S. HRG. 106–168

SELF-GOVERNANCE

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

ON

S. 979

TO AMEND THE INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT TO PROVIDE FOR FURTHER SELF-GOVERNANCE BY INDIAN TRIBES

JULY 28, 1999
WASHINGTON, DC

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SELF-GOVERNANCE

WEDNESDAY, JULY 28, 1999

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m. in room 485, Senate Russell Building, Hon. Ben Nighthorse Campbell (chairman of the committee) presiding.

Present: Senators Campbell, Inouye, and Murkowski.

STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO, CHAIRMAN COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. The Committee on Indian Affairs will be in order.

This morning the committee will deal with a bill that I recently introduced, and we have two panels of people that are going to testify.

We've been told we're going to have a vote at 9:45 a.m. and Senator Inouye may not be here, so, unless someone is here that we can keep the flow of the testimony going, I'll have to recess the committee for a few minutes while I run over to vote, but hopefully you'll bear with us on that.

In July 1970, President Nixon delivered his message to Congress, laying the groundwork for what has become the most successful Federal Indian policy to date, Indian self-determination.

Based on the government-to-government relationship, self-governance allows tribes to step into the shoes of the United States and administer Federal programs and services provided by the Bureau of Indian Affairs [BIA] and the Indian Health Service [IHS].

Since its inception, self-governance has resulted in a higher quality of services, more skilled tribal personnel, political and economic self-determination among tribes, and, in many instances, a more-efficient use of scarce Federal dollars.

My colleagues are familiar with the poor state of Native health. Diabetes, cancer, alcoholism, drug abuse, fetal alcohol syndrome, among other diseases, are rampant in Native communities.

Today the committee will receive testimony on S. 979, a bill that I introduced along with Senator McCain, to amend the Indian Self-Determination and Education Assistance Act.

As of 1999, Indian tribes managed some 43 percent of all IHS dollars dedicated to providing health care to Indian people. In just five years, it is projected that the majority of all IHS dollars will

be administered by tribes, either through self-determination contracts or self-governance contracts. The legislation we consider today will facilitate that transaction.

S. 979 will make permanent the IHS self-governance demonstration project within the Department of Health and Human Services. In addition to making the demonstration project permanent, S. 979 would expand self-governance by establishing a demonstration project for other non-IHS-related programs in the IHS.

[Text of S. 979 follows:]

106TH CONGRESS
1ST SESSION

S. 979

To amend the Indian Self-Determination and Education Assistance Act to provide for further self-governance by Indian tribes, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 6, 1999

Mr. CAMPBELL (for himself and Mr. MCCAIN) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

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A BILL

To amend the Indian Self-Determination and Education Assistance Act to provide for further self-governance by Indian tribes, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Tribal Self-Governance Amendments of 1999".

SEC. 2. FINDINGS.

Congress finds that—

(1) the tribal right of self-government flows from the inherent sovereignty of Indian tribes and nations;

1 (2) the United States recognizes a special gov-
2 ernment-to-government relationship with Indian
3 tribes, including the right of the Indian tribes to
4 self-governance, as reflected in the Constitution,
5 treaties, Federal statutes, and the course of dealings
6 of the United States with Indian tribes;
7 (3) although progress has been made, the Fed-
8 eral bureaucracy, with its centralized rules and regu-
9 lations, has eroded tribal self-governance and domi-
10 nates tribal affairs;
11 (4) the Tribal Self-Governance Demonstration
12 Project, established under title III of the Indian
13 Self-Determination and Education Assistance Act
14 (25 U.S.C. 450f note) was designed to improve and
15 perpetuate the government-to-government relation-
16 ship between Indian tribes and the United States
17 and to strengthen tribal control over Federal fund-
18 ing and program management;
19 (5) although the Federal Government has made
20 considerable strides in improving Indian health care,
21 it has failed to fully meet its trust responsibilities
22 and to satisfy its obligations to the Indian tribes
23 under treaties and other laws; and
24 (6) Congress has reviewed the results of the
25 Tribal Self-Governance Demonstration Project and

1 finds that transferring full control and funding to
2 tribal governments, upon tribal request, over deci-
3 sion making for Federal programs, services, func-
4 tions, and activities (or portions thereof)—
5 (A) is an appropriate and effective means
6 of implementing the Federal policy of govern-
7 ment-to-government relations with Indian
8 tribes; and
9 (B) strengthens the Federal policy of In-
10 dian self-determination.

11 **SEC. 3. DECLARATION OF POLICY.**

12 It is the policy of Congress—
13 (1) to permanently establish and implement
14 tribal self-governance within the Department of
15 Health and Human Services;
16 (2) to call for full cooperation from the Depart-
17 ment of Health and Human Services and its con-
18 stituent agencies in the implementation of tribal self-
19 governance—
20 (A) to enable the United States to main-
21 tain and improve its unique and continuing re-
22 lationship with, and responsibility to, Indian
23 tribes;
24 (B) to permit each Indian tribe to choose
25 the extent of its participation in self-governance

1 in accordance with the provisions of the Indian
2 Self-Determination and Education Assistance
3 Act relating to the provision of Federal services
4 to Indian tribes;
5 (C) to ensure the continuation of the trust
6 responsibility of the United States to Indian
7 tribes and Indian individuals;
8 (D) to affirm and enable the United States
9 to fulfill its obligations to the Indian tribes
10 under treaties and other laws;
11 (E) to strengthen the government-to-gov-
12 ernment relationship between the United States
13 and Indian tribes through direct and meaning-
14 ful consultation with all tribes;
15 (F) to permit an orderly transition from
16 Federal domination of programs and services to
17 provide Indian tribes with meaningful authority,
18 control, funding, and discretion to plan, con-
19 duct, redesign, and administer programs, serv-
20 ices, functions, and activities (or portions there-
21 of) that meet the needs of the individual tribal
22 communities;
23 (G) to provide for a measurable parallel re-
24 duction in the Federal bureaucracy as pro-

1 grams, services, functions, and activities (or
2 portion thereof) are assumed by Indian tribes;
3 (H) to encourage the Secretary to identify
4 all programs, services, functions, and activities
5 (or portions thereof) of the Department of
6 Health and Human Services that may be man-
7 aged by an Indian tribe under this Act and to
8 assist Indian tribes in assuming responsibility
9 for such programs, services, functions, and ac-
10 tivities (or portions thereof); and
11 (I) to provide Indian tribes with the earli-
12 est opportunity to administer programs, serv-
13 ices, functions, and activities (or portions there-
14 of) from throughout the Department of Health
15 and Human Services.

16 **SEC. 4. TRIBAL SELF-GOVERNANCE.**

17 The Indian Self-Determination and Education Assist-
18 ance Act (25 U.S.C. 450 et seq.) is amended by adding
19 at the end the following:

20 **"TITLE V—TRIBAL SELF-**
21 **GOVERNANCE**

22 **"SEC. 501. DEFINITIONS.**

23 "(a) IN GENERAL.—In this title:
24 "(1) CONSTRUCTION PROJECT.—The term 'con-
25 struction project'—

1 "(A) means an organized noncontinuous
2 undertaking to complete a specific set of pre-
3 determined objectives for the planning, environ-
4 mental determination, design, construction, re-
5 pair, improvement, or expansion of buildings or
6 facilities, as described in a construction project
7 agreement; and
8 "(B) does not include construction pro-
9 gram administration and activities described in
10 paragraphs (1) through (3) of section 4(m),
11 that may otherwise be included in a funding
12 agreement under this title.
13 "(2) CONSTRUCTION PROJECT AGREEMENT.—
14 The term 'construction project agreement' means a
15 negotiated agreement between the Secretary and an
16 Indian tribe, that at a minimum—
17 "(A) establishes project phase start and
18 completion dates;
19 "(B) defines a specific scope of work and
20 standards by which it will be accomplished;
21 "(C) identifies the responsibilities of the
22 Indian tribe and the Secretary;
23 "(D) addresses environmental consider-
24 ations;

1 "(E) identifies the owner and operations
2 and maintenance entity of the proposed work;
3 "(F) provides a budget;
4 "(G) provides a payment process; and
5 "(H) establishes the duration of the agree-
6 ment based on the time necessary to complete
7 the specified scope of work, which may be 1 or
8 more years.
9 "(3) INHERENT FEDERAL FUNCTIONS.—The
10 term 'inherent Federal functions' means those Fed-
11 eral functions which cannot legally be delegated to
12 Indian tribes.
13 "(4) INTER-TRIBAL CONSORTIUM.—The term
14 'inter-tribal consortium' means a coalition of 2 or
15 more separate Indian tribes that join together for
16 the purpose of participating in self-governance, in-
17 cluding a tribal organization.
18 "(5) GROSS MISMANAGEMENT.—The term
19 'gross mismanagement' means a significant, clear,
20 and convincing violation of a compact, funding
21 agreement, or regulatory, or statutory requirements
22 applicable to Federal funds transferred to an Indian
23 tribe by a compact or funding agreement that re-
24 sults in a significant reduction of funds available for

1 the programs, services, functions, or activities (or
2 portions thereof) assumed by an Indian tribe.
3 "(6) SECRETARY.—The term 'Secretary' means
4 the Secretary of Health and Human Services.
5 "(7) SELF-GOVERNANCE.—The term 'self-gov-
6 ernance' means the program of self-governance es-
7 tablished under section 502.
8 "(8) TRIBAL SHARE.—The term 'tribal share'
9 means an Indian tribe's portion of all funds and re-
10 sources that support secretarial programs, services,
11 functions, and activities (or portions thereof) that
12 are not required by the Secretary for performance of
13 inherent Federal functions.
14 "(b) INDIAN TRIBE.—In any case in which an Indian
15 tribe has authorized another Indian tribe, an inter-tribal
16 consortium, or a tribal organization to plan for or carry
17 out programs, services, functions, or activities (or portions
18 thereof) on its behalf under this title, the authorized In-
19 dian tribe, inter-tribal consortium, or tribal organization
20 shall have the rights and responsibilities of the authorizing
21 Indian tribe (except as otherwise provided in the authoriz-
22 ing resolution or in this title). In such event, the term
23 'Indian tribe' as used in this title shall include such other
24 authorized Indian tribe, inter-tribal consortium, or tribal
25 organization.

1 **"SEC. 502. ESTABLISHMENT.**

2 "The Secretary of Health and Human Services shall
3 establish and carry out a program within the Indian
4 Health Service of the Department of Health and Human
5 Services to be known as the 'Tribal Self-Governance Pro-
6 gram' in accordance with this title.

7 **"SEC. 503. SELECTION OF PARTICIPATING INDIAN TRIBES.**

8 "(a) CONTINUING PARTICIPATION.—Each Indian
9 tribe that is participating in the Tribal Self-Governance
10 Demonstration Project under title III on the date of enact-
11 ment of this title may elect to participate in self-govern-
12 ance under this title under existing authority as reflected
13 in tribal resolution.

14 "(b) ADDITIONAL PARTICIPANTS.—

15 "(1) IN GENERAL.—In addition to those Indian
16 tribes participating in self-governance under sub-
17 section (a), each year an additional 50 Indian tribes
18 that meet the eligibility criteria specified in sub-
19 section (c) shall be entitled to participate in self-gov-
20 ernance.

21 "(2) TREATMENT OF CERTAIN INDIAN
22 TRIBES.—

23 "(A) IN GENERAL.—An Indian tribe that
24 has withdrawn from participation in an inter-
25 tribal consortium or tribal organization, in
26 whole or in part, shall be entitled to participate

1 in self-governance provided the Indian tribe
2 meets the eligibility criteria specified in sub-
3 section (c).
4 "(B) EFFECT OF WITHDRAWAL.—If an In-
5 dian tribe has withdrawn from participation in
6 an inter-tribal consortium or tribal organiza-
7 tion, that Indian tribe shall be entitled to its
8 tribal share of funds supporting those pro-
9 grams, services, functions, and activities (or
10 portions thereof) that the Indian tribe will be
11 carrying out under the compact and funding
12 agreement of the Indian tribe.
13 "(C) PARTICIPATION IN SELF-GOVERN-
14 ANCE.—In no event shall the withdrawal of an
15 Indian tribe from an inter-tribal consortium or
16 tribal organization affect the eligibility of the
17 inter-tribal consortium or tribal organization to
18 participate in self-governance.
19 "(c) APPLICANT POOL.—
20 "(1) IN GENERAL.—The qualified applicant
21 pool for self-governance shall consist of each Indian
22 tribe that—
23 "(A) successfully completes the planning
24 phase described in subsection (d);

1 "(B) has requested participation in self-
2 governance by resolution or other official action
3 by the governing body of each Indian tribe to
4 be served; and
5 "(C) has demonstrated, for the preceding
6 period of 3 full fiscal years, financial stability
7 and financial management capability.
8 "(2) CRITERIA FOR DETERMINING FINANCIAL
9 STABILITY AND FINANCIAL MANAGEMENT CAPAC-
10 ITY.—For purposes of this subsection, evidence that,
11 during the 3-year period referred to in paragraph
12 (1)(C), an Indian tribe had no uncorrected signifi-
13 cant and material audit exceptions in the required
14 annual audit of the Indian tribe's self-determination
15 contracts or self-governance funding agreements
16 with any Federal agency shall be conclusive evidence
17 of the required stability and capability.
18 "(d) PLANNING PHASE.—Each Indian tribe seeking
19 participation in self-governance shall complete a planning
20 phase. The planning phase shall be conducted to the satis-
21 faction of the Indian tribe and shall include—
22 "(1) legal and budgetary research; and
23 "(2) internal tribal government planning and
24 organizational preparation relating to the adminis-
25 tration of health care programs.

1 "(e) GRANTS.—Subject to the availability of appro-
2 priations, any Indian tribe meeting the requirements of
3 paragraphs (2) and (3) of subsection (c) shall be eligible
4 for grants—
5 "(1) to plan for participation in self-governance;
6 and
7 "(2) to negotiate the terms of participation by
8 the Indian tribe or tribal organization in self-govern-
9 ance, as set forth in a compact and a funding agree-
10 ment.
11 "(f) RECEIPT OF GRANT NOT REQUIRED.—Receipt
12 of a grant under subsection (e) shall not be a requirement
13 of participation in self-governance.
14 **"SEC. 504. COMPACTS.**
15 "(a) COMPACT REQUIRED.—The Secretary shall ne-
16 gotiate and enter into a written compact with each Indian
17 tribe participating in self-governance in a manner consist-
18 ent with the Federal Government's trust responsibility,
19 treaty obligations, and the government-to-government re-
20 lationship between Indian tribes and the United States.
21 "(b) CONTENTS.—Each compact required under sub-
22 section (a) shall set forth the general terms of the govern-
23 ment-to-government relationship between the Indian tribe
24 and the Secretary, including such terms as the parties in-

1 tend shall control year after year. Such compacts may only
2 be amended by mutual agreement of the parties.

3 "(c) EXISTING COMPACTS.—An Indian tribe partici-
4 pating in the Tribal Self-Governance Demonstration
5 Project under title III on the date of enactment of this
6 title shall have the option at any time after the date of
7 enactment of this title to—

8 "(1) retain the Tribal Self-Governance Dem-
9 onstration Project compact of that Indian tribe (in
10 whole or in part) to the extent that the provisions
11 of that compact are not directly contrary to any ex-
12 press provision of this title; or

13 "(2) instead of retaining a compact or portion
14 thereof under paragraph (1), negotiate a new com-
15 pact in a manner consistent with the requirements
16 of this title.

17 "(d) TERM AND EFFECTIVE DATE.—The effective
18 date of a compact shall be the date of the approval and
19 execution by the Indian tribe or another date agreed upon
20 by the parties, and shall remain in effect for so long as
21 permitted by Federal law or until terminated by mutual
22 written agreement, retrocession, or reassumption.

23 **"SEC. 505. FUNDING AGREEMENTS.**

24 "(a) FUNDING AGREEMENT REQUIRED.—The Sec-
25 retary shall negotiate and enter into a written funding

1 agreement with each Indian tribe participating in self-gov-
2 ernance in a manner consistent with the Federal Govern-
3 ment's trust responsibility, treaty obligations, and the gov-
4 ernment-to-government relationship between Indian tribes
5 and the United States.

6 "(b) CONTENTS.—

7 "(1) IN GENERAL.—Each funding agreement
8 required under subsection (a) shall, as determined
9 by the Indian tribe, authorize the Indian tribe to
10 plan, conduct, consolidate, administer, and receive
11 full tribal share funding, including tribal shares of
12 discretionary Indian Health Service competitive
13 grants (excluding congressionally earmarked com-
14 petitive grants), for all programs, services, functions,
15 and activities (or portions thereof), that are carried
16 out for the benefit of Indians because of their status
17 as Indians without regard to the agency or office of
18 the Indian Health Service (or of such other agency)
19 within which the program, service, function, or activ-
20 ity (or portion thereof) is performed.

21 "(2) INCLUSION OF CERTAIN PROGRAMS, SERV-
22 ICES, FUNCTIONS, AND ACTIVITIES.—Such pro-
23 grams, services, functions, or activities (or portions
24 thereof) include all programs, services, functions, ac-
25 tivities (or portions thereof) with respect to which

1 Indian tribes or Indians are primary or significant
2 beneficiaries, administered by the Department of
3 Health and Human Services through the Indian
4 Health Service and grants (which may be added to
5 a funding agreement after award of such grants)
6 and all local, field, service unit, area, regional, and
7 central headquarters or national office functions ad-
8 ministered under the authority of—
9 "(A) the Act of November 2, 1921 (42
10 Stat. 208, chapter 115; 25 U.S.C. 13);
11 "(B) the Act of April 16, 1934 (48 Stat.
12 596, chapter 147; 25 U.S.C. 452 et seq.);
13 "(C) the Act of August 5, 1954 (68 Stat.
14 674, chapter 658);
15 "(D) the Indian Health Care Improvement
16 Act (25 U.S.C. 1601 et seq.);
17 "(E) the Indian Alcohol and Substance
18 Abuse Prevention and Treatment Act of 1986
19 (25 U.S.C. 2401 et seq.);
20 "(F) any other Act of Congress authoriz-
21 ing any agency of the Department of Health
22 and Human Services to administer, carry out,
23 or provide financial assistance to such a pro-
24 gram, service, function or activity (or portions
25 thereof) described in this section; or

1 "(G) any other Act of Congress authorizing such a program, service, function, or activity (or portions thereof) under which appropriations are made available to any agency other than an agency within the Department of Health and Human Services, in any case in which the Secretary administers that program, service, function, or activity (or portion thereof).

