DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATEMENT OF
LUANA L. REYES
DIRECTOR OF HEADQUARTER OPERATIONS
INDIAN HEALTH SERVICE
BEFORE THE
INDIAN AFFAIRS COMMITTEE
OF THE
UNITED STATES SENATE
HEARING
ON
H.R. 1833, Tribal Self-Governance Amendments of 1998
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OPENING STATEMENT
LUANA L. REYES
DIRECTOR OF HEADQUARTERS OPERATIONS
INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

Good morning. I am Luana L. Reyes, Director of Headquarters .Operations-(IHS). Accompanying me today is Paula K. Williams, Director, Office of Tribal Self-Governance. We are pleased to be here today to discuss H.R. 1833, the "Tribal Self-Governance Amendments of 1998."

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 1997, 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 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 1993,1 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. As part of these agreements, we have negotiated the transfer of $347 million in program services and $63 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.

The 249 tribes participating in this project constitute 45% of the federally recognized tribes and they collectively serve over 31% of the total IHS users. We anticipate that participation in the Self-Governance will continue to grow by approximately 15 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 Commission on Accreditation of Health care Organizations.

.The Self-Governance Demonstration Project has been a success. However, we must 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 Indian Health Services's 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 Indian Health Service 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.

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 H.R. 1833. The version of H.R. 1833 we are discussing today is the result of many in-depth discussions and analysis.

Efforts to promote Tribal self-determination must continue to allow us to perform inherent functions and maintain our trust responsibility to all Tribes.

Any redesign of programs or eligibility for services resulting from funding agreements must not disenfranchise groups or individuals who are currently eligible for services. The Department's eligibility regulations must apply to title V in order to ensure IHS and the Department have 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.

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 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.