

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, Director, Office of Tribal Self-Governance, Indian Health Service

Douglas Black, Director, Office of Tribal Programs, Indian Health Service

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

MICHEL E. LINCOLN

DEPUTY DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

INDIAN AFFAIRS COMMITTEE

OF THE

UNITED STATES SENATE

HEARING

ON

S. 979, TRIBAL SELF-GOVERNANCE AMENDMENTS OF 1999

July 28, 1999

STATEMENT OF THE
INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

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

Accompanying me today is Paula K. Williams, Director, Office of Tribal Self-Governance, and Douglas Black, Director, Office of Tribal Programs. We are pleased to be here today to discuss S. 979, the "Tribal Self-Governance Amendments of 1999."

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 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 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 affect Indian people.

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, IHS

began its first compact negotiations with tribes under the demonstration authority. Since that time, the Agency has entered into 42 Self-Governance (SG) Compacts and 59 Annual Funding Agreements (AFA) through Fiscal Year (FY) 1998. These compacts transfer approximately \$549 million to 216 tribes in Alaska and 43 tribes in the lower 48 states participating in the SGDP. These negotiated agreements transfer the funding associated with programs, functions, services and activities assumed by the tribes, from Area and Headquarters budgets to those tribes.

The 259 tribes participating in this project constitute 46.5% of the federally recognized tribes and they collectively serve over 32% of the total IHS users. This Project has provided Tribal Governments the needed local control of their health programs and allows 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. Some have implemented special services to address the unique needs of the elderly. The Mississippi Band of Choctaw Indians Health Center's Radiology Department has been awarded the Nashville Area Radiology Technologist of the Year Award for two consecutive years. In addition, their Health Center's Women's Wellness Center and Choctaw Community Integrated Service System has been recognized by the Department of Health and Human Services, Maternal and Children's Health Bureau, as a "model" for State Health Departments nationwide. 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 Self-Governance Demonstration Project has been a success.

We do need to continue to assess 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 applied expertise of the Indian Health Service in core public health functions that are critical to elevating the health status of American Indians/Alaska Natives 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 Indian Health Service supports the spirit and intent of the Tribal Self-Governance Amendments. S. 979 is consistent with our goal of providing maximum participation of tribes in the development and management of Indian health programs.

In the 105th Congress, the Department closely worked with Congress and the tribes on H.R. 1833, the predecessor legislation to S. 979 and H.R. 1167. Agreement was reached on many points, as was reflected in the version of H.R. 1833 that passed the House on October 5, 1998. The Department testified favorably on H.R. 1833 before this Committee after it passed the House and, with a few exceptions, supported the bill. We would like to highlight for you our major concerns with certain provisions contained in S. 979. In fact, some were concerns we raise with H.R. 1833 last year and again appear in S. 979. While these represent our significant concerns, we acknowledge that there has been a great deal of hard work and a spirit of compromise on the part of all parties that brought us this far. In this same manner, we believe that we will continue to move forward.

Proposed sec. 512(b) -- Facilitation: regulation waiver.

S. 979 appears to have inadvertently dropped the language “promulgated under this act,” from Section 512(b)(1), the effect of which is that the applicability of this provision becomes overly broad applying to regulations promulgated by HHS as well as other Departments thereby creating the potential for unforeseen consequences outside of HHS’ control. As a result of this omission, we have serious concerns with Section 512 (b) (1), particularly in the context of language found in the next paragraph, (b) (2), which specifies that the Secretary shall only deny a waiver if it is otherwise prohibited by Federal law. Taken together, these two provisions are a significant concern.

Title VI, Section 5 -- Amendments Clarifying Civil Proceedings.