10 "(c) INCLUSION IN COMPACT OR FUNDING AGREEMENT.—It shall not be a requirement that an Indian tribe or Indians be identified in the authorizing statute for a program or element of a program to be eligible for inclusion in a compact or funding agreement under this title.

15 "(d) FUNDING AGREEMENT TERMS.—Each funding agreement under this title shall set forth—

17 "(1) terms that generally identify the programs, services, functions, and activities (or portions thereof) to be performed or administered; and

20 "(2) for the items identified in paragraph (1)—

21 "(A) the general budget category assigned;

22 "(B) the funds to be provided, including those funds to be provided on a recurring basis;

24 "(C) the time and method of transfer of the funds;

1 "(D) the responsibilities of the Secretary;
2 and
3 "(E) any other provision with respect to
4 which the Indian tribe and the Secretary agree.
5 "(e) SUBSEQUENT FUNDING AGREEMENTS.—Absent
6 notification from an Indian tribe that is withdrawing or
7 retroceding the operation of 1 or more programs, services,
8 functions, or activities (or portions thereof) identified in
9 a funding agreement, or unless otherwise agreed to by the
10 parties, each funding agreement shall remain in full force
11 and effect until a subsequent funding agreement is exe-
12 cuted, and the terms of the subsequent funding agreement
13 shall be retroactive to the end of the term of the preceding
14 funding agreement.
15 "(f) EXISTING FUNDING AGREEMENTS.—Each In-
16 dian tribe participating in the Tribal Self-Governance
17 Demonstration Project established under title III on the
18 date of enactment of this title shall have the option at
19 any time thereafter to—
20 "(1) retain the Tribal Self-Governance Dem-
21 onstration Project funding agreement of that Indian
22 tribe (in whole or in part) to the extent that the pro-
23 visions of that compact are not directly contrary to
24 any express provision of this title; or

1 "(2) instead of retaining a funding agreement
2 portion thereof under paragraph (1), negotiate a
3 new funding agreement in a manner consistent with
4 the requirements of this title.

5 "(g) STABLE BASE FUNDING.—At the option of an
6 Indian tribe, a funding agreement may provide for a stable
7 base budget specifying the recurring funds (including, for
8 purposes of this provision, funds available under section
9 106(a)) to be transferred to such Indian tribe, for such
10 period as may be specified in the funding agreement, sub-
11 ject to annual adjustment only to reflect changes in con-
12 gressional appropriations by sub-sub activity excluding
13 earmarks.

14 **"SEC. 506. GENERAL PROVISIONS.**

15 "(a) APPLICABILITY.—The provisions of this section
16 shall apply to compacts and funding agreements nego-
17 tiated under this title and an Indian tribe may, at its op-
18 tion, include provisions that reflect such requirements in
19 a compact or funding agreement.

20 "(b) CONFLICTS OF INTEREST.—Indian tribes par-
21 ticipating in self-governance under this title shall ensure
22 that internal measures are in place to address conflicts
23 of interest in the administration of self-governance pro-
24 grams, services, functions, or activities (or portions there-
25 of).

1 "(c) AUDITS.—

2 "(1) SINGLE AGENCY AUDIT ACT.—The provi-
3 sions of chapter 75 of title 31, United States Code,
4 requiring a single agency audit report shall apply to
5 funding agreements under this title.

6 "(2) COST PRINCIPLES.—An Indian tribe shall
7 apply cost principles under the applicable Office of
8 Management and Budget Circular, except as modi-
9 fied by section 106, or by any exemptions to applica-
10 ble Office of Management and Budget Circulars sub-
11 sequently granted by the Office of Management and
12 Budget. No other audit or accounting standards
13 shall be required by the Secretary. Any claim by the
14 Federal Government against the Indian tribe relat-
15 ing to funds received under a funding agreement
16 based on any audit under this subsection shall be
17 subject to the provisions of section 106(f).

18 "(d) RECORDS.—

19 "(1) IN GENERAL.—Unless an Indian tribe
20 specifies otherwise in the compact or funding agree-
21 ment, records of the Indian tribe shall not be consid-
22 ered Federal records for purposes of chapter 5 of
23 title 5, United States Code.

24 "(2) RECORDKEEPING SYSTEM.—The Indian
25 tribe shall maintain a recordkeeping system, and,

1 after 30 days advance notice, provide the Secretary
2 with reasonable access to such records to enable the
3 Department of Health and Human Services to meet
4 its minimum legal recordkeeping system require-
5 ments under sections 3101 through 3106 of title 44,
6 United States Code.

7 "(e) REDESIGN AND CONSOLIDATION.—An Indian
8 tribe may redesign or consolidate programs, services, func-
9 tions, and activities (or portions thereof) included in a
10 funding agreement under section 313 and reallocate or re-
11 direct funds for such programs, services, functions, and
12 activities (or portions thereof) in any manner which the
13 Indian tribe deems to be in the best interest of the health
14 and welfare of the Indian community being served, only
15 if the redesign or consolidation does not have the effect
16 of denying eligibility for services to population groups oth-
17 erwise eligible to be served.

18 "(f) RETROCESSION.—An Indian tribe may retro-
19 cede, fully or partially, to the Secretary programs, serv-
20 ices, functions, or activities (or portions thereof) included
21 in the compact or funding agreement. Unless the Indian
22 tribe rescinds the request for retrocession, such retroces-
23 sion will become effective within the timeframe specified
24 by the parties in the compact or funding agreement. In

1 the absence of such a specification, such retrocession shall
2 become effective on—
3 "(1) the earlier of—
4 "(A) 1 year after the date of submission of
5 such request; or
6 "(B) the date on which the funding agree-
7 ment expires; or
8 "(2) such date as may be mutually agreed upon
9 by the Secretary and the Indian tribe.
10 "(g) WITHDRAWAL.—
11 "(1) PROCESS.—
12 "(A) IN GENERAL.—An Indian tribe may
13 fully or partially withdraw from a participating
14 inter-tribal consortium or tribal organization its
15 share of any program, function, service, or ac-
16 tivity (or portions thereof) included in a com-
17 pact or funding agreement.
18 "(B) EFFECTIVE DATE.—The withdrawal
19 referred to in subparagraph (A) shall become
20 effective within the timeframe specified in the
21 resolution which authorizes transfer to the par-
22 ticipating tribal organization or inter-tribal con-
23 sortium. In the absence of a specific timeframe
24 set forth in the resolution, such withdrawal
25 shall become effective on—

1 "(i) the earlier of—

2 "(I) 1 year after the date of sub-

3 mission of such request; or

4 "(II) the date on which the fund-

5 ing agreement expires; or

6 "(ii) such date as may be mutually

7 agreed upon by the Secretary, the with-

8 drawing Indian tribe, and the participating

9 tribal organization or inter-tribal consor-

10 tium that has signed the compact or fund-

11 ing agreement on behalf of the withdraw-

12 ing Indian tribe, inter-tribal consortium, or

13 tribal organization.

14 "(2) DISTRIBUTION OF FUNDS.—When an In-

15 dian tribe or tribal organization eligible to enter into

16 a self-determination contract under title I or a com-

17 pact or funding agreement under this title fully or

18 partially withdraws from a participating inter-tribal

19 consortium or tribal organization—

20 "(A) the withdrawing Indian tribe or tribal

21 organization shall be entitled to its tribal share

22 of funds supporting those programs, services,

23 functions, or activities (or portions thereof) that

24 the Indian tribe will be carrying out under its

25 own self-determination contract or compact and

1 funding agreement (calculated on the same
2 basis as the funds were initially allocated in the
3 funding agreement of the inter-tribal consor-
4 tium or tribal organization); and
5 "(B) the funds referred to in subparagraph
6 (A) shall be transferred from the funding agree-
7 ment of the inter-tribal consortium or tribal or-
8 ganization, on the condition that the provisions
9 of sections 102 and 105(i), as appropriate, shall
10 apply to that withdrawing Indian tribe.
11 "(3) REGAINING MATURE CONTRACT STATUS.—
12 If an Indian tribe elects to operate all or some pro-
13 grams, services, functions, or activities (or portions
14 thereof) carried out under a compact or funding
15 agreement under this title through a self-determina-
16 tion contract under title I, at the option of the In-
17 dian tribe, the resulting self-determination contract
18 shall be a mature self-determination contract.
19 "(h) NONDUPLICATION.—For the period for which,
20 and to the extent to which, funding is provided under this
21 title or under the compact or funding agreement, the In-
22 dian tribe shall not be entitled to contract with the Sec-
23 retary for such funds under section 102, except that such
24 Indian tribe shall be eligible for new programs on the same
25 basis as other Indian tribes.

1 **"SEC. 507. PROVISIONS RELATING TO THE SECRETARY.**

2 "(a) MANDATORY PROVISIONS.—

3 "(1) HEALTH STATUS REPORTS.—Compacts or
4 funding agreements negotiated between the Sec-
5 retary and an Indian tribe shall include a provision
6 that requires the Indian tribe to report on health
7 status and service delivery—

8 "(A) to the extent such data is not other-
9 wise available to the Secretary and specific
10 funds for this purpose are provided by the Sec-
11 retary under the funding agreement; and

12 "(B) if such reporting shall impose mini-
13 mal burdens on the participating Indian tribe
14 and such requirements are promulgated under
15 section 517.

16 "(2) REASSUMPTION.—

17 "(A) IN GENERAL.—Contracts or funding
18 agreements negotiated between the Secretary
19 and an Indian tribe shall include a provision
20 authorizing the Secretary to reassume operation
21 of a program, service, function, or activity (or
22 portions thereof) and associated funding if
23 there is a specific finding relative to that pro-
24 gram, service, function, or activity (or portion
25 thereof) of—

1 "(i) imminent endangerment of the
2 public health caused by an act or omission
3 of the Indian tribe, and the imminent
4 endangerment arises out of a failure to
5 carry out the compact or funding agree-
6 ment; or
7 "(ii) gross mismanagement with re-
8 spect to funds transferred to a tribe by a
9 compact or funding agreement, as deter-
10 mined by the Secretary in consultation
11 with the Inspector General, as appropriate.
12 "(B) PROHIBITION.—The Secretary shall
13 not reassume operation of a program, service,
14 function, or activity (or portions thereof) un-
15 less—
16 "(i) the Secretary has first provided
17 written notice and a hearing on the record
18 to the Indian tribe; and
19 "(ii) the Indian tribe has not taken
20 corrective action to remedy the imminent
21 endangerment to public health or gross
22 mismanagement.
23 "(C) EXCEPTION.—
24 "(i) IN GENERAL.—Notwithstanding
25 subparagraph (B), the Secretary may,

1 upon written notification to the Indian
2 tribe, immediately reassume operation of a
3 program, service, function, or activity (or
4 portion thereof) if—
5 "(I) the Secretary makes a find-
6 ing of imminent substantial and irrep-
7 arable endangerment of the public
8 health caused by an act or omission of
9 the Indian tribe; and
10 "(II) the endangerment arises
11 out of a failure to carry out the com-
12 pact or funding agreement.
13 "(ii) REASSUMPTION.—If the Sec-
14 retary reassumes operation of a program,
15 service, function, or activity (or portion
16 thereof) under this subparagraph, the Sec-
17 retary shall provide the Indian tribe with a
18 hearing on the record not later than 10
19 days after such reassumption.
20 "(D) HEARINGS.—In any hearing or ap-
21 peal involving a decision to reassume operation
22 of a program, service, function, or activity (or
23 portion thereof), the Secretary shall have the
24 burden of proof of demonstrating by clear and

1 convincing evidence the validity of the grounds
2 for the reassumption.
3 "(b) FINAL OFFER.—In the event the Secretary and
4 a participating Indian tribe are unable to agree, in whole
5 or in part, on the terms of a compact or funding agree-
6 ment (including funding levels), the Indian tribe may sub-
7 mit a final offer to the Secretary. Not more than 45 days
8 after such submission, or within a longer time agreed upon
9 by the Indian tribe, the Secretary shall review and make
10 a determination with respect to such offer. In the absence
11 of a timely rejection of the offer, in whole or in part, made
12 in compliance with subsection (c), the offer shall be
13 deemed agreed to by the Secretary.
14 "(c) REJECTION OF FINAL OFFERS.—
15 "(1) IN GENERAL.—If the Secretary rejects an
16 offer made under subsection (b) (or 1 or more provi-
17 sions or funding levels in such offer), the Secretary
18 shall provide—
19 "(A) a timely written notification to the
20 Indian tribe that contains a specific finding
21 that clearly demonstrates, or that is supported
22 by a controlling legal authority, that—
23 "(i) the amount of funds proposed in
24 the final offer exceeds the applicable fund-

1 ing level to which the Indian tribe is enti-
2 tled under this title;
3 "(ii) the program, function, service, or
4 activity (or portion thereof) that is the
5 subject of the final offer is an inherent
6 Federal function that cannot legally be del-
7 egated to an Indian tribe;
8 "(iii) the Indian tribe cannot carry
9 out the program, function, service, or ac-
10 tivity (or portion thereof) in a manner that
11 would not result in significant danger or
12 risk to the public health; or
13 "(iv) the Indian tribe is not eligible to
14 participate in self-governance under section
15 503;
16 "(B) technical assistance to overcome the
17 objections stated in the notification required by
18 subparagraph (A);
19 "(C) the Indian tribe with a hearing on the
20 record with the right to engage in full discovery
21 relevant to any issue raised in the matter and
22 the opportunity for appeal on the objections
23 raised, except that the Indian tribe may, in lieu
24 of filing such appeal, directly proceed to initiate

1 an action in a Federal district court pursuant
2 to section 110(a); and
3 "(D) the Indian tribe with the option of
4 entering into the severable portions of a final
5 proposed compact or funding agreement, or
6 provision thereof, (including a lesser funding
7 amount, if any), that the Secretary did not re-
8 ject, subject to any additional alterations nec-
9 essary to conform the compact or funding
10 agreement to the severed provisions.
11 "(2) EFFECT OF EXERCISING CERTAIN OP-
12 TION.—If an Indian tribe exercises the option speci-
13 fied in paragraph (1)(D), that Indian tribe shall re-
14 tain the right to appeal the Secretary's rejection
15 under this section, and subparagraphs (A), (B), and
16 (C) of that paragraph shall only apply to that por-
17 tion of the proposed final compact, funding agree-
18 ment, or provision thereof that was rejected by the
19 Secretary.
20 "(d) BURDEN OF PROOF.—With respect to any hear-
21 ing or appeal or civil action conducted pursuant to this
22 section, the Secretary shall have the burden of dem-
23 onstrating by clear and convincing evidence the validity
24 of the grounds for rejecting the offer (or a provision there-
25 of) made under subsection (b).

1 "(e) GOOD FAITH.—In the negotiation of compacts
2 and funding agreements the Secretary shall at all times
3 negotiate in good faith to maximize implementation of the
4 self-governance policy. The Secretary shall carry out this
5 title in a manner that maximizes the policy of tribal self-
6 governance, in a manner consistent with the purposes
7 specified in section 3 of the Tribal Self-Governance
8 Amendments of 1999.

9 "(f) SAVINGS.—To the extent that programs, func-
10 tions, services, or activities (or portions thereof) carried
11 out by Indian tribes under this title reduce the administra-
12 tive or other responsibilities of the Secretary with respect
13 to the operation of Indian programs and result in savings
14 that have not otherwise been included in the amount of
15 tribal shares and other funds determined under section
16 508(c), the Secretary shall make such savings available
17 to the Indian tribes, inter-tribal consortia, or tribal organi-
18 zations for the provision of additional services to program
19 beneficiaries in a manner equitable to directly served, con-
20 tracted, and compacted programs.

21 "(g) TRUST RESPONSIBILITY.—The Secretary is pro-
22 hibited from waiving, modifying, or diminishing in any
23 way the trust responsibility of the United States with re-
24 spect to Indian tribes and individual Indians that exists

1 under treaties, Executive orders, other laws, or court deci-
2 sions.

3 "(h) DECISIONMAKER.—A decision that constitutes
4 final agency action and relates to an appeal within the
5 Department of Health and Human Services conducted
6 under subsection (c) shall be made either—

7 "(1) by an official of the Department who holds
8 a position at a higher organizational level within the
9 Department than the level of the departmental agen-
10 cy in which the decision that is the subject of the
11 appeal was made; or

12 "(2) by an administrative judge.

13 **"SEC. 508. TRANSFER OF FUNDS.**

14 "(a) IN GENERAL.—Pursuant to the terms of any
15 compact or funding agreement entered into under this
16 title, the Secretary shall transfer to the Indian tribe all
17 funds provided for in the funding agreement, pursuant to
18 subsection (c), and provide funding for periods covered by
19 joint resolution adopted by Congress making continuing
20 appropriations, to the extent permitted by such resolu-
21 tions. In any instance where a funding agreement requires
22 an annual transfer of funding to be made at the beginning
23 of a fiscal year, or requires semiannual or other periodic
24 transfers of funding to be made commencing at the begin-
25 ning of a fiscal year, the first such transfer shall be made

1 not later than 10 days after the apportionment of such
2 funds by the Office of Management and Budget to the
3 Department, unless the funding agreement provides other-
4 wise.

5 "(b) MULTIYEAR FUNDING.—The Secretary may em-
6 ploy, upon tribal request, multiyear funding agreements.
7 References in this title to funding agreements shall include
8 such multiyear funding agreements.

9 "(c) AMOUNT OF FUNDING.—The Secretary of
10 Health and Human Services shall provide funds under a
11 funding agreement under this title in an amount equal to
12 the amount that the Indian tribe would have been entitled
13 to receive under self-determination contracts under this
14 Act, including amounts for direct program costs specified
15 under section 106(a)(1) and amounts for contract support
16 costs specified under section 106(a) (2), (3), (5), and (6),
17 including any funds that are specifically or functionally
18 related to the provision by the Secretary of services and
19 benefits to the Indian tribe or its members, all without
20 regard to the organizational level within the Department
21 where such functions are carried out.

22 "(d) PROHIBITIONS.—

23 "(1) IN GENERAL.—Except as provided in para-
24 graph (2), the Secretary is expressly prohibited
25 from—

1 "(A) failing or refusing to transfer to an
2 Indian tribe its full share of any central, head-
3 quarters, regional, area, or service unit office or
4 other funds due under this Act, except as re-
5 quired by Federal law;
6 "(B) withholding portions of such funds
7 for transfer over a period of years; and
8 "(C) reducing the use of funds, from the
9 the amount of funds that the Secretary is au-
10 thorized to use under this title—
11 "(i) to make funding available for
12 self-governance monitoring or administra-
13 tion by the Secretary;
14 "(ii) in subsequent years, except pur-
15 suant to—
16 "(I) a reduction in appropria-
17 tions from the previous fiscal year for
18 the program or function to be in-
19 cluded in a compact or funding agree-
20 ment;
21 "(II) a congressional directive in
22 legislation or accompanying report;
23 "(III) a tribal authorization;

1 "(IV) a change in the amount of
2 pass-through funds subject to the
3 terms of the funding agreement; or
4 "(V) completion of a project, ac-
5 tivity, or program for which such
6 funds were provided;
7 "(iii) to pay for Federal functions, in-
8 cluding Federal pay costs, Federal em-
9 ployee retirement benefits, automated data
10 processing, technical assistance, and mon-
11 itoring of activities under this Act; or
12 "(iv) to pay for costs of Federal per-
13 sonnel displaced by self-determination con-
14 tracts under this Act or self-governance;
15 "(2) EXCEPTION.—The funds described in
16 paragraph (1)(C) may be increased by the Secretary
17 if necessary to carry out this Act or as provided in
18 section 105(c)(2).
19 "(e) OTHER RESOURCES.—In the event an Indian
20 tribe elects to carry out a compact or funding agreement
21 with the use of Federal personnel, Federal supplies (in-
22 cluding supplies available from Federal warehouse facili-
23 ties), Federal supply sources (including lodging, airline
24 transportation, and other means of transportation includ-
25 ing the use of interagency motor pool vehicles) or other

1 Federal resources (including supplies, services, and re-
2 sources available to the Secretary under any procurement
3 contracts in which the Department is eligible to partici-
4 pate), to the extent allowable under law, the Secretary
5 shall acquire and transfer such personnel, supplies, or re-
6 sources to the Indian tribe.

7 "(f) REIMBURSEMENT TO INDIAN HEALTH SERV-
8 ICE.—With respect to functions transferred by the Indian
9 Health Service to an Indian tribe, the Indian Health Serv-
10 ice is authorized to provide goods and services to the In-
11 dian tribe, on a reimbursable basis, including payment in
12 advance with subsequent adjustment. The reimbursements
13 received from those goods and services, along with the
14 funds received from the Indian tribe pursuant to this title,
15 may be credited to the same or subsequent appropriation
16 account which provided the funding, such amounts to re-
17 main available until expended.

18 "(g) PROMPT PAYMENT ACT.—Chapter 39 of title
19 31, United States Code, shall apply to the transfer of
20 funds due under a compact or funding agreement author-
21 ized under this title.

22 "(h) INTEREST OR OTHER INCOME ON TRANS-
23 FERS.—An Indian tribe is entitled to retain interest
24 earned on any funds paid under a compact or funding
25 agreement to carry out governmental or health purposes

1 and such interest shall not diminish the amount of funds
2 the Indian tribe is authorized to receive under its funding
3 agreement in the year the interest is earned or in any sub-
4 sequent fiscal year. Funds transferred under this title
5 shall be managed using the prudent investment standard.
6 "(i) CARRYOVER OF FUNDS.—All funds paid to an
7 Indian tribe in accordance with a compact or funding
8 agreement shall remain available until expended. In the
9 event that an Indian tribe elects to carry over funding
10 from 1 year to the next, such carryover shall not diminish
11 the amount of funds the Indian tribe is authorized to re-
12 ceive under its funding agreement in that or any subse-
13 quent fiscal year.
14 "(j) PROGRAM INCOME.—All medicare, medicaid, or
15 other program income earned by an Indian tribe shall be
16 treated as supplemental funding to that negotiated in the
17 funding agreement. The Indian tribe may retain all such
18 income and expend such funds in the current year or in
19 future years except to the extent that the Indian Health
20 Care Improvement Act (25 U.S.C. 1601 et seq.) provides
21 otherwise for medicare and medicaid receipts. Such funds
22 shall not result in any offset or reduction in the amount
23 of funds the Indian tribe is authorized to receive under
24 its funding agreement in the year the program income is
25 received or for any subsequent fiscal year.

1 "(k) LIMITATION OF COSTS.—An Indian tribe shall
2 not be obligated to continue performance that requires an
3 expenditure of funds in excess of the amount of funds
4 transferred under a compact or funding agreement. If at
5 any time the Indian tribe has reason to believe that the
6 total amount provided for a specific activity in the com-
7 pact or funding agreement is insufficient the Indian tribe
8 shall provide reasonable notice of such insufficiency to the
9 Secretary. If the Secretary does not increase the amount
10 of funds transferred under the funding agreement, the In-
11 dian tribe may suspend performance of the activity until
12 such time as additional funds are transferred.

13 **"SEC. 509. CONSTRUCTION PROJECTS.**

14 "(a) IN GENERAL.—Indian tribes participating in
15 tribal self-governance may carry out construction projects
16 under this title if they elect to assume all Federal respon-
17 sibilities under the National Environmental Policy Act of
18 1969 (42 U.S.C. 4321 et seq.), the National Historic
19 Preservation Act (16 U.S.C. 470 et seq.), and related pro-
20 visions of law that would apply if the Secretary were to
21 undertake a construction project, by adopting a resolu-
22 tion—

23 "(1) designating a certifying officer to rep-
24 resent the Indian tribe and to assume the status of
25 a responsible Federal official under such laws; and

1 "(2) accepting the jurisdiction of the Federal
2 court for the purpose of enforcement of the respon-
3 sibilities of the responsible Federal official under
4 such environmental laws.

5 "(b) NEGOTIATIONS.—Construction project proposals
6 shall be negotiated pursuant to the statutory process in
7 section 105(m) and resulting construction project agree-
8 ments shall be incorporated into funding agreements as
9 addenda.

10 "(c) CODES AND STANDARDS.—The Indian tribe and
11 the Secretary shall agree upon and specify appropriate
12 building codes and architectural and engineering stand-
13 ards (including health and safety) which shall be in con-
14 formity with nationally recognized standards for com-
15 parable projects.

16 "(d) RESPONSIBILITY FOR COMPLETION.—The In-
17 dian tribe shall assume responsibility for the successful
18 completion of the construction project in accordance with
19 the negotiated construction project agreement.

20 "(e) FUNDING.—Funding for construction projects
21 carried out under this title shall be included in funding
22 agreements as annual advance payments, with semiannual
23 payments at the option of the Indian tribe. Annual ad-
24 vance and semiannual payment amounts shall be deter-
25 mined based on mutually agreeable project schedules re-

1 flecting work to be accomplished within the advance pay-
2 ment period, work accomplished and funds expended in
3 previous payment periods, and the total prior payments.
4 The Secretary shall include associated project contingency
5 funds with each advance payment installment. The Indian
6 tribe shall be responsible for the management of the con-
7 tingency funds included in funding agreements.

8 "(f) APPROVAL.—The Secretary shall have at least
9 1 opportunity to approve project planning and design doc-
10 uments prepared by the Indian tribe in advance of con-
11 struction of the facilities specified in the scope of work
12 for each negotiated construction project agreement or
13 amendment thereof which results in a significant change
14 in the original scope of work. The Indian tribe shall pro-
15 vide the Secretary with project progress and financial re-
16 ports not less than semiannually. The Secretary may con-
17 duct onsite project oversight visits semiannually or on an
18 alternate schedule agreed to by the Secretary and the In-
19 dian tribe.

20 "(g) WAGES.—All laborers and mechanics employed
21 by contractors and subcontractors in the construction, al-
22 teration, or repair, including painting or decorating of a
23 building or other facilities in connection with construction
24 projects undertaken by self-governance Indian tribes
25 under this Act, shall be paid wages at not less than those

1 prevailing wages on similar construction in the locality as
2 determined by the Indian tribe.

3 "(h) APPLICATION OF OTHER LAWS.—Unless other-
4 wise agreed to by the Indian tribe, no provision of the Of-
5 fice of Federal Procurement Policy Act, the Federal Ac-
6 quisition Regulations issued pursuant thereto, or any
7 other law or regulation pertaining to Federal procurement
8 (including Executive orders) shall apply to any construc-
9 tion project conducted under this title.

10 **"SEC. 510. FEDERAL PROCUREMENT LAWS AND REGULA-**
11 **TIONS.**

12 "Notwithstanding any other provision of law, unless
13 expressly agreed to by the participating Indian tribe, the
14 compacts and funding agreements entered into under this
15 title shall not be subject to Federal contracting or coopera-
16 tive agreement laws and regulations (including Executive
17 orders and the regulations relating to procurement issued
18 by the Secretary), except to the extent that such laws ex-
19 pressly apply to Indian tribes.

20 **"SEC. 511. CIVIL ACTIONS.**

21 "(a) CONTRACT DEFINED.—For the purposes of sec-
22 tion 110, the term 'contract' shall include compacts and
23 funding agreements entered into under this title.

24 "(b) APPLICABILITY OF CERTAIN LAWS.—Section
25 2103 of the Revised Statutes (25 U.S.C. 81) and section

1 16 of the Act of June 18, 1934 (48 Stat. 987; chapter
2 576; 25 U.S.C. 476), shall not apply to attorney and other
3 professional contracts entered into by Indian tribes par-
4 ticipating in self-governance under this title.

5 "(c) REFERENCES.—All references in this Act to sec-
6 tion 1 of the Act of June 26, 1936 (49 Stat. 1967; chapter
7 831) are hereby deemed to include the first section of the
8 Act of July 3, 1952 (66 Stat. 323, chapter 549; 25 U.S.C.
9 82a).

10 **"SEC. 512. FACILITATION.**

11 "(a) SECRETARIAL INTERPRETATION.—Except as
12 otherwise provided by law, the Secretary shall interpret
13 all Federal laws, Executive orders and regulations in a
14 manner that will facilitate—

15 "(1) the inclusion of programs, services, func-
16 tions, and activities (or portions thereof) and funds
17 associated therewith, in the agreements entered into
18 under this section;

19 "(2) the implementation of compacts and fund-
20 ing agreements entered into under this title; and

21 "(3) the achievement of tribal health goals and
22 objectives.

23 "(b) REGULATION WAIVER.—

24 "(1) IN GENERAL.—An Indian tribe may sub-
25 mit a written request to waive application of a regu-

1 lation for a compact or funding agreement entered
2 into with the Indian Health Service under this title,
3 to the Secretary identifying the applicable Federal
4 regulation sought to be waived and the basis for the
5 request.

6 "(2) APPROVAL.—Not later than 90 days after
7 receipt by the Secretary of a written request by an
8 Indian tribe to waive application of a regulation for
9 a compact or funding agreement entered into under
10 this title, the Secretary shall either approve or deny
11 the requested waiver in writing. A denial may be
12 made only upon a specific finding by the Secretary
13 that identified language in the regulation may not be
14 waived because such waiver is prohibited by Federal
15 law. A failure to approve or deny a waiver request
16 not later than 90 days after receipt shall be deemed
17 an approval of such request. The Secretary's deci-
18 sion shall be final for the Department.

19 "(c) ACCESS TO FEDERAL PROPERTY.—In connec-
20 tion with any compact or funding agreement executed pur-
21 suant to this title or an agreement negotiated under the
22 Tribal Self-Governance Demonstration Project established
23 under title III, as in effect before the enactment of the
24 Tribal Self-Governance Amendments of 1999, upon the re-
25 quest of an Indian tribe, the Secretary—

1 "(1) shall permit an Indian tribe to use existing
2 school buildings, hospitals, and other facilities and
3 all equipment therein or appertaining thereto and
4 other personal property owned by the Government
5 within the Secretary's jurisdiction under such terms
6 and conditions as may be agreed upon by the Sec-
7 retary and the Indian tribe for their use and mainte-
8 nance;

9 "(2) may donate to an Indian tribe title to any
10 personal or real property found to be excess to the
11 needs of any agency of the Department, or the Gen-
12 eral Services Administration, except that—

13 "(A) subject to the provisions of subpara-
14 graph (B), title to property and equipment fur-
15 nished by the Federal Government for use in
16 the performance of the compact or funding
17 agreement or purchased with funds under any
18 compact or funding agreement shall, unless oth-
19 erwise requested by the Indian tribe, vest in the
20 appropriate Indian tribe;

21 "(B) if property described in subparagraph
22 (A) has a value in excess of $5,000 at the time
23 of retrocession, withdrawal, or reassumption, at
24 the option of the Secretary upon the retroces-
25 sion, withdrawal, or reassumption, title to such

1 property and equipment shall revert to the De-
2 partment of Health and Human Services; and
3 "(C) all property referred to in subpara-
4 graph (A) shall remain eligible for replacement,
5 maintenance, and improvement on the same
6 basis as if title to such property were vested in
7 the United States; and
8 "(3) shall acquire excess or surplus Government
9 personal or real property for donation to an Indian
10 tribe if the Secretary determines the property is ap-
11 propriate for use by the Indian tribe for any purpose
12 for which a compact or funding agreement is author-
13 ized under this title.
14 "(d) MATCHING OR COST-PARTICIPATION REQUIRE-
15 MENT.—All funds provided under compacts, funding
16 agreements, or grants made pursuant to this Act, shall
17 be treated as non-Federal funds for purposes of meeting
18 matching or cost participation requirements under any
19 other Federal or non-Federal program.
20 "(e) STATE FACILITATION.—States are hereby au-
21 thorized and encouraged to enact legislation, and to enter
22 into agreements with Indian tribes to facilitate and supple-
23 ment the initiatives, programs, and policies authorized by
24 this title and other Federal laws benefiting Indians and
25 Indian tribes.

1 "(f) RULES OF CONSTRUCTION.—Each provision of
2 this title and each provision of a compact or funding
3 agreement shall be liberally construed for the benefit of
4 the Indian tribe participating in self-governance and any
5 ambiguity shall be resolved in favor of the Indian tribe.
6 **"SEC. 513. BUDGET REQUEST.**
7 "(a) IN GENERAL.—
8 "(1) IN GENERAL.—The President shall iden-
9 tify in the annual budget request submitted to Con-
10 gress under section 1105 of title 31, United States
11 Code, all funds necessary to fully fund all funding
12 agreements authorized under this title, including
13 funds specifically identified to fund tribal base budg-
14 ets. All funds so appropriated shall be apportioned
15 to the Indian Health Service. Such funds shall be
16 provided to the Office of Tribal Self-Governance
17 which shall be responsible for distribution of all
18 funds provided under section 505.
19 "(2) RULE OF CONSTRUCTION.—Nothing in
20 this subsection shall be construed to authorize the
21 Indian Health Service to reduce the amount of funds
22 that a self-governance tribe is otherwise entitled to
23 receive under its funding agreement or other appli-
24 cable law, whether or not such funds are appor-

1 tioned to the Office of Tribal Self-Governance under
2 this section.
3 "(b) PRESENT FUNDING; SHORTFALLS.—In such
4 budget request, the President shall identify the level of
5 need presently funded and any shortfall in funding (in-
6 cluding direct program and contract support costs) for
7 each Indian tribe, either directly by the Secretary of
8 Health and Human Services, under self-determination
9 contracts, or under compacts and funding agreements au-
10 thorized under this title.
11 **"SEC. 514. REPORTS.**
12 "(a) ANNUAL REPORT.—
13 "(1) IN GENERAL.—Not later than January 1
14 of each year after the date of enactment of the Trib-
15 al Self-Governance Amendments of 1999, the Sec-
16 retary shall submit to the Committee on Indian Af-
17 fairs of the Senate and the Committee on Resources
18 of the House of Representatives a written report re-
19 garding the administration of this title.
20 "(2) ANALYSIS.—The report under paragraph
21 (1) shall include a detailed analysis of the level of
22 need being presently funded or unfunded for each
23 Indian tribe, either directly by the Secretary, under
24 self-determination contracts under title I, or under
25 compacts and funding agreements authorized under

1 this Act. In compiling reports pursuant to this sec-
2 tion, the Secretary may not impose any reporting re-
3 quirements on participating Indian tribes or tribal
4 organizations, not otherwise provided in this Act.
5 "(b) CONTENTS.—The report under subsection (a)
6 shall—
7 "(1) be compiled from information contained in
8 funding agreements, annual audit reports, and data
9 of the Secretary regarding the disposition of Federal
10 funds; and
11 "(2) identify—
12 "(A) the relative costs and benefits of self-
13 governance;
14 "(B) with particularity, all funds that are
15 specifically or functionally related to the provi-
16 sion by the Secretary of services and benefits to
17 self-governance Indian tribes and their mem-
18 bers;
19 "(C) the funds transferred to each self-
20 governance Indian tribe and the corresponding
21 reduction in the Federal bureaucracy;
22 "(D) the funding formula for individual
23 tribal shares of all headquarters funds, together
24 with the comments of affected Indian tribes or

1 tribal organizations, developed under subsection
2 (c); and
3 "(E) amounts expended in the preceding
4 fiscal year to carry out inherent Federal func-
5 tions, including an identification of those func-
6 tions by type and location;
7 "(2) contain a description of the method or
8 methods (or any revisions thereof) used to determine
9 the individual tribal share of funds controlled by all
10 components of the Indian Health Service (including
11 funds assessed by any other Federal agency) for in-
12 clusion in self-governance compacts or funding
13 agreements;
14 "(3) before being submitted to Congress, be dis-
15 tributed to the Indian tribes for comment (with a
16 comment period of no less than 30 days, beginning
17 on the date of distribution); and
18 "(4) include the separate views and comments
19 of the Indian tribes or tribal organizations.
20 "(c) REPORT ON FUND DISTRIBUTION METHOD.—
21 Not later than 180 days after the date of enactment of
22 the Tribal Self-Governance Amendments of 1999, the Sec-
23 retary shall, after consultation with Indian tribes, submit
24 a written report to the Committee on Resources of the
25 House of Representatives and the Committee on Indian

1 Affairs of the Senate which describes the method or meth-
2 ods used to determine the individual tribal share of funds
3 controlled by all components of the Indian Health Service
4 (including funds assessed by any other Federal agency)
5 for inclusion in self-governance compacts or funding
6 agreements.

7 **"SEC. 515. DISCLAIMERS.**

8 "(a) NO FUNDING REDUCTION.—Nothing in this
9 title shall be construed to limit or reduce in any way the
10 funding for any program, project, or activity serving an
11 Indian tribe under this or other applicable Federal law.
12 Any Indian tribe that alleges that a compact or funding
13 agreement is in violation of this section may apply the pro-
14 visions of section 110.

15 "(b) FEDERAL TRUST AND TREATY RESPONSIBIL-
16 ITIES.—Nothing in this Act shall be construed to diminish
17 in any way the trust responsibility of the United States
18 to Indian tribes and individual Indians that exists under
19 treaties, Executive orders, or other laws and court deci-
20 sions.

21 "(c) TRIBAL EMPLOYMENT.—For purposes of section
22 2(2) of the Act of July 5, 1935 (49 Stat. 450, chapter
23 372) (commonly known as the 'National Labor Relations
24 Act'), an Indian tribe carrying out a self-determination
25 contract, compact, annual funding agreement, grant, or

1 cooperative agreement under this Act shall not be consid-
2 ered an employer.
3 "(d) OBLIGATIONS OF THE UNITED STATES.—The
4 Indian Health Service under this Act shall neither bill nor
5 charge those Indians who may have the economic means
6 to pay for services, nor require any Indian tribe to do so.
7 **"SEC. 516. APPLICATION OF OTHER SECTIONS OF THE ACT.**
8 "(a) MANDATORY APPLICATION.—All provisions of
9 sections 5(b), 6, 7, 102 (c) and (d), 104, 105 (k) and (l),
10 106 (c) through (k), and 111 of this Act and section 314
11 of Public Law 101–512 (coverage under chapter 171 of
12 title 28, United States Code, commonly known as the
13 'Federal Tort Claims Act'), to the extent not in conflict
14 with this title, shall apply to compacts and funding agree-
15 ments authorized by this title.
16 "(b) DISCRETIONARY APPLICATION.—At the request
17 of a participating Indian tribe, any other provision of title
18 I, to the extent such provision is not in conflict with this
19 title, shall be made a part of a funding agreement or com-
20 pact entered into under this title. The Secretary is obli-
21 gated to include such provision at the option of the partici-
22 pating Indian tribe or tribes. If such provision is incor-
23 porated it shall have the same force and effect as if it
24 were set out in full in this title. In the event an Indian
25 tribe requests such incorporation at the negotiation stage

1 of a compact or funding agreement, such incorporation
2 shall be deemed effective immediately and shall control the
3 negotiation and resulting compact and funding agreement.

4 **"SEC. 517. REGULATIONS.**

5 "(a) IN GENERAL.—

6 "(1) PROMULGATION.—Not later than 90 days
7 after the date of enactment of the Tribal Self-Gov-
8 ernance Amendments of 1999, the Secretary shall
9 initiate procedures under subchapter III of chapter
10 5 of title 5, United States Code, to negotiate and
11 promulgate such regulations as are necessary to
12 carry out this title.

13 "(2) PUBLICATION OF PROPOSED REGULA-
14 TIONS.—Proposed regulations to implement this title
15 shall be published in the Federal Register by the
16 Secretary no later than 1 year after the date of en-
17 actment of the Tribal Self-Governance Amendments
18 of 1999.

19 "(3) EXPIRATION OF AUTHORITY.—The author-
20 ity to promulgate regulations under paragraph (1)
21 shall expire 21 months after the date of enactment
22 of the Tribal Self-Governance Amendments of 1999.

23 "(b) COMMITTEE.—

24 "(1) IN GENERAL.—A negotiated rulemaking
25 committee established pursuant to section 565 of

1 title 5, United States Code, to carry out this section
2 shall have as its members only Federal and tribal
3 government representatives, a majority of whom
4 shall be nominated by and be representatives of In-
5 dian tribes with funding agreements under this Act.
6 "(2) REQUIREMENTS.—The committee shall
7 confer with, and accommodate participation by, rep-
8 resentatives of Indian tribes, inter-tribal consortia,
9 tribal organizations, and individual tribal members.
10 "(c) ADAPTATION OF PROCEDURES.—The Secretary
11 of Health and Human Services shall adapt the negotiated
12 rulemaking procedures to the unique context of self-gov-
13 ernance and the government-to-government relationship
14 between the United States and Indian tribes.
15 "(d) EFFECT.—The lack of promulgated regulations
16 shall not limit the effect of this title.
17 "(e) EFFECT OF CIRCULARS, POLICIES, MANUALS,
18 GUIDANCES, AND RULES.—Unless expressly agreed to by
19 the participating Indian tribe in the compact or funding
20 agreement, the participating Indian tribe shall not be sub-
21 ject to any agency circular, policy, manual, guidance, or
22 rule adopted by the Indian Health Service, except as pro-
23 vided in section 105(g).

1 **"SEC. 518. APPEALS.**

2 "In any appeal (including civil actions) involving deci-
3 sions made by the Secretary under this title, the Secretary
4 shall have the burden of proof of demonstrating by clear
5 and convincing evidence—

6 "(1) the validity of the grounds for the decision
7 made; and

8 "(2) that the decision is fully consistent with
9 provisions and policies of this title.

10 **"SEC. 519. AUTHORIZATION OF APPROPRIATIONS.**

11 "There are authorized to be appropriated such sums
12 as may be necessary to carry out this title.".

13 **SEC. 5. TRIBAL SELF-GOVERNANCE DEPARTMENT.**

14 The Indian Self-Determination and Education Assist-
15 ance Act (25 U.S.C. 450 et seq.) is amended by adding
16 at the end the following:

17 "TITLE VI—TRIBAL SELF-GOV-
18 ERNANCE—DEPARTMENT OF
19 HEALTH AND HUMAN SERV-
20 ICES

21 **"SEC. 601. DEFINITIONS.**

22 "(a) IN GENERAL.—In this title, the Secretary may
23 apply the definitions contained in title V.

24 "(b) OTHER DEFINITIONS.—In this title:

25 "(1) AGENCY.—The term the term 'agency'
26 means any agency or other organizational unit of the

1 Department of Health and Human Services, other
2 than the Indian Health Service.
3 "(2) SECRETARY.—The term 'Secretary' means
4 the Secretary of Health and Human Services.

5 **"SEC. 602. DEMONSTRATION PROJECT FEASIBILITY.**

6 "(a) STUDY.—The Secretary shall conduct a study
7 to determine the feasibility of a tribal self-governance
8 demonstration project for appropriate programs, services,
9 functions, and activities (or portions thereof) of the agen-
10 cy.
11 "(b) CONSIDERATIONS.—In conducting the study,
12 the Secretary shall consider—
13 "(1) the probable effects on specific programs
14 and program beneficiaries of such a demonstration
15 project;
16 "(2) statutory, regulatory, or other impedi-
17 ments to implementation of such a demonstration
18 project;
19 "(3) strategies for implementing such a dem-
20 onstration project;
21 "(4) probable costs or savings associated with
22 such a demonstration project;
23 "(5) methods to assure quality and accountabil-
24 ity in such a demonstration project; and

1 "(6) such other issues that may be determined
2 by the Secretary or developed through consultation
3 pursuant to section 605.
4 "(c) REPORT.—Not later than 18 months after the
5 date of enactment of this title, the Secretary shall submit
6 a report to the Committee on Indian Affairs of the Senate
7 and the Committee on Resources of the House of Rep-
8 resentatives. The report shall contain—
9 "(1) the results of the study under this section;
10 "(2) a list of programs, services, functions, and
11 activities (or portions thereof) within each agency
12 with respect to which it would be feasible to include
13 in a tribal self-governance demonstration project;
14 "(3) a list of programs, services, functions, and
15 activities (or portions thereof) included in the list
16 provided pursuant to paragraph (2) that could be in-
17 cluded in a tribal self-governance demonstration
18 project without amending statutes, or waiving regu-
19 lations that the Secretary may not waive;
20 "(4) a list of legislative actions required in
21 order to include those programs, services, functions,
22 and activities (or portions thereof) included in the
23 list provided pursuant to paragraph (2) but not in-
24 cluded in the list provided pursuant to paragraph

1 (3) in a tribal self-governance demonstration project;
2 and
3 "(5) any separate views of tribes and other en-
4 tities consulted pursuant to section 603 related to
5 the information provided pursuant to paragraphs (1)
6 through (4).

7 **"SEC. 603. CONSULTATION.**

8 "(a) STUDY PROTOCOL.—
9 "(1) CONSULTATION WITH INDIAN TRIBES.—
10 The Secretary shall consult with Indian tribes to de-
11 termine a protocol for consultation under subsection
12 (b) prior to consultation under such subsection with
13 the other entities described in such subsection.
14 "(2) REQUIREMENTS FOR PROTOCOL.—The
15 protocol shall require, at a minimum, that—
16 "(A) the government-to-government rela-
17 tionship with Indian tribes forms the basis for
18 the consultation process;
19 "(B) the Indian tribes and the Secretary
20 jointly conduct the consultations required by
21 this section; and
22 "(C) the consultation process allows for
23 separate and direct recommendations from the
24 Indian tribes and other entities described in
25 subsection (b).

1 "(b) CONDUCTING STUDY.—In conducting the study
2 under this title, the Secretary shall consult with Indian
3 tribes, States, counties, municipalities, program bene-
4 ficiaries, and interested public interest groups, and may
5 consult with other entities as appropriate.

6 **"SEC. 604. AUTHORIZATION OF APPROPRIATIONS.**

7 "There are authorized to be appropriated for fiscal
8 years 2000 and 2001 such sums as may be necessary to
9 carry out this title. Such sums shall remain available until
10 expended.".

11 **SEC. 6. AMENDMENTS CLARIFYING CIVIL PROCEEDINGS.**

12 (a) BURDEN OF PROOF IN DISTRICT COURT AC-
13 TIONS.—Section 102(e)(1) of the Indian Self-Determina-
14 tion and Education Assistance Act (25 U.S.C. 450f(e)(1))
15 is amended by inserting after "subsection (b)(3)" the fol-
16 lowing: "or any civil action conducted pursuant to section
17 110(a)".

18 (b) EFFECTIVE DATE.—The amendments made by
19 subsection (a) shall apply to any proceedings commenced
20 after October 25, 1994.

21 **SEC. 7. SPEEDY ACQUISITION OF GOODS, SERVICES, OR**
22 **SUPPLIES.**

23 Section 105(k) of the Indian Self-Determination and
24 Education Assistance Act (25 U.S.C. 450j(k)) is amend-
25 ed—

1 (1) by striking "deemed an executive agency"
2 and inserting "deemed an executive agency and part
3 of the Indian Health Service"; and
4 (2) by adding at the end the following: "At the
5 request of an Indian tribe, the Secretary shall enter
6 into an agreement for the acquisition, on behalf of
7 the Indian tribe, of any goods, services, or supplies
8 available to the Secretary from the General Services
9 Administration or other Federal agencies that are
10 not directly available to the Indian tribe under this
11 section or any other Federal law, including acquisi-
12 tions from prime vendors. All such acquisitions shall
13 be undertaken through the most efficient and speedy
14 means practicable, including electronic ordering ar-
15 rangements.

16 **SEC. 8. REPEAL.**

17 (a) IN GENERAL.—Title III of the Indian Self-Deter-
18 mination and Education Assistance Act (25 U.S.C. 450f
19 note) is hereby repealed.
20 (b) EFFECTIVE DATE.—This section shall take effect
21 on October 1, 1999.

22 **SEC. 9. SAVINGS PROVISION.**

23 Funds appropriated for title III of the Indian Self-
24 Determination and Education Assistance Act (25 U.S.C.

1 450f note) shall be available for use under title V of such

2 Act.

The CHAIRMAN. I would like to call our first witness, which will be Michel Lincoln, and we'll start with your statement.

I would tell all the people who are going to testify, too, that your complete written testimony will be included in the record and you may wish to abbreviate.

I might also say to you, Mr. Lincoln, it is my understanding that your department has known about this bill since June. We didn't receive your testimony until 8 p.m. last night, so I haven't had a chance to go over it very much. But if you are invited before the committee again, if you can get your testimony in a little earlier, we'd certainly appreciate it so we can look at it.

STATEMENT OF MICHEL LINCOLN, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY PAULA WILLIAMS, DIRECTOR, OFFICE OF TRIBAL SELF-GOVERNANCE AND DOUGLAS BLACK, DIRECTOR, OFFICE OF TRIBAL PROGRAMS, INDIAN HEALTH SERVICE

Mr. LINCOLN. Yes, Mr. Chairman; thank you. Thank you very much for having this hearing, to begin with, and I do apologize for getting the written opening statement to you at such a late time. We were literally working until 9 p.m. or 10 p.m. last night as we were negotiating this statement with the Department and with the Office of Management and Budget.

Mr. Chairman, I would like to introduce two very key people to the entire self-governance effort that is occurring within the Indian Health Service.

First of all, to my left is Paula Williams. Paula is the director of the Office of Tribal Self-Governance and is an individual who has been involved in self-governance for many years, actually since its inception, both on the tribal side and then we had the good fortune, in working with the self-governance tribes, in having Ms. Williams apply for the position of the director of the office and be selected.

She enjoys the support of the director of the IHS, I believe in a very significant way, but she also is the—I think is the key individual that we look to guide us from a policy and from an operational standpoint as we continue to progress in self-governance.

She is an individual of integrity and an individual that I know the committee will continue to work with.

On my right is Douglas Black. Mr. Black is the director of our Office of Tribal Programs and is an individual also who was involved in self-governance from the Indian Health Service perspective, initially as we got the demonstration language in title 3. That title was made available to us and we started moving into self-governance.

Much of the progress associated, I think, in those early years was Mr. Black taking great risks and unpopular positions as we moved forward to implement, in advance of any real guidance from the agency, department, and others.

Mr. Black also is an individual who handles title one contracting, works with tribes who do not contract as of this moment, and is an individual who we rely on relative to contract support cost policy.

So, with those two individuals, I hope we will be able to be responsive to the committee's questions.

I appreciate you mentioning that the testimony provided here is part of the record, and so I will just summarize very, very briefly what is in our testimony.

First of all, I would like to point out that the—I think the understanding of the Indian Health Service and of the department relative to this very special government-to-government relationship that exists between Indian tribes and the United States, and at all levels of the United States throughout the three branches of government, it is—I believe this bill, I believe S. 979 kind of reaffirms that government-to-government relationship and reaffirms those actions that have been taken by the executive, legislative, and judicial branches.

Second, I think I would be remiss of not relating S. 979 to the mission and the goal of Indian Health Service, which is, I believe, the goal and mission of every Indian tribe in this country relative to the health of their individual citizens, and that is to raise their health status to the highest level possible, but also it is the mission to provide comprehensive health service delivery systems for our citizens, with the opportunity for maximum tribal involvement.

I think that is a real key. It is the combination of raising health status with the tribes in control and with their maximum involvement. I think this legislation takes us in that direction forcefully.

I would like to mention and kind of give you just a status, and I'll repeat just a couple of numbers that you have given, Mr. Chairman.

We do have 42 self-governance compacts and 59 annual funding agreements in place today. These represent approximately $549 million that are being utilized by 259 tribes in providing health care services, preventive health services, and other important community development activities that have resulted in those successes that you've mentioned before.

We believe that this is a most successful program. We believe an integral component of that success is the control exercised by tribal governments on behalf of their own citizens.

I would like to mention that, as tribes hire more physicians and more providers, as they increase those numbers, they, indeed, have expanded access to health services for their tribal members.

We have some shining examples that are written in the testimony, such as the Rocky Boy—a quite remarkable success in acquiring a 100 percent score through the Joint Commission on Accreditation of Health Care Organizations for their facility and for their chemical dependency center, a score of 98.

In addition, there are just numerous examples of how tribes are being creative in using these resources to improve their health services at the same time as tribal government develops and expands.

I would like to make just a few more very brief comments.

Before I just briefly outline what issues remain to be resolved, I want to describe briefly a process that, over the last couple of years, has resulted in S. 979. That process has involved tribal governments and their representatives, has involved the Indian Health Service, the Department of Health and Human Services,

other executive branch agencies, and the Congress, itself—your staff to your committee as with the staff within the House.

In the beginning of that process, there were in excess of 60 issues that we had disagreements on or that we had to clarify, and over the years this team, this very large team representing all these different interests, have managed to resolve almost all of those issues.

We now find ourselves with a very great opportunity presented to you and Mr. McCain through S. 979 to actually provide permanent authorization and permanent legislation for the self-governance effort that has occurred over the last half a dozen years within the Indian Health Service.

I mention the process only in that it is our understanding, it is our belief that even the remaining issues where there needs to be further agreement can be worked out through a process that involves the tribal governments, the Executive branch, and your committee. We believe and are committed to work with you on that basis.

Having said that, I would like to point out that there are a couple of areas that we would like to have continuing discussions with you and with the tribal representatives, and I'll be very brief about them.

There is an area of regulation waiver that appears in section 512(b)(1) that we believe must be reviewed and must be further discussed.

This section essentially would provide—would cause regulations, in our opinion, to be interpreted in an overly-broad manner, and it might affect other departments, but it also might affect various agencies, in addition to the Indian Health Service, within the Department of Health and Human Services. And we believe that we'll need to talk through this to a greater extent to make sure that we all have the same understanding of how these regulations will impact on the Indian Health Service and other agencies.

In addition, there is a section 512(b)(2) that deals with waivers that the Secretary can use, and it is the Department's position that this section may unduly limit the Secretary's ability to provide waivers, and we want to continue our discussion in that regard.

There is a section—a very important section. I would be remiss by not emphasizing this section to the committee, and that has to do with basically clarifying civil proceedings, but, more specifically, kind of dealing with what we are kind of calling the "de novo provision" within S. 979.

This is one of those very real issues where it appears that the executive branch, the administration, has a very real, honest difference with the tribal input on what should appear in this section. I think it is important to note that we, I believe, as the deputy director of the agency, but also as the department's witness, that we can work through these differences, even on this very, very important provision.

I'll just mention a couple of other provisions and stop, Mr. Chairman.

There have been a few provisions that have resulted in—we just think in oversights that appear within S. 979 that we would like to point out to the committee, and they are outlined in the testimony that has been provided. I think those provisions are ones

that, even yesterday, as the tribes and as the executive branch, the Indian Health Service, in particular, but with support from the Department of Health and Human Services, have discussed and are moving toward resolution of these other issues.

They are, indeed, dealing with the application of title 5 to other sections of the act, the various funding agreements.

I would, in closing, like to express my appreciation to this title 5 tribal work group that I've mentioned before, an enormous amount of expertise gathered in one room for a long period of time over the years, a very committed group that has—that knows the importance of this legislation that is in front of us today, a group that has offered their wisdom and have compromised and worked with each other in a manner that we believe allows the administration, certainly with tribal governance, to strongly support S. 979 and strongly support the enactment of permanent legislation for self-governance this year.

With that, Mr. Chairman, we would attempt to answer any questions the committee may have.

The CHAIRMAN. Thank you.

[Prepared statement of Mr. Lincoln appears in appendix.]

The CHAIRMAN. Ms. Williams and Mr. Black, are you here basically as resource people, or did you have additional comments?

Ms. WILLIAMS. Resource people.

The CHAIRMAN. Resource people. Okay.

We're joined by Senator Murkowski, the chairman of the Energy Committee and a valued member of this committee.

Senator did you have an opening comment?

STATEMENT OF HON. FRANK H. MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. I just wanted to introduce Stephanie Rainwater on behalf of the Indian Corporation of Ketchikan, AK, which is my home town, and I wanted to acknowledge that Ketchikan is richer because of the contributions of her corporation. They own a fish hatchery, the Deer Mount Fish Hatchery, which they have operated successfully. They also own a bald eagle habitat interpretive center and they're building a new tribal center, about 35,000 square feet, on a lot that I said was too small and she proved me wrong. That doesn't—well, it happens once in a while. My wife has been known to do that, as well. So I look forward to Stephanie's participation.

I want to just point out one thing. Compacting works. It works in Alaska. We have, I think, 223 tribes. Every single one is involved in compacting.

The problem we have in Alaska is with the Secretary of the Interior, who is very reluctant to use this same application of contracting to allow some of our Native people to basically manage some of the isolated parks, where we have more activity from park service personnel going in and out than we have visitors, for example, and the Secretary of the Interior absolutely refuses to follow a similar compacting concept where the Native people that are familiar with the area can play the role of the park rangers and the Department of the Interior can train these people, and so forth.

Anyway, I have an ongoing dispute on policies within the Park Service, and that's certainly one of them.

But I think the point is: This works, and this can be applied, this same concept, to other services from Native Americans in their own area, and I just wanted to add that in.

You know, we've had $271 million that has been spent for tribal members by tribal members who are, after all, the ones who really know the needs as a concept of this compacting, so I want to commend you, and I did want to welcome Stephanie.

I guess we have a vote?

The CHAIRMAN. Yes; we have one on.

Senator MURKOWSKI. Thank you, Mr. Chairman.

The CHAIRMAN. Let me just ask a couple questions before I excuse this panel, and then we'll wait until after the break for the next panel.

You mentioned a number of compacts. I believe you said 42 were negotiated, if I'm not mistaken?

Mr. LINCOLN. Yes; that's correct.

The CHAIRMAN. And 59 self-governance agreements. Of that, how many programs have been ceded back to the department? Has any tribe signed a compact and later on found out they don't have the administrative ability, or whatever?

Mr. LINCOLN. They've all been successful, to varying degrees. We have many of the compacts that have been just absolutely outstanding, performed in a manner that the agency could not have performed under the restrictions that the agency has. All of them, we believe, have been successful.

The CHAIRMAN. Well, I'm in agreement with Senator Murkowski. I think self-governance is a step in the right direction and works well.

Do you give some kind of incentives or somehow encourage the tribes to compact, or do you just let them do it of their own volition?

Mr. LINCOLN. The basic position of the agency and our interpretation of the Indian Self-Determination Act is that it is the responsibility of the department to inform the tribes of their options, and not just that simply but make information available to the tribes where they can make an informed judgment to either contract or compact.

It is at the tribes' decision, though. The tribes are the ones who decide whether or not they'll enter into a contract or a compact.

This legislation, as a matter of fact, would authorize the agency to enter into 50 new compacts per year, but we anticipate that there will be, at least initially, a number less than that.

The CHAIRMAN. Would that create a problem? For instance, how many compacts annually do you have now?

Mr. LINCOLN. We have 42 compacts, and within those 42 compacts there's 59 annual funding agreements, so we're dealing with 59 tribal entities.

The CHAIRMAN. But the anticipated increase of compact requests under this bill, would that create an administrative problem for you?

Mr. LINCOLN. We do not believe it would create a problem. And this is something that—it's time for this step to be taken, Mr. Chairman.

The CHAIRMAN. The supporters of the bill, most of them assert that the Indian Health Service has an inherent conflict if it decides tribal disputes under the act.

Is there any opposition you know of to allowing Federal courts to make these decisions?

Mr. LINCOLN. Mr. Chairman, in talking with Ms. Williams, I have to admit to you that I'm not, myself, familiar with whether or not there would be any disagreement with referring to tribal courts. I do not recall that provision in the bill.

The CHAIRMAN. Yes.

Mr. LINCOLN. It is something that we would get back to you on if we could. It's just not an area that I'm prepared to address today.

The CHAIRMAN. All right. Those are the only questions I have, but some of the other committee members may wish to have you answer some in writing, so if any come forward we'll send them to you if you could answer them.

Mr. LINCOLN. Thank you, Mr. Chairman.

The CHAIRMAN. With that, the committee will be in recess for about 10 minutes while I go vote.

[Recess.]

The CHAIRMAN. We'll proceed with our second panel, which will be: Stephanie Rainwater-Sande, president of the Ketchikan Indian Corporation; Henry Cagey, chairman of the Self-Governance Tribal Advisory Task Force; and Buford Rolin, chairman of the National Indian Health Board.

With that, we'll go ahead and proceed. When we have witnesses from the administration, we give them a little more latitude, but we try and ask people to observe these lights when they're testifying. So your complete written testimony will be included in the record, and if you could keep your abbreviated comments within the light timeframe, I'd appreciate it.

Why don't we go ahead and start with Ms. Rainwater-Sande.

Senator Murkowski gave you a glowing introduction.

Ms. RAINWATER-SANDE. I'll thank him for that.

The CHAIRMAN. Very good.

STATEMENT OF STEPHANIE RAINWATER-SANDE, PRESIDENT, KETCHIKAN INDIAN CORPORATION, KETCHIKAN, AK, ACCOMPANIED BY CHARLIE WHITE, GENERAL MANAGER, KETCHIKAN INDIAN CORP, AND LLOYD MILLER, ESQUIRE, LAW FIRM OF SONOSKY AND CHAMBERS

Ms. RAINWATER-SANDE. Good morning, Mr. Chairman. My English name is Stephanie Rainwater-Sande. My Haida name is Dat Kan San, which means "asking for something."

I am the president of Ketchikan Indian Corporation.

The CHAIRMAN. Excuse me—asking for something?

Ms. RAINWATER-SANDE. Yes.

The CHAIRMAN. We've got a lot of people with that name around here. [Laughter.]

Ms. RAINWATER-SANDE. But I was officially given that name, and I have used it and used it and used it. [Laughter.]

The CHAIRMAN. All right.

I am here this morning with Lloyd Miller of the Sonosky and Chambers Law Firm and Charlie White, our general manager of Ketchikan Indian Corporation.

Our tribe has a 1940 constitution adopted under the Indian Reorganization Act, and our current tribal enrollment is 4,217, an enrollment that continues to grow, along with our services, thanks to the opportunity available under self-governance compacting.

I would like to thank you for the opportunity to testify in support of the Tribal Self-Governance Amendments of 1999. This legislation, when passed, will provide permanent Federal authority for health care delivery by self-governance tribes and will build upon the remarkable and positive results of the self-governance demonstration project.

Our tribe was among the first Indian tribes in the country to begin operating Federal programs under title one of the Indian Self-Determination Act, and over time we have expanded into economic development, job training, job placement, and apprenticeship programs, working with the local higher education community.

Building on these successes, including our fish hatchery, our bald eagle center, and our housing authority, in 1997 we took over responsibility for administering all Indian Health Service-funded programs under an Indian Health Service self-governance compact.

As a result, today we have seen a virtual explosion in services and in what we can do for our people. In fact, in 1999, patient visits were up 78 percent, nearly double over 1998 levels. And, while waiting lines have increased, our quality of care has remained high.

With self-governance now a reality, we are today building a brand new, five-story, 35,000-square-foot health facility. This achievement is even more satisfying because it was done—because our tribe has accomplished construction entirely through private financing, no Federal dollars.

When we begin serving patients in February next year, the health facility will include a dental hygienist, a physical therapist, a midwife, colonoscopy evaluations, cardiac treadmill testing, state-of-the-art teleradiology, a tobacco cessation program, and our critical diabetes program.

KIC's future under self-governance compacting remains intensely bright and optimistic, and we, therefore, ask this committee to now make sure this important health care initiative becomes permanent.

The bill is critical, not only because it will give our tribal health programs long-term stability, but because it will provide a means of resolving impasses. It will facilitate negotiations of new funding agreements each year. It will confirm our responsibilities to carryout our programs as our people determine is best. It will protect our funding, while authorizing multi-year funding agreements to enhance long-range planning. It will enhance our access to the Federal resources to carryout these Federal programs as efficiently as possible. And it will permit us to explore expanding our successes to other divisions of DHHS.

While we urge prompt passage of S. 979, we have provided committee staff with a list of recommended improvements, some of which I would like to also mention here.

First, we ask that the funding provision of the bill in section 508(d) be revised to clearly prohibit the Secretary from unilaterally reducing a tribe's funding entitlement.

Second, we recommend that section 517(e) be clarified so that it is clear that tribes are not required to follow Indian Health Service program regulations. The whole point of self-governance is for the tribe to determine how a program will be administered within the limits of any applicable statutory restriction.

Third, a new section should be added to clarify the conflicting payments provisions by existing law. When Congress, in 1994, enacted the detailed funding provisions that appear in section 106 of the act, which also controls self-governance funding, and when Congress assured tribes the right to receive all contract funds up front in a single lump sum, Congress overlooked repealing the old and inconsistent funding language found in the original section 105(b). The first two sentences of the section 105(b) should, therefore, now be removed.

Thank you once again for the privilege of providing this testimony today. If the committee has any technical questions, I will be pleased to answer with the assistance of our general manager, Mr. White, and Mr. Miller, an attorney well known to the committee and who was key to drafting many of the tribal proposals that are now reflected in the bill.

Before closing, I do want to offer a special thank you to the Congressional delegation from Alaska, and especially to Senator Murkowski for his efforts in passing the Coast Guard Authorization Act of 1996. This act enabled KIC to receive ownership of the property where our new health clinic is being built. [Native word] once again.

[Prepared statement of Ms. Rainwater-Sande appears in appendix.]

The CHAIRMAN. And in the process, you proved him wrong. Good.

Mr. Cagey, why don't you go ahead and proceed.

STATEMENT OF HENRY CAGEY, CHAIRMAN, SELF-GOVERNANCE TRIBAL ADVISORY TASK FORCE, BELLINGHAM, WA, ACCOMPANIED BY PAUL ALEXANDER, ESQUIRE

Mr. CAGEY. Good morning, Mr. Chairman. My name is Henry Cagey. I'm chairman of the tribal task force that has been designated by the self-governing tribes nationwide to develop this legislation and work with Congress to assure its passage.

In 1975, Congress enacted Public Law 93–638, the Indian Self-Determination and Education Assistance Act, legislation which called for a dramatic change. Tribes could operate Federal programs on the reservations through self-determination contracts.

Some tribes feared that Public Law 93–638 would terminate the trust responsibility. This did not happen. Neither, however, did Public Law 93–638 contracting result in the reduction of Federal bureaucracy and the transfer of funds that its sponsors had hoped for.

Ten years ago, as Congress was contemplating reforming Public Law 93–638, the "Arizona Republic" published a series of articles on IHS and BIA fraud in Indian Country that attracted the nationwide attention and Congressional demands for reform.

The tribes knew that the so-called "good ideas" for previous reforms hadn't always worked out well for Indian Country. We create a project that began with research, allowed experimentation, maintained the trust responsibility, was voluntary on the part of the tribes, and designated to find the best way to transfer decision-making and resources to the reservations.

In 1988, Congress passed the demonstration project and provided appropriations to undertake the project. With support from the congressional authorizing and appropriation committees and the personal commitment of the Secretary of the Interior, we've made progress.

Model compacting outlining the government-to-government relationship was developed. Simple, straightforward documents for funding transfers called "funding agreements" were created to replace contracts.

We developed the concept that once a tribe established its fiscal and planning eligibility, it had a clear right to its tribal share of financial resources that Congress had provided for for Indians.

We eliminated the big brother/big sister second guessing of tribes.

In 1991, the IHS was added to the demonstration project. In 1994, self-governance was made permanent at the Department of the Interior.

S. 979 now proposes to make self-governance permanent at the IHS and authorize a study of other agencies at DHHS.

We have submitted to this committee staff our suggested changes and corrections to S. 979. Although most of the recommended changes are technical or drafting clarifications, there are several areas that we need to address today.

Section 7 of H.R. 1167, as amended at markup, would amend title one by clarifying that a participating tribe's patient records may be considered Federal records for purposes of storing them at Federal record centers. There is no parallel section in S. 979.

In 1994 amendments to title one, Congress approved tribes with expedited and special appeal rights to Federal court to review agency actions. Several Federal district courts have been reluctant to permit more than the standard APA review of agency decisions, in effect mooting or negating the 1994 amendments.

Section 5(b) of H.R. 1833, as introduced during the last Congress, would have amended title 1 of the Indian Self-Determination and Education Assistance Act to clarify that de novo review is the proper judicial review standard for actions brought in Federal district court. This important provision should not be overlooked and included in S. 979 and S. 1167.

The Federal Report Elimination Act of 1998, Public Law 105–362, eliminated the reporting requirements of section 105(c) of the ISDEAA. These important requirements are critical to assuring that Congress is kept informed about critical funding issues. The committee should add a new section to S. 979 that reinstates 106(c).

In addition, Mr. Chairman, is that S. 979 is similar to H.R. 1833 of the past Congress. Questions were raised at the last minute related to H.R. 1833 that we were not able to respond to in that short timeframe at the end of the last session of the 105th Congress.

Key among the issues raised last year were the assumptions that permanent self-governance authorization would dramatically expand the availability of self-governance agreements to additional tribes and tribal organizations; two, that the permanent authorization would also lead to the significant increases in the need for contract support costs.

Although both of these assumptions appear reasonable on the surface, both of these assumptions are misleading.

Key to the permanent legislation is not new or expanded authorization; rather, it is establishing permanent authority for the tribes to utilize the self-governance compacting as a mechanism to transfer IHS Federal functions to tribal governments. It also refines the unique legal relationship between IHS and the tribes.

S. 979 requires tribes to be self-determination contractors prior to transferring the self-governance status. To date, all self-governing compacts with IHS were preceded by self-determination contracts. This means that most, if not all, contract support costs are already in the system under self-determination contracting and will not be new costs.

In health services, Indian Country receives far fewer dollars than anyone else. It is also flexibility that reforms of 1988 and 1994 [sic], and the impetus of the Indian Health Care Improvement Act that allows Indian health care to make the progress in health care that we have made to date.

We need the best tools that we can devise to maximize the limited Federal resources provided to tribes for the benefit of health care services. Senate bill 979 is one of these tools, and I urge this committee to move forward to the passage of legislation as practical.

Thank you very much.

The CHAIRMAN. Thank you.

[Prepared statement of Mr. Cagey appears in appendix.]

The CHAIRMAN. Chairman Rolin, would you go ahead?

STATEMENT OF BUFORD ROLIN, CHAIRMAN, NATIONAL INDIAN HEALTH BOARD, DENVER, CO

Mr. ROLAND. Thank you, Mr. Chairman.

I am pleased to offer testimony on behalf of the National Indian Health Board on S. 979, Tribal Self-Governance Amendments of 1999, to provide for greater self-governance by Indian tribes and for other purposes.

The National Indian Health Board represents 558 tribal governments, promoting the highest level of health for American Indians and Alaska Natives and advising the Federal Government on the development of responsible health policy.

With funding from the Administration for Native Americans and the Indian Health Service, the National Indian Health Board completed a study entitled, "The Perspectives on Indian Self-Determination and Self-Governance and Health Care Management." It is significant because it offers a tribal perspective on changes that

have occurred in the past 3 or 4 years in which tribal self-governance demonstration projects have become part of the landscape of Indian Country.

This study provided the opportunity to survey a broad cross section of tribal leaders, health directors, and from every area of IHS and every type of health care delivery system. A total of 200 tribes and tribal organizations participated in this project. This represents about 38 percent of the federally-recognized tribes.

I would like to share with you sections of this study, as time will not allow me to address them all.

The Federal policy of self-determination contracting and self-governance compacting is working, but it could be better. The health of American Indians and Alaska Native people has improved at the same time that there has been a growth in tribal management of programs. On average, every type of tribe—IHS direct services, contracting, and compacting—has achieved a higher level of health care since the self-governance demonstration projects began.

When tribes assume control of health care, they give a high priority to prevention programs. Tribes do not have more difficulty than the IHS in recruiting and retention of health professionals.

The motivation of compacting is just not increased funding. As a matter of fact, when tribal leaders were surveyed, a majority of those leaders of compacting tribes cited tribal sovereignty and local control.

As the Federal system of Indian health care changes, integration of services is occurring throughout tribally-controlled organizations. Self-governance compacting is not hurting most of the Indian tribes. The Federal Government could do more to assure that self-determination contracting and self-governance compacting will not lead to determination [sic].

If the Federal Government wants to encourage tribal management, policies could be changed to remove barriers and increase opportunities. According to the findings of our study, these could include—and I emphasize—full funding for both direct and indirect costs for tribal management of health services, including contract support costs. Remove limits on the number of compacting tribes. More training needs to be made available locally to provide entry for tribal members into health careers. And more training and technical assistance to help these tribes acquire and maintain management expertise. And most important is a change in attitude in those few IH area offices where tribes perceive that compacting is discouraged.

Now, while the self-governance demonstration project has proven that self-governance can be an effective way to deliver health care, not all American Indians and Alaska Native areas have agreed. Despite slight increases in actual congressional appropriations, there has been an 18 percent decline in the inflation adjustment per capita expenditure for health care, and that has happened since 1973.

Now, clearly, some tribes have felt that their services and facilities have suffered due to a combination of problems, including population growth, inflation, and unfunded mandates. However, most tribes in the study, even those that have seen dramatic improvements, feel that there are more health care services needed and that we require greater funding from Congress.

Before I close, I want to convey the position of tribal governments on the merits of S. 979.

During our annual meeting held in Anchorage, AK, in October 1998, we received resolutions from five areas that included a total of 331 tribes that supported the H.R. 1833. We understood that four areas had chosen not to endorse this concept, and we respect them because they felt like this was a tribal decision. However, two of the other areas that chose not to support the policy, out of them, now one of the areas is considering contracting their program.

After lengthy discussions and extensive deliberation, the National Indian Health Board set forth the following position on H.R. 1833:

The NIHB affirms the solemn right of tribal governments to determine their own respective positions on the policy of self-governance. Now, this position is not against the matter at all. We just simply feel that it merely supports what the tribes have said they wish to do.

While we understand today's hearings on the matter of S. 979, we feel the new bill under consideration is quite similar in nature to H.R. 1833, and we maintain our position set forth at our annual meeting.

Our board of directors will not be meeting until December of this year, and we are certainly—in time, hearings, we will be supportive of the S. 979.

Personally, my own tribe, who is a compacted tribe as of January 1 this year, we have noticed definite changes and advantages in compacting.

In closing, I call upon my American Indians and Alaska Native friends and to this committee to be supportive of S. 979.

Thank you.

The CHAIRMAN. Thank you.

[Prepared statement of Mr. Rolin appears in appendix.]

The CHAIRMAN. We have received, by the way, the GAO study on contract support costs, and it will be back in—it is now and we'll be studying it to try to find out if we're getting—you know, one of the goals of contracting, of course, is not only that tribes will have the ability to make their own decisions and determine their own future better, but also that you have a better and more-efficient use of tax money because you have a direct infusion to the tribes rather than it being filtered through the bureaucracy here in Washington.

The unfortunate part, the unfortunate thing that has happened is that, even though the contracting has gone up, the bureaucracy hasn't gone down, and so we are still, in my view, spending more money than we need to on all these folks here in Washington that, in my view, could probably be retired rather than fulfilling those slots when they come open.

Let me ask you just a couple of questions, each one—and, Stephanie, if I could ask you first—you mentioned the explosion of use, the huge increase of patient visits, double, I think you mentioned. Why is that? Is it just—were they just the services weren't there before, or people were just reluctant to use it? Why has it exploded so fast?

Ms. RAINWATER-SANDE. I think it had to do with the economy in Ketchikan, and when the pulp mill shut down and they had insur-

ance and they decided to go to the clinic because they didn't have insurance any more, and the fishing industry is down, and with that our people started to come back to the clinic.

Now, we have 4,217 members, and we also administer health care to Saxman, which has a population of about 250. But our patient charts are 6,000 today, and still growing. But, because of the staff that we have and running the clinic efficiently, we're able to run the clinic with the dollars we have. Of course, we have to watch that we don't take patients from Prince of Wales Island or other areas because we just can't afford it.

The CHAIRMAN. You mentioned some additional things that you suggested in this bill that put some restrictions on the secretary and the administration, I think, is in general support of the bill now. We, of course, have to be careful about how we adjust It. We don't want to lose that support, but we'll take those into consideration for sure before we have a markup on the bill.

You also mentioned that the new facility was financed privately without the need to encumber Federal funds. How did the self-governance help you to privately finance that facility?

Ms. RAINWATER-SANDE. I'm going to let our general manager, Charles White, come up and manage that.

The CHAIRMAN. All right. Charlie.

Mr. WHITE. Mr. Chairman——

The CHAIRMAN. And identify yourself for the record there, again.

Mr. WHITE. Charles White, general manager, Ketchikan Indian Corporation.

The ability to compact gave us the ability to diversify and develop economic development, as our Senator Murkowski has stated, and generate revenues through that hatchery and economic development, and the ability to—large third-party revenues, and clinic operations. It has also given us that cash flow to be able to finance independently.

We have gone through—our permanent financing will be through AIDA at a lower rate, though.

The CHAIRMAN. That brings up another point. I'm going to introduce two more bills to consolidate employment training and substance abuse programs, and I'm hoping that those programs also could be considered as making them part of self-governance, too, and have the training on site. I just wanted to make you aware of that.

Mr. Cagey, you alluded to some difference of opinion in the tribes between self-governance and non-self-governance tribes dealing with funding, and I, frankly, think that this bill is pretty safe, and the ones that we've already put in place, the compacting bills have already been pretty safe because tribes can opt in or opt out. They're not obligated to stay in. But do you think some tribes worry there is a weakening of trust responsibility if they compact more?

Mr. CAGEY. What I've seen, Mr. Chairman, over the past several years—I guess the fear that a lot of tribes has is the fear of termination, you know, that we're taking on responsibilities and functions of the government, where, you know, some tribes see it as the responsibility of the United States as a trust responsibility.

I do some of the treaties that a lot of tribes really hold up high, and there's just a lot of misinformation, I guess, that floats around from the area offices to different Federal employees that seem to feel that self-governance was taking away from other tribes.

There is a education and communication project that allows the tribes to further communicate what is going on with self-governance, and the committee has supported our process to provide workshops and conferences every year.

The CHAIRMAN. Some tribes have had some bad experiences going through the negotiated rulemaking process, would you say?

Mr. CAGEY. On negotiated rulemaking?

The CHAIRMAN. Yes; I mean, there have got to be rules to implement every bill that we pass around here, you know, and sometimes that bogs down because it loses the intent of the bill, as you probably know.

Mr. CAGEY. What I've seen with the Interior, for example, it has taken several years, I think, to really sit down and negotiate meaningful negotiations, I guess, with the tribes and Interior. It has taken quite some time.

If you want further information on it, we have our attorney here, Paul Alexander, that could explain a little bit more on what's happening with the negotiated rulemaking.

The CHAIRMAN. Well, I know there are some problems with it.

Can you think of any incentives that we might offer tribes to get involved in these compacts?

Mr. CAGEY. Incentives?

The CHAIRMAN. Yes.

Mr. CAGEY. I think, Mr. Chairman, the incentive right now, I think, is the flexibility that empowers the councils and the people that receive the services a lot more flexibility, and I think the heightened awareness of being able to communicate some of those advantages, such as Ketchikan and Porch Creek, what is happening, and the more we can share that with other tribes, I think the more that we will be able to, I guess, let the tribes see that the advantages of self-government provides more flexibility for them.

The CHAIRMAN. Yes; do you know if there's anything in place now in which those tribes that are considering entering into compacts can view the successful—the tribes that have had successes in doing that, so they could use that as a model or—it seems to me if there is some worry among tribes about the loss or erosion of Federal trust responsibility by entering the compacts, the best thing they could do is look at the tribes that already have and get some ideas from them, if it has worked or it hasn't worked.

Mr. CAGEY. Yes; I think there is a lot of opportunity to do that, and I think what I see right now, today, is the reluctance to even look at contracting or compact because what is happening with contract support, you know, is that we're watching a battle take place in fully funding it. Sometimes it is not enough money to offset the cost to run programs or services for the people.

I think some of the help that the committee could offer is fully funding contract support.

The CHAIRMAN. Okay. Thank you.

Buford, you suggest more training should be available locally to encourage people to go into health careers. One of the things we're

dealing with here on almost a constant basis is the role of the government with tribal colleges. They are growing, the enrollment is growing, the need is growing, and some of us are trying to help as much as we can with tribal colleges. Do you see that as an initiative that could be integrated somehow in cooperation with the tribal colleges, that type of health training?

Mr. ROLAND. Yes, sir; I do. As a matter of fact, we support that and encourage that, Senator.

Also, within our own areas—I know in my particular area we have now moved into where we have developed—have a training center at the hospital.

The CHAIRMAN. The hospital does?

Mr. ROLAND. Yes; and through the Cherokee Indian Hospital there, but it is a technical support center that they have there that works with us in our area.

Certainly, we would encourage our colleges, Indian colleges——

The CHAIRMAN. The training that you do in your hospital, can the people that are recipients of that training apply for any college credit?

Mr. ROLAND. Actually, it is through a support center, and all there at the Cherokee Reservation through the hospital, and yes, it is accredited programs that we provide training, such as CHRs and others.

The CHAIRMAN. Yes; the NIHB did a study on incentives, and you also said that the Native peoples, the health improved due to tribal management of health programs. Can you tell me something about if there are any statistics that have changed in a positive manner?

Mr. ROLAND. Yes, sir.

The CHAIRMAN. Or you mentioned something about that study on incentives, either one.

Mr. ROLAND. In our study, which we have provided to the committee—and hopefully you have a copy. If not, I have a summary of it that I will provide you—it has shown that there has been significant change in the improvement of health care where tribes have managed their programs and continue to manage them.

Certainly, our direct facilities, we had responses from them and it is reflected in that report, as well.

The CHAIRMAN. Okay. We'll study that report.

All right. I appreciate you being here today. I have no further questions, but we may be submitting some questions in writing to you, and the record of this hearing will stay open for two weeks for any additional comments by the panel or anybody from the audience.

With that, this hearing is adjourned. Thank you.

[Whereupon, at 10:40 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF W. RON ALLEN, CHAIRMAN AND EXECUTIVE DIRECTOR, JAMESTOWN S'KLALLAM TRIBE AND PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS

Good morning Chairman Campbell, Vice Chairman Inouye and distinguished members of the Senate Committee on Indian Affairs. My name is W. Ron Allen. I am Chairman of the Jamestown S'Klallam Tribe located in Washington State and President of the National Congress of American Indians (NCAI). I thank you for the opportunity to testify this morning on S. 979.

In the final days of the last Congress, this Committee considered H.R. 1833, the House-passed version of the permanent authorization for Self-Governance at the Indian Health Service (IHS), and study of Self-Governances applicability to other agencies within the Department of Health and Human Services. This bill was substantially similar to S. 979 that you are considering today. Questions were raised at the last minute related to H.R. 1833 that we were not able to respond to timely, that apparently prevented passage in that short timeframe at the end of the last session of the 105th Congress.

Key among the issues raised last year were the assumptions that a permanent Self-Governance authorization would: (1) dramatically expand the availability of Self-Governance agreements to additional tribes and tribal organizations; and (2) that the permanent authorization would also lead to a significant increase in the need for contract support cost funds. Although both of these assumptions appear reasonable on the surface, both assumptions are misleading.

Title III, the IHS Self-Governance Demonstration Project, of the Indian Self-Determination and Education Assistance Act (ISDEAA) provides that tribes and tribal organizations shall be permitted to negotiate funding agreements if they meet the criteria of fiscal responsibility (3 years of clean audits relative to government funds) and complete a planning phase. Up to 30 tribes or tribal organizations 1 year may achieve Self-Governance status under title III—that is the existing law. Under S. 979, the eligibility provisions follow similar criteria: 3 years of clean audits and a limitation of up to 50 tribes or tribal organizations per year. The permanent legislation only adds 20 new tribes that could enter under the Demonstration Project. This number is not significant for in no recent year has the 30 tribe limitation been met or exceeded.

The key to the permanent legislation is not new or expanded authorization; rather it is establishing permanent authority for the tribes to utilize the self-governance compacting as a mechanism to transfer IHS Federal functions to tribal governments. It also refines the unique legal relationship between the IHS and the tribes.

The other key concern raised in the original legislation last congressional session was that passage of permanent IHS Self-Governance legislation would substantially increase contract support costs. This is an issue of intense tribal and congressional interest. NCAI recently released its report on contract support costs. Further, in June, the General Accounting Office (GAO) also released its report of contract support shortfalls. This hearing is not the forum for fully addressing these issues. How-

ever, in the minds of some, the fate of this permanent legislation is tied to the resolution of contract support costs shortfall issues.

I think it should be clear for the discussion on expansion of contracting and compacting, that since the permanent legislation focuses on tribe/agency relationship issues, not expanded eligibility, it does not significantly implicate the contract support cost debate and quest for solutions in a meaningful way. As such, S. 979 should not be held hostage as we struggle with the difficult resolutions to the shortfall in contract support funding. To the extent that S. 979, can play any role in identifying the solutions, it does so by requiring clear reporting from the Administration as to programmatic funding needs as well as contract support cost requirements; one of the issues that GAO noted to be a problem in their report.

The ISDEAA authorizes and requires tribes to be Self-Determination contractors before transferring to Self-Governance status. To date, all Self-Governance compacts with IHS were preceded by Self-Determination contracting. This means that most, if not all, contract support costs are already in the system under self-determination contracting and were not new costs.

As the recent NCAI Final Report on Contract Support Costs has demonstrated, tribal contracting and compacting activities accelerated to their peak in the mid–1990's in response to the 1994 ISDEAA Amendments and extension of the self-governance initiative to IHS. The trend in the transfer of Federal Indian programs to tribal operation under the ISDEAA has now leveled off from the peak experienced in the mid–1 990's, and with a few notable exceptions should remain constant in the years ahead.

S. 979 is but one step in the empowerment of tribal governments process (i.e., the devolution movement in Indian Country) that began in 1975 to transfer responsibility on a voluntary basis to tribes to manage funds and programs at home, away from the control of distant agencies with their swollen bureaucracies. As progress has been made, the lessons learned in Self-Governance have been applied in P.L. 93–638 tribal contracting and vice versa. Many changes have occurred—agency bureaucracies have downsized as a result of tribal contracting and compacting and are not as swollen. Therefore, competition between tribes and agencies over funding has increased.

In recent years, we have focused on contract support shortfalls in part because they are quite visible and unnecessarily controversial in the process of how we appropriate Federal funds. In fact, however, as every tribe knows the even more extensive but less visible shortfalls are in program dollars. In health services, Indian country receives far fewer dollars than anyone else in mainstream America for the provision of health care. It is only the flexibility that the reforms of 1988 and 1994 have provided, and the impetus of the Indian Health Care Improvement Act that allows Indian country to make the progress in health care that we have made to date. We need the best tools we can devise to maximize the limited Federal resources provided to the tribes for the benefit of health care services. S. 979 is one of these tools and I urge the Committee to move it to legislative passage as soon as practical.

The permanent authorization will reduce the need for rulemaking by providing clear guidelines for tribal rights as well as agency rights. For example, there was a significant negotiation between the tribes and IHS, with the assistance of congressional staff, that led to provisions in S. 979 that detail what tribal non-performance would be under Self-Governance, and what the exact procedures, rights and remedies, are provided for remedying such non-performance.

1To summarize, the permanent legislation focuses on the details of the inter-action between the agency and the tribes, not on expansion of the demonstration project. This proposed legislation would realize the goals and objectives set out in 1975 under the ISDEAA to empower the tribal governments to manage their own affairs. The American Indian and Alaska Native communities continue to be the most impoverished people in the American society. The Congress has a historical, legal and moral obligation to address this condition by investing the necessary resources to responsibly address the needs of these communities to raise their status to that equal to mainstream America.

Thank you for your consideration and for the continuing hard work and dedication we have come to expect from you and your able staff.

PREPARED STATEMENT OF HENRY CAGEY, LUMMI INDIAN NATION, BELLINGHAM, WA

Mr. Chairman, members of the committee, I wish to thank the committee for the opportunity to testify today. I am appearing as the Chairman of the Title V Tribal Task Force. This Task Force was designated by Self-Governance Tribes at a national

Self-Governance conference to work on the development of permanent legislative authority (known as Title V) for Tribal Self-Governance in the Indian Health Service (IHS). I am a Business Council member of the Lummi Indian Nation, which has Self-Governance Compacts and Funding Agreements with both the Department of the Interior and the Department of Health and Human Services. The Lummi Indian Nation also administers the Self-Governance Education and Communication Project on behalf of a Six Tribe Consortium under grants from both departments.

To begin with, we wish to compliment the Chairman for introducing S. 979, as well as the long-term support of Tribal Self-Governance that the committee and its leadership have continually demonstrated. This Bill reflects many of the elements that have characterized the evolution of Self-Governance. It is a tribally developed and driven initiative produced with bipartisan Congressional support.

We believe it is important to reflect on why we developed Self-Governance and to keep in clear focus the policy goals that we seek to achieve. Self-Governance is fundamentally designed to provide Tribal governments with control and decision-making authority over the Federal financial resources provided for the benefit of Indian people.

Tribal societies were self-sufficient for thousands of years prior to western European exploration and colonization of this continent. Tribal cultures and governing systems contributed to the basic democratic philosophies embodied in the United States Constitution. Valuable Tribal resources changed European civilization. Through the course of dealings with the United States, often through formal treaties, Tribes relinquished ownership to millions of acres of land, containing invaluable natural resources. In exchange, the United States, as Trustee for Tribes, was to protect Tribal sovereignty or self-governing status, protect Tribal lands and other resources and rights, as well as provide services to Indian people.

At best, these promises were not well kept. Instead tribal self-sufficiency was replaced as the United States, particularly through its Federal bureaucracy, transformed, sometimes brutally, independent tribal status into virtual tribal dependency. However, in each generation, Tribal spiritual elders and Tribal leaders reminded Tribes of their rightful role as Self-Governing Indian Nations in a government-to-government relationship with the United States.

In the 19th century, the removal of Tribes to Reservations, accompanied by the suppression of traditional governance and customs, the imposition of Federal military or Indian agents, the Bureau of Indian Affairs (B.I.A.) police, and the use of rations to replace traditional work and food, induced great Tribal dependency on the Federal bureaucracy. It almost became the norm for the Federal Government to regulate or decide (often by inaction) most governmental matters on Reservations.

In the 20th century, with the exception of the notorious "termination era" of the 1950's and 1960's, Federal Indian policy, albeit not very effective or consistent, has been to support the revitalization of Tribal Governments. The 1921 Snyder Act and the 1934 Indian Reorganization Act reflect this imperfect effort.

In 1975, Congress enacted legislation that set a fundamental turning point in modern Federal Indian policy. This legislation, the Indian Self-Determination and Education Assistance Act, envisioned a critical change—Tribes would be allowed to operate Federal programs on their Reservations through what has become known as Self-Determination contracts. The process of returning decisionmaking and funds to local Tribal governments had begun in earnest.

Some Tribes, however, were concerned that the Self-Determination Act would cause or result in the termination of, or a diminution of, the Federal Trust Responsibility. These fears have not come to pass. Neither, however, did Self-Determination contracting result in the scope of transfer of power and resources to Tribes as originally envisioned. Instead of reducing bloated Federal bureaucracies, the agencies used Self-Determination contracting to support a new Federal industry—contract compliance. By the mid–1980's, Self-Determination contracts, originally conceived as simple documents, had grown to literally hundreds of pages—with every variety of oversight requirements, reports, and forms; a true bureaucratic nightmare. Clearly, reform was required. As Tribal advocates and Congress struggled with how to fix Self-Determination contracting, a series of 1987 articles in the Arizona Republic focused attention on severe bureaucratic abuse in both the IHS and the BIA.

These articles served as a catalyst to action. The then Chairman of the House Appropriations Subcommittee on Interior and related agencies, Sidney Yates, invited the Department of the Interior Assistant Secretary for Indian Affairs and Tribal leaders to propose new solutions or options. Although Chairman Yates and the Tribal leaders thought a consensus had been struck on streamlining the delivery of funds and decisionmaking to Reservation communities, the Department proposed an amendment to the Self-Determination Act to provide "revenue sharing" to Reserva-

tions in exchange for a waiver of the Federal Trust responsibility to Indians. Tribal leaders opposed this action and instead developed their own legislative proposals—proposals that became Self-Governance.

Tribes, cognizant that so-called "good" ideas of previous laws and reforms had produced some unexpected disastrous results, opted to proceed cautiously. We designed a Project that began with research, allowed experimentation, and was limited to a few (10) volunteer Tribes to determine the best mechanism(s) for delivering financial resources and decisionmaking to the Reservation. Chairman Yates provided the funds for these Tribes to begin the planning. The Authorization Committees developed, with substantial Tribal input, a Bill that became P.L. 110–472, which provided for some reform of Self-Determination contracting. Title III of that law authorized the establishment of the Demonstration Project. Initially Departmental opposition was fierce. For example, the appropriations planning funds specifically designed for the ten named Tribes was published as grant applications for 50 Tribes.

The efforts of Tribal leaders, with able assistance from Chairman Yates and the support of Secretary Lujan, were critical in getting the Demonstration Project to move forward. Critical progress was made: a model compact outlining the government-to-government relationship was developed; simple, straight-forward documents for funds transfers termed "Funding Agreements" were developed to replace contracts; a means to assure that Tribal trust resources were protected; and, fundamentally the concept was developed that once a Tribe established its fiscal and planning eligibility, it had unequivocal right to its "Tribal share" of the financial resources that Congress had provided for Indians. Gone was contract compliance; gone was "big brother" second guessing Tribes at every turn. The Indian Health Service was added to the Demonstration Project by Congress in 1991 in Public Law 102–184.

In 1994, after 6 years of research and actual experience, Tribes were determined and Congress was receptive to making Self-Governance a permanent part of the Bureau of Indian Affairs (BIA) within the Department of the Interior. At the suggestion of the Secretary, Congress also provided for funding agreements with other agencies within the Department with terms to be negotiated where the Indian Tribe had an historical, cultural or geographic association with the program administered. Congress had determined that Self-Governance was an "effective way to implement the Federal policy of government-to-government relations with Indian Tribes," and that "transferring control to Tribal governments, upon request, over funding and decisionmaking for Federal programs, services, functions, and activities, strengthens the Federal policy of Indian Self-Determination."

This permanent authority, known as Title IV, was contained in P.L. 103–413; amendments to the Self-Determination Act to again reform Self-Determination Contracting. Interestingly, Title IV reflected some of the reforms designed for contracting, and the contracting amendments likewise contained many of the concepts developed in Self-Governance. Today, some 206 Tribes (including consortia and Tribal organizations) have Compacts and or funding agreements, accounting for $180 million in fund transfers to Tribes.

Title IV was a skeletal legislation requiring rulemaking to fill in the details for implementation. The Title IV rulemaking effort, which had no enforceable deadlines, no mechanisms for resolving agency-Tribal disputes, and no limitations on Secretarial rulemaking authority, has proven to be quite conflicted and very difficult to resolve.

S. 979 is a much more detailed legislation than Title IV and that is appropriate. It attempts to provide the full framework for Self-Governance at the IHS and limits the need for rulemaking substantially. The Tribes that I am speaking for today support the thrust and policy of S. 979. Key provisions of S. 979 include:

Establishing the Self-Governance Initiative as a permanent part of IHS; .

Providing authorization of "demonstration" projects for other non-IHS programs administered by the DHHS (subject to terms that the Tribe and Secretary may agree upon);

Describing eligibility criteria for selection of participating Tribes; We have submitted to the Committee staff our suggested changes and corrections to S. 979. Although most of the recommended changes are technical or drafting clarifications, there are several areas that we need to address today:

Patient records. Section 7 of H.R. 1167, as amended at markup would amend title I by clarifying that a participating tribe's patient records may be considered Federal records for purposes of storing them at Federal Records Centers. There is no pallel section in S. 979. We understand that the committee is researching the issue to assure that such a provision would not subject such records to disclosure under the Freedom of Information Act (FOIA). We agree with the Committee's concerns and believe the research will provide important reassurances on this point,

but we believe that inclusion of a provision substantively similar to section 7 of H.R. 1167 should be included in S. 979.

Federal Sources of Personnel, Supplies (Sec. 508 (e)). Section 508(e) of S. 979 would require the Secretary to "acquire and transfer" personnel, supplies or resources to tribes that elect to carryout their funding agreements with those resources. The provision, however, limits the Secretary's authority to transfer resources "to the extent allowable under law." While the mandatory language in S. 979 is a welcome improvement over the corresponding provision in H.R. 1167, the S. 979 section does not actually authorize the Secretary to transfer Federal resources. Since there is concern in DHHS that the Secretary's current authority is not sufficient to transfer Federal resources, and since the IHS/DHHS concurred with the House authorizing language, the phrase "to the extent allowable under law" should be dropped.

Technical Amendment Regarding Contract Payments. As a result of the amendment process to title I of the ISDEA, an ambiguity exists that has proven to be a problem and that we believe should be corrected in both S. 979 and H.R. 1167. In 1994, when Congress enacted the detailed funding provisions that appear in section 108 (25 U.S.C. 450(l), Congress did not repeal the old and inconsistent funding language found in original section 105(b) (25 U.S.C. 450(b)). The 1994 provisions grant tribes the absolute right to receive all their contract funds up front in a single lump sum "notwithstanding any other provision of law." The original 1975 provisions, however, gave the Secretary discretion in how to pay tribes, and also instructed the Secretary to minimize the time between payment to the tribes and expenditure by the tribes. The 1975 provisions should have been repealed when the 1994 provisions were added. The Committee should add a new section to S. 979, making a technical correction to conform 450(b) with 450(l). .

De Novo review. In the 1994 amendments to title I, Congress provided tribes with an expedited and special appeal rights to Federal court to review agency actions. Several Federal district courts have been reluctant to permit more than the standard APA review of agency decisions; in effect mooting or negating the 1994 amendments. Section 5(b) of H.R. 1833, as introduced last Congress would have amended title I of the Indian Self-Determination and Education Assistance Act to "clarify" that "de novo" review is the proper judicial review standard for actions brought in Federal district court. This important provision should be included in both S. 979 and H.R. 1167.

Annual Reports. The Federal Reports Elimination Act of 1998, P.L. 105–362, eliminated the reporting requirements of section 105(c) of the ISDEA. Section 106(c) had required the Secretaries of the Interior and Health and Human Services to report to Congress on an annual basis direct program and contract support cost deficiencies and indirect cost rates for Indian tribes and Tribal organizations. These reporting requirements are critical to assuring that Congress is kept informed about critical funding issues. The committee should add a new section to S. 979 that reinstates 106(c).

Mr. Chairman, with these changes we recommend S. 979 will have the full support of our tribal groups and we urge the Committee to move expeditiously to markup and Senate passage.

The balance of my testimony will focus on my tribes' experiences concerning how Self-Governance has improved health care delivery at the Lummi Indian Reservation.

Following are some of the improvements that have been possible for the Lummi Nation under Self-Governance. We fully believe that the benefits to Tribal members realized under Tribal Self-Governance will be preserved and enhanced through the proposed Title V Legislation.

End of the IHS Deferred Services

Lists under IHS management, the Lummi Nation Health Clinic maintained lists of patients whose diagnosed health services needs could not be provided due to budget constraints. Deferred services lists were common for dental, optical, and even chronic conditions such as diabetes. During the traditional end-of-the-year budget crunch, diabetics were required to save and re-use disposable syringes in order to save funds. After only 3 years of tribal management, with literally the same level of funding, there are no deferred services lists for the Lummi Indian Nation. This is a major improvement in the basic health available to the Nation which was only possible through the Self-Governance Initiative.

This does not mean an end to the development of the Lummi Nation Health Care System. It is, however, the beginning of a new era of Tribally directed development which holds the promise of reaching the level of health care service now enjoyed by most Americans. This promise was not fulfilled by the IHS.

Tribal Veterans Services Office

In 1991, the Lummi Nation utilized its authority under the Self-Governance Initiative to fund the development and operation of a Tribal Veterans office. As some of you may know, a U.S. Veterans Administration study in the late 1980's determined that less than 5 percent of Native Americans Veterans received the benefits they earned through service to the United States of America. The Lummi Indian Nation is proud that nearly 25 percent of its members are either Veterans or dependents of Veterans. The IHS does not provide funds to assist Tribal Veterans to access these services. While Lummi Nation funds were controlled by the IHS, it could not address the problems of its veterans. Under the Self-Governance Initiative, the Lummi Nation has the flexibility to address the real needs of its membership.

Tribal Member Participation Increased

Tribal participation in the operation of tribal government has significantly increased due to the Self-Governance Initiative. Under Self-Governance, the Tribe is able to factor in Tribal members' preferences in allocating resources. Bringing government and services closer to the people results in more democratic participation. The number of eligible voters actually voting in Tribal elections has more than doubled. Many jurisdictions in the United States do not have this level of voter turn out. Participation by Tribal members in Tribal elections has also translated into increased Tribal voter turnout for general elections.

Increased Accountability and Responsibility of Tribal Government

Due to the increased participation of Tribal members, Tribal government has become more accountable to its constituency than in the past. Because of Self-Governance, Tribal governments are able to incorporate Tribal members' needs into their plans. Previously, Tribal members' input would result in an explanation that the IHS does not provide funding for their needs.

The Lummi Nation has reorganized to ensure that Tribal members can participate in the budget development process. Tribal members are able to participate through three different public hearings and through membership on the Tribal Budget committee which is responsible for development of the first draft of the budget which is finally approved by the Tribal Council. The Tribal Budget Ordinance requires that the Tribal Council only approve a balanced budget, which is a subject of considerable discussion within the tribe.

Challenges for Change and Continued Development

These are exciting and challenging times for Tribal governments. The Lummi Nation and many other Tribes have demonstrated their willingness to develop the changes that are needed to meet future and present challenges. In many cases, the Tribal governments have initiated these changes. However, Tribal governments are not able to implement change without adequate financial support.

Reduced Need for Service Delivery Systems

With the growth of tribal services delivery systems, tribal governments have become less dependent on the assistance of the Indian Health Services for service delivery. Tribal governments are pushing the IHS, to perform more administrative tasks such as:

Assisting tribal governments to get their needs to factor equitably into the President's budget request and into final Congressional appropriations; Assisting tribal governments' efforts to waive, modify or change Federal regulations consistent with tribal resource needs and opportunities;

Requesting apportionment of funding appropriated by Congress and authorizing distribution of funds to tribal governments consistent with current funding agreements; and,

Monitoring tribal management of Trust resources and authorizing corrective action, as needed.

Tribes have yet to see these agencies actually reorganize to support these functions which will have continuing value for tribal governments as they increasingly assume the service delivery functions of these two agencies. The hesitancy of both of these agencies to develop to meet the changing needs of their client groups is both puzzling and frustrating for tribal governments. We believe the limit has been reached by bureaucracies in their willingness to yield authority and financial resources to tribal governments.

Simultaneously, we are faced with major challenges which have serious impacts on the health and health status of members of the Lummi Indian Nation.

Welfare reform, which challenges our ability to provide job training and creation on an unprecedented scale, with fewer resources to support job training and creation than we had previously.

Housing: While housing needs on the Lummi Reservation are at an all-time high, funding for Housing and Urban Development has decreased over the past few years.

Through the new Native American Self-Determination Housing Act, we are now challenged to develop comprehensive housing plans and programs.

The foregoing demonstrates the considerable development in the governmental, legal, administrative and programmatic structures needed to support and implement tribal Self-Governance within IHS and within the Tribal governments. Substantial information has also been presented that significant costs savings available through tribal government operations have been used to expand programs and services consistent with health needs of tribal communities. Tribal Self-Governance works for those tribal governments which have participated.

In fiscal year 1999, IHS has transferred approximately $549 million to 254 tribal governments (including consortia and organizations) under the IHS Self-Governance Demonstration Project. In keeping with the permanent legislation passed for the Department of the Interior, tribal governments are ready to move forward to establish Self-Governance as a permanent option with IHS. We are eager to extend the Self-Governance initiative to other programs within DHHS and are ready to work cooperatively with the departmental representatives to effect a successful demonstration project.

Self-Governance began as a demonstrative effort 11 years ago within the Department of the Interior. We have now completed 7 years of a demonstration project under Self-Governance with IHS. S. 979, is the next logical step to continue the advancement of Self-Governance. This legislation affords tribal governments the local control necessary to evolve from a successful demonstration project to permanent implementation.

I thank the committee for the continued non-partisan support we have enjoyed under tribal Self-Governance this past decade.

Finally, I seek your full consideration of the tribal amendments proposed to S. 979.

Thank you.

PREPARED STATEMENT OF STEPHANIE RAINWATER-SANDE, PRESIDENT, KETCHICAN INDIAN CORPORATION, KETCHIKAN, AK

Good Morning Mr. Chairman and committee members. My English name is Stephanie Rainwater-Sande. My Haida name is Dat Kan San, which means "asking for something". My elders knew what they were doing when they gave me that name, because on behalf of Ketchikan people, I am here to ask for something—your support of Senate Bill 979, the Tribal Self Governance Amendments of 1999.

I am President of the Ketchikan Indian Corporation (KIC), a federally recognized tribal government formed under the Indian Reorganization Act. The current KIC certified enrollment is 4,217 members, and has been growing every month. Many native people in the local community are eligible to enroll in a number of different tribes and have chosen to enroll in KIC because of the services we are able to provide through self-governance compacting.

I am honored to be here as an elected official and would like to thank you for this opportunity to present testimony before you today. We applaud the efforts and determination of this committee to pass legislation that will further the policy of allowing tribes to govern their own programs. This legislation will create "Title V" to P.L. 93–638 and will establish permanent Federal authority for health-related tribal self-governance. Title III, the present authority and demonstration project, has allowed KIC to exercise tribal self governance and we believe we have been very successful in our endeavors.

This new chapter of self-governance will better define Federal and tribal responsibilities. It will also enable increased program innovations and, hopefully, eliminate hindrances to our ability to access IHS resources.

We support the proposed legislation because the 638 contract process and the subsequent Self-Governance Compacting process has worked for our Tribe and many Tribal Organizations across the country. I would like to describe our Self-Governance successes for KTC and why we believe that S. 979 will further benefit our tribal members.

KIC was one of the original participants in the 638 contracting process and the Self-Governance Demonstration Project and assumed tribal management of programs previously run by the Bureau of Indian Affairs. Over the past 20 years, KTC has entered into several 638 contracts and in 1994 entered into a single Self-Governance Compact. Under this Compact KIC manages all BIA programs. In 1997, KIC entered into an IHS Self-Governance Compact pursuant to the title III Demonstration Project, and continues to operate under that authority today. As described below it has been an immensely successful project for KIC.

In 1975 we received our first Public Law 93–638 contract to run the cultural instructors program provided for in the Johnson O'Malley Program. When we first took over this program we had two or three cultural instructors in the public schools. Now the program has grown to five instructors and three apprentices. KIC is currently looking at providing an Early Childhood Program, where instructors would go into the homes of preschool children, preparing them to enter the public school system.

We have also assumed management of the BIA General Assistance program under a 638 contract. Prior to our management, the program consisted of the Federal Government giving us general assistance payments and the tribe in turn simply handing out checks to eligible members. Through the self-governance process, the program—today has been revised significantly. We now require and provide vocational training to eligible members, with the ultimate goal of full time permanent employment. The Tribal Council determined that direct training, job placement, tribal employment, and apprenticeship programs would be important keys to success. In effect, KIC has created it's own welfare to work program and has operated it successfully for a number of years. Our Tribal members appreciate and participate in this program. In fact, our General Assistance Training Opportunities (GATO) Program experienced a dramatic increase of tribal member requests for training assistance in 1998, 2,748 requests, tripling from 964 requests in 1997.

We have also managed our Social Services program under a 638 contract for a number of years. Under our management of this program we have been able to provide additional services to our members. For example we have established a Domestic Violence program and provide one-on-one and group counseling services to women who are victims of domestic violence. Future expansion of this program would include another specialist who would provide counseling services to men involved in domestic violence cases. We have also added a Indian Child Welfare Act specialist to our Social Services Department to assist the tribe in adoption and placement proceedings.

In 1994, KIC assumed the ownership and operation of the Deer Mountain Fish Hatchery from the State and city governments who indicated their intent to close the facility due to the high cost of operations. KIC has successfully operated the facility using approximately half the funding that the State required when it managed the facility. In 1998, KIC added a Bald Eagle Habitat and in 1999, an Interpretive Center to the hatchery and employed 30 tribal members in the process. Today the Tribal Hatchery and Eagle Center is a major tourist destination for Alaska visitors. As a result of our successful management of this facility, the State of Alaska has committed over one million dollars in Economic Development Administration grants for this facility. This project now employs three permanent positions and about 18 seasonal personnel from May through October.

In 1994 KIC entered into one of the first Self-Governance Compacts in the country. Under a single compact we manage all BIA programs, including those mentioned above.

This compacting process has enabled KIC to run all of our BIA programs in the most efficient and cost effective manner. We have been able to utilize innovative ways to combine funding sources that were previously restricted to specific programs. For example we have used the General Assistance Training Opportunities (GATO) program in combination with the Summer Youth Employment Program to provide seasonal jobs at the Tribal Hatchery and Eagle Center. This opportunity has provided invaluable experience to those who have participate, and has taught job skills that can be carried elsewhere. It has also benefited the operation of the facility.

In 1997, KIC established a Housing Authority, to receive a HUD Indian Housing Block Grant, under the Native American Housing Assistance and Self-Determination Act (NAHASDA). Through the compacting process, we have been able to combine NAHASDA funding with BIA Home Improvement Program (HIP) funding to repair and renovate tribal member homes. We have also combined NAHASDA funding with the Higher Education and vocational programs to provide much-needed student housing grants. Finally, KIC has also been able to integrate this program with the Emergency General Assistance program and provide emergency rental assistance to tribal members.

We have gained invaluable experience, knowledge and skill in managing our programs through the compacting process. We are now able to enter into cooperative agreements with state and local governments, and other tribes and tribal organizations to manage or co-manage state, local and tribal services or programs. For example, KIC co-manages the Indian Education Act program with the local school district. This program provides tutors in the elementary and middle schools for all students, native and nonnative.

In 1997, KIC entered into a Title I, IHS 638 contract. Shortly thereafter, we converted the contract to a title III demonstration project and became a party to the Alaska Tribal Health Compact (ATHC) . This compact consists of approximately twenty two tribes and tribal organizations, in Alaska, that negotiate our compact agreement and individual annual funding agreements together for the fifty plus tribes represented. KIC's Tribal Alcohol Program, a 638 contract entered into in 1992, was compacted with the health services funding.

With the acquisition of KIC's health services funding, a Medical Social Services Department was acquired. On April 1, 1999 the General Social Services Department (which is funded by BIA, IHS and the Department of Justice) was combined with the Medical Social Services Department under the direction of the KIC Tribal Health Clinic Administrator. The combined Social Services Department can better serve our tribal members. The Social Services Director is currently working to certify the program to be able to bill and collect fees for services from third parties when eligible health coverage is available.

KIC has implemented many of the goals in its strategic plan, including the building of our five-story 35,000 square foot health facility. What makes this achievement more satisfying, is that it was done through private financing. KIC did not have to encumber any Federal dollars for the project. The new KIC Tribal Health Clinic is approximately 40 percent complete, and is scheduled to begin serving eligible patients in February 2000.

This year, KIC was able to obtain membership on the Alaska Native Health Board (ANHB) . The achievement of this goal will enable KIC to network with other members on the many pressing health care issues of today. Since taking over health care for the Ketchikan Gateway Borough (KGB) service area, the KIC Tribal Health Clinic has seen a dramatic increase in patient visits. The number of patient visits is 78 percent higher in 1999 than it was in 1998. KIC has been able to maintain high-quality health care through these trying times, with no significant IHS funding increases. This has been accomplished through staff dedication, obtaining grants and working with other programs, such as GATO, BIA Social Services, and the Job Training Partnership Act (JTPA). In less than 2 years the KIC Tribal Health facility has been able to increase the services offered. This was accomplished through the efficiency of an experienced staff, and the integration of compact programs. Some of the new services are a dental hygienist, a physical therapist, a midwife, colonoscopy evaluations, cardiac treadmill testing, state-of-the-art Tele-radiology, a Tobacco Cessation Program, and the Diabetes Program.

It is easy to see the benefits derived from the ability to compact as an Indian Tribe. These inherent rights are confirmed and established through the law created by our legislative process. The future remains intensely bright for tribes, tribal organizations, and the Federal Government, as more compacting tribal governments are formed. KIC's compact and enterprises continue to grow and provide employment opportunities for tribal members. The revenue generated from these ventures will provide a much needed cash supplement for these tribal government programs. It is with great expectation and enthusiasm that the tribes and the Senate can travel down this evolutionary road of tribal self-determination. It is with this in mind that KIC asks this committee to support title V legislation, thus making Self-Governance for IHS programs permanent under P.L. 93–638. This act has enabled tribes to exercise their rights to assume local control over Federal Indian Programs. In exercising this authority, greater cost efficiencies have been established to maximize the benefits of every dollar. KIC's growth has expanded through the ability to compact from $2.5 million annually, 2 years ago, to a projected $12 million annually, in fiscal year 2000. Our employment levels have gone from a staff of 25, a couple of years ago, to 125 during our peak tourism months.

KIC urges prompt passage of S. 979 and would like to ensure that the language include these suggestions from the Joint Contract Support/Title V Coalition. These may or may not be included in the latest draft of the legislation.

1. The definition of "Inter-Tribal Consortium" (Sec. 501(a)(4)). is not clear. Do entities other than Tribal Organizations, such as the members of the Alaska Tribal Health Compact, also satisfy the definition of inter-tribal consortium? We recommend that the definition be amended to read in pertinent part "includes, but is not limited to, tribal organizations."

2. The criteria for Self-Governance Eligibility (Section 503 (c) (1) (C)) should be consistent with title III language "the previous three fiscal years" should be sufficient.

3. Section 506 authorizes tribes to redesign and consolidate programs, services, functions and activities (PSFA's). The phrase 101 "under Federal Law" needs-to be added at—the end of section 506(e). This omission could result in keeping tribes from redesign and consolidation of PFSA's. This phrase was agreed to by the HHS/

IHS to assure that any Federal authorized purpose accompany the authority to redesign.

4. KIC asks that the funding provisions of the bill in section 508 (d) (1) (C) be revised to clearly prohibit the Secretary from unilaterally reducing a tribe's funding entitlement. Sections 106(a) and (b) must be incorporated to ensure that Self-Governance, tribes will be treated no better or no worse than title I tribes in the determination of funding levels.

5. S. 979 requires the Secretary to acquire and transfer personnel, supplies or resources to tribes that elect to carryout their funding agreements with those revenues. Section 508(e) should require and state "authorize and mandate transfer of Federal resources to tribes" not "to the extent allowable."

6. KIC recommends that section 517(e) be clarified so that it is clear that tribes are not required to follow HIS program regulations, circulars, policies, manuals, instructions and rules.

The whole point of self-governance is for the tribe to determine how a program will be administered within the limits of any applicable statutory regulations.

7. A new section should be added to clarify the conflicting payment provisions of existing law. In 1994, when Congress enacted the detailed funding-provisions that appear in section 106 of the Act (which controls self governance funding), and when Congress assured tribes the right to receive all contract funds up front in a single lump sum, Congress overlooked repealing the old and inconsistent funding language found in the original section 105(b) (25 U.S.C. δ 450j(b)). The first two sentences of section 105(b) should therefore now be removed.

8. KIC recommends that the Committee make clear that Federal courts should give a "fresh look", de novo review, when faced with challenges to IHS activities. Courts have been reluctant to permit more than the standard Administrative Practices Act review of agency decisions. As one Federal judge correctly observed last year, it is not appropriate for the court to defer to IHS judgment about its own funding because when IHS has a clear conflict of interest when it is called upon to turn its funding and programs over to tribal governments.

9. The Federal Reports Elimination Act of 1998, Public Law 105–362 eliminated the reporting requirements of section 105(c) of the ISDEAA. It had required the Secretaries of the Interior and HHS to report to Congress on an annual basis on direct and indirect program cost deficiencies for Indian Tribes and Tribal Organizations. These reports are critical to assuring Congress is kept informed about critical funding issues. A new section should be added to S. 979 addressing this issue.

Thank you once again for the privilege of providing written and oral testimony. A special thanks to the congressional delegation from Alaska, and especially to Senator Murkowski, for their efforts in passing the "'Coast Guard Authorization Act of 1996." This Act enabled KIC to receive ownership of the property where the new KIC Tribal Health Clinic is being built. Please do not hesitate to let me or my staff know if we can provide any further information to this Committee in its deliberations. Thank you once again.

PREPARED STATEMENT OF BUFORD L. ROLIN, CHAIRMAN AND NASHVILLE AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD, DENVER, CO

Chairman Nighthorse Campbell, Vice Chairman Inouye, and distinguished members of the U.S. Senate Committee on Indian Affairs, I am pleased to offer testimony on behalf of the National Indian Health Board (NIHB) on S. 979, Tribal Self-Governance Amendments of 1999, to provide for greater self-governance by Indian tribes, and for other purposes. The NIHB represents all 558 tribal governments in advocating for the improvement of health care delivery. Our Board Members represent each of the 12 Indian Health Service Areas, and are generally elected at-large by tribal governmental officials within their respective regional Areas.

The NIHB has a duty to represent the sovereign right of all tribal governments to promote the highest levels of health for American Indians and Alaska Natives, and to advise the Federal Government in the development of responsible health policy. It is my understanding that more than 800 treaties, executive orders, and statutes were negotiated between the United States and our native ancestors. These ancestors were men and women who shed blood and witnessed the massacre of their people, by the U.S. Army and other non-Natives who sought to carryout "Manifest Destiny". American Indian and Alaska Native governments were forced to turn over more than 450 million acres of land with the promise that their sovereign nationhood would be preserved. In exchange for this precious land, which had sustained for them a quality lifestyle, our Indian leaders were promised health care, edu-

cation, housing, and other forms of Federal assistance, all intended to enable Indian people to retain their self-sufficiency.

Much of what was promised has historically not been provided, and many of our people have since then fallen out of self-sufficiency. This fact is well documented. As a result of the initiative of many tribal leaders, the historical preference of the legislative branch of the United States Government that self-sufficiency of tribes be fostered and encouraged, and the foresight of the Presidential administration at that time, the Indian Self-Determination and Education Assistance Act was enacted into law in 1975 as P.L. 93–638. Under this act, and the many subsequent amendments, the process by which tribes may manage their own affairs has developed into a viable option for tribes to take care of themselves. After all, are not the tribes, as a local form of government, best suited to take care of their own people, if they only have the resources to do so?

What I would like to share with you today is that the policy of Self-Determination and Self-Governance is working out very well. This point is borne out by the experience of my own tribe, by the tribes of many other tribal leaders with whom I have frequent contact, and, as I will discuss today, by a study recently finished by the National Indian Health Board.

Before I comment on the specific findings of this national study, I want to convey the position of Tribal Governments on the merits of S. 979. Early last year, the Board of Directors of the National Indian Health Board met to discuss the first legislative proposal, H.R. 1833, a bill to permanently establish the Self-Governance program within the Indian Health Service. Bearing this information, each of our Board Representatives were to return to the 12 Areas of the Indian Health Service to elicit the position of their respective tribal governments on whether these governing authorities supported the former legislation permanently authorizing Self-Governance as a policy within the Indian Health Service.

During our Annual Board Meeting held on October 5, 1998, the NIHB received resolutions from five Areas: the Alaska Native Health Board; the California Rural Indian Health Board; the Montana-Wyoming Health Board; the Northwest Portland Area Indian Health Board; and the United South and Eastern Tribes, which collectively represent the views of 331 Tribal Governments who supported H.R. 1833. Upon polling the Board Representatives of the remaining seven Areas of the Indian Health Service, we understand that four Areas have chosen to not endorse or oppose the policy of Self-Governance as they feel it is a matter of tribal choice to contract or compact for health services. These four Areas with neutral positions are Albuquerque, Bemidji, Phoenix Area and Tucson Areas. Two other Areas had not met to consider the policy, these Areas include Navajo and Oklahoma Areas. (At the present time, the Navajo Nation is now preparing to enter into Self-Determination contracting for their health care services with an implementation date planned in Fiscal Year 2000.) Finally, the Aberdeen Area Tribal Chairman's Health Board issued a resolution in opposition to permanent establishment of Self-Governance.

After lengthy discussion and extensive deliberation, the National Indian Health Board set forth the following position on H.R. 1833. The NIHB affirms the solemn right of tribal governments to determine their own respective position on the policy of Self-Governance. This position is not for or against the matter of permanent self-governance within the Indian Health Service, our position merely supports the right of each Tribal Government to determine it's own destiny.

While we understand that today's hearing is on the matter of S. 979, we feel the new bill under consideration is quite similar in nature to H.R. 1833 and we maintain our position set forth at our 1998 Annual Board Meeting. Our Board of Directors will not be meeting until December 7, 8, and 9, 1999, and I anticipate they will consider the official position of the National Indian Health Board on S. 979, if deemed necessary.

With funding from the Administration for Native Americans and the Indian Health Service, the NIHB has gathered and summarized information on the effects of tribal control of health care programs from those in the most appropriate position to evaluate the impacts: the tribes themselves.

The purpose of the study was to explore from a tribal perspective how Self-Determination and Self-Governance was working, and what could be done to further the policy. The final report includes a financial analysis, as well as an assessment of the changes in services and facilities, management changes and challenges, and the impacts on quality of care. The study also considered the opportunities and barriers to contracting and compacting, the issue of tribal sovereignty, future trends, and recommendations from tribal leaders.

Four different types of research were conducted: (1) review of previous studies; (2) financial analysis using the Department of Health and Human Services (DHHS) Financial Data System; (3) survey of tribes; and (4) analysis of training needs. An Ad-

visory Committee was formed to help guide the development of the tribal survey and to review draft reports.

The survey of tribes was the most critical element of the study, since it provided the tribal perspectives necessary to accomplish the goal of the study: Evaluating the impacts of tribal choices in health care. Two surveys were conducted, one of tribal leaders and one of tribal health directors. The questionnaire used to survey tribal leaders was intended to be brief and policy oriented. The health directors questionnaire was longer, and it requested more detailed quantitative information.

A total of 210 tribes and tribal organizations participated in this study. This represents 36 percent of the 587 tribes and tribal organizations that received questionnaires. It is about 38 percent of the 554 federally recognized tribes. Every IHS administrative area was represented in the study. The rate of participation by tribes within the areas ranged from 24 percent to 100 percent.

For the tribal leader survey, 171 questionnaires were received, This is 29 percent of the total 587 mailed and 31 percent of the 554 federally recognized tribes. Tribal leaders from every area participated with a response rate ranging from 16 percent to 100 percent by area. Tribal leaders from every type of tribe participated, with 40 from IHS direct service tribes, 36 from contracting tribes and 95 from compacting tribes.

The health director survey was sent to 256 people in 239 organizations. A total of 71 questionnaires were received representing 30 percent of the organizations. Every Area was represented, with response rates ranging from 15 percent to 100 percent. Health director questionnaires were received from 21 IHS direct service tribes, 31 contracting tribes and 19 compacting tribes.

Overall, the survey sample appears to be representative of the whole. Where responses from an Area are low, they have been combined with those from other Areas to form larger groups for some types of analysis. It should be noted that this survey presents a tribal perspective giving equal weight to every federally recognized tribe regardless of the number of members enrolled or the amount of the IHS budget allocated to the tribe or the number of facilities serving the tribe.

The study provided the opportunity to survey a broad cross-section of tribal leaders and health directors from every Area of the IHS and every type of health care delivery system. In combination with financial analysis, the information obtained provides a quantitative and qualitative assessment of the impacts of self-determination contracting and self-governance compacting on the system of health care services for American Indians and Alaska Natives. It is significant because it offers a tribal perspective on the changes that have occurred in the past 3–4 years in which tribal self-governance demonstration projects have become part of the landscape of Indian Country. Evidence presented in this study suggests the following conclusions:

The Federal policy of self-determination contracting and self-governance compacting is working, but it could be improved. Overall, self-determination is working in that tribes that have chosen to manage their health care programs are very successful. However, a significant number of leaders of IHS direct service and contracting tribes felt that they had no choice, or that their choices were more limited than the law provides. Furthermore, the lack of Indian Self-Determination (ISD) contract support funding is preventing some tribes from exercising their options.

The health of American Indian and Alaska Native people has improved at the same time that there has been a growth in tribal management of programs. Numerous indicators show that the health status of American Indian and Alaska Native people has improved, and there is no direct evidence that tribal management has caused a decline in the health status of American Indians and Alaska Natives. In fact, tribal management has led to many improvements in the health systems that serve these communities, and many of these improvements are illustrated in the results of this study.

On average, every type of tribe—IHS direct service, contracting, and compacting—has achieved a higher level of health care since the self-governance demonstration project began. Tribally managed programs have an even better track record than IHS direct service programs in the addition of new services and facilities. Clearly, some tribes feel that their services and facilities have suffered due to a combination of problems, including population growth, inflation, and unfunded mandatories. Most tribes in the study, even those that have seen dramatic improvements, feel that there are many more health care services needed and that this requires greater funding by Congress.

When tribes assume control of health care, they give a high priority to prevention programs. When tribally operated programs have had the opportunity to add or expand services, prevention has been the leading area for expansion.

When forced to eliminate programs, IHS direct service was more likely to eliminate prevention services than tribally operated programs.

Tribes more commonly perceive an improvement in the quality of care when they, manage their own health care systems. Tribal leaders and tribal health directors in this study more commonly rated the quality of care over the last 3–4 years as "better", especially if they represented compacting tribes. In addition, the tribal leaders and health directors that rated the quality of care as "worse" were more commonly from IHS direct service tribes.

Population growth and inflation have reduced the purchasing power of Congressional appropriations for Indian health. Despite slight increases in actual Congressional appropriations, there has been an 18 percent decline in the adjusted per capita expenditures, or purchasing power, of IHS dollars from fiscal year 1993 to fiscal year 1998. This reduction is affecting all types of tribes in all Areas of the IHS. A significant increase in Medicaid rates provided some relief during the period of this study.

Tribes do not have more difficulty than the IHS in recruiting and retaining health care professionals. Recruitment and retention of health professionals is a problem for all parts of the Indian health system, due in large part to location of health facilities in remote, rural areas. Tribes report fewer problems recruiting health care professionals than the IHS direct service programs. There appears to be little difference in retention of health care professionals between IHS direct service tribes and tribally operated programs.

The motivation for compacting is not just increased funding. When tribal leaders were asked the reasons they chose their form of health care management, a majority of