intent of the Tribal Self-Governance Amendments. H.R. 1833 is consistent with our goal of providing maximum participation of tribes in the development and management of Indian health programs. Although we have concerns about certain provisions contained in the bill as it was introduced, we are committed to working with the Committee to resolve these issues.

The Agency in consultation with Tribal Governments will continue to conduct an assessment of the impact of continued 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 out paced by increased compacting and certain provisions of this bill.

The challenge before the Tribes, Indian health programs, the IHS and the Congress is to retain the expertise of the Indian Health Services 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.

Efforts to promote Tribal self-determination must likewise allow us to perform inherent functions and maintain our trust responsibility to all Tribes. The Indian Self-Determination and Education Assistant Act (the Act) at present recognizes that there are federal functions that will not be subject to contracting but does not define them, leaving any disputes over such issues to be determined on a case by case basis. We concur with the recommendations of the Department of the Interior's Office of the Solicitor that any final determination of whether a particular activity is inherently federal should be conducted on a case-by-case basis.

Any redesign of IHS programs or eligibility for IHS services resulting from funding agreements must not disenfranchise groups or individuals who are currently eligible for services. Under section 510 of H.R. 1833, as introduced, Tribes could receive funding to provide services to an identified population and through a "redesign" of eligibility for services could restrict services to a different or smaller population. The Agency's eligibility regulations must apply to the proposed new title V in order to ensure IHS has the resources and responsibility to provide services to otherwise eligible American Indians and Alaska Natives. The ability of the Secretary to allocate resources and provide adequate services to members of non-compacting Tribes must be preserved.

While we respect the process of negotiated rulemaking, we believe that it is critical that the Secretary continue to have discretion in determining what regulations will be published. H.R. 1833, as introduced, would prohibit the publication of any regulations unless they are recommended by a negotiated rulemaking committee. Currently, under title I of the Act, regulations are developed in consultation and negotiation with Tribes consistent with the Negotiated Rulemaking Act (5 U.S.C. 561), but the Secretary is the final decision maker in the publication of regulations.

The Act recognizes the unique nature of facilities construction by authorizing a specific process for Tribes to follow when contracting for this activity. The construction methodology developed and demonstrated under Title III has been an important factor in the successful completion of facilities construction projects undertaken by Self-Governance Tribes. We believe the Title III construction process should be further streamlined and made applicable to the proposed new Title V.

Proposed section 505(b) of the Act provides that funding agreements will include Tribal shares of IHS competitive grants for Tribes and individuals. This provision would have an adverse affect on programs established for a specific public purpose with funding awards based on national competition, such as the Indian Health Professions Scholarships and the Tribal Management Grant Program. Title V should be amended to exempt all IHS and Department competitive grant programs which are statutorily authorized by Congress.

The Department supports exploring the extension of a self-governance demonstration to some of its non-IHS programs provided there is time for careful planning and consultation with all affected stakeholders. Efforts to promote self-governance must recognize the very different ways that the Department's programs operate. The potential impact of Tribal operation and the distribution of Tribal shares on Tribes electing not to operate their own programs, on State and local governments, on others operating non-Tribal programs, and on Tribal and non-Tribal program beneficiaries must be more fully assessed. Questions related to the funding of administrative and contract support costs must be adequately addressed. The numerous Congressional committees that have jurisdiction and oversight over the Department's activities should have the opportunity to consider the role of self-governance in non-IHS programs.

Prior to the expansion of a self-governance demonstration to non-IHS programs, we propose to engage in a period of assessment and planning in partnership with Tribes, Tribal organizations, and other program stakeholders, including Congress and State and local governments. This period of study would allow us to examine fundamental questions about the scope and design of a non-IHS demonstration, the roles of stakeholders, methods of ensuring quality and accountability, evaluation, and estimated implementation and administrative costs. We believe this process will take 18 months, and we would be pleased to provide the Congress with a report.

In conclusion, we support making self-governance authority permanent within the IHS, while maintaining the ability of the Agency to perform necessary inherent functions, and to maintain trust responsibility to all Tribes. We also support exploring the expansion of self-governance demonstration authority to non-IHS programs of the Department, after consultation with all stakeholders and more specific guidance from Congress.

I commend you for your commitment to rights of the Nation's Tribes and for providing them opportunities to administer those federal programs affecting the health and welfare of their people. The Indian Health Service and the entire Department of Health and Human Services stand ready to work collaboratively with this Committee, the Congress, and the Tribes to ensure that such efforts are successful.

Mr. Chairman, this concludes my statement. I will be pleased to answer any questions that you may have. Thank You.

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