Last year, H.R. 1833 contained a de novo standard of judicial review which would have retroactively overruled judicial determinations applying the Administrative Procedures Act (APA) standard of review in ISDA cases. After negotiations with Tribal representatives, the House Committee on Resources and Administration Officials, the de novo provision was removed. We appreciate that this provision has remained out of the current House and Senate bills. However, we continue to have concerns about the remaining section concerning judicial proceedings. As this provision is currently drafted, its impact extends well beyond the scope of self-governance affecting any litigation that is currently on-going between tribes and HHS or the Department of Interior. It would change the burden of proof in favor of the tribes in the middle of such litigation. This change would be in addition to the change effected by Section 507(d) of the bill, which already increases the Secretary's burden of proof to "clear and convincing evidence" prospectively for litigation involving self-governance funding agreements. It is important that the legislation remain litigation neutral. The entire Section 6 in Title VI contained in S. 979 should be removed.

Title V, Section 516 -- Application of Other Sections of The Act.

The proposed section 516 of the new Title V seems to make an inadvertent drafting error which makes it unclear whether funding is subject to the availability of appropriations or is an entitlement irrespective of the funding level of appropriations. We believe that this issue is easily resolved and we will work with

Committee staff to address this error. We also will continue to work with the tribes and the Authorizing and Appropriations Committee to address the ever-growing contract support funding within the annual appropriations. In doing so, we will work collectively to ensure that funding for contract support costs will not adversely affect funding for other IHS programs, including services delivered to non-contracting and non-compacting tribes.

Title V, Section 505 -- Funding Agreements.

Section 505 establishes the scope of IHS programs, services, functions and activities (PFSAs) that are subject to self-governance funding agreements. Last year, Title VI was added to H.R. 1833 to address the Administration's concerns about moving too quickly to include non-IHS PFSAs without first determining whether other Department of Health and Human Services (HHS) programs should be brought within the scope of this self-governance legislation. Hence, Title VI was added to H.R. 1833, and also is included in both S. 979 and H.R. 1167 to authorize a study to assess the feasibility of expanding the scope of this legislation to other HHS programs. We believe that the two provisions of Section 505, (F) and (G), would expand the scope of the PFSAs subject to funding agreements under this legislation to programs outside the IHS, even while the Title VI study is underway. We believe that before any potential expansion of the scope of self-governance funding agreements is authorized, the study authorized in Title VI should be completed and the results analyzed. We will work with you to make sure that different provisions of the bill work together.

In general, we will be happy to work with the Committee to address any of the concerns we have raised as well as any others that may arise. We note that other Federal Departments may have concerns about S. 979. For example, we have been advised by the Department of the Interior that it has serious concerns regarding the definition of the

term “inherent Federal functions”, and recommends that the term not be defined in the bill. It is our understanding that the Department of the Interior plans to send a letter to the Committee setting forth its concerns in greater detail.

I want to express my appreciation to the Title V Tribal Workgroup and to commend their cooperative spirit in working with the IHS and other components of the Department in the evolution of S.979. The version of S. 979 that we are discussing today is the result of many in-depth discussions and a great deal of analysis.

We are pleased to note that the IHS and tribal representatives have successfully negotiated provisions in the bill for tribal assumption of construction projects. The negotiated provisions of the bill authorize a specific process for tribes to elect to carry out construction of health and sanitation facilities as a self-governance activity.

Competitive grant programs such as the Indian Health Professions Scholarships and the Tribal Management Grant Program have been established for specific public purposes. Likewise, the Department and IHS have agency-wide initiatives that address national concerns and are carried out under general grant authorities from general agency funds. All competitive grant programs, including those that support national needs and benefit all Tribes, should be exempted from Tribal shares. We believe that this bill sufficiently addresses our concerns in this area.

In conclusion, we support making self-governance authority permanent within the IHS so long as these changes continue to allow the Department and the IHS to perform its inherent functions and to maintain its trust responsibility to all Tribes. We also support exploring the expansion of self-governance demonstration authority to

non-IHS programs of the Department, but only after consultation with all stakeholders and more specific guidance from Congress.

I commend you for your commitment to rights of the Nation's Indian Tribes and to providing them opportunities to administer those federal programs affecting the health and welfare of their people. The Indian Health Service and the 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. We will be pleased to answer any questions that you may have.

Thank You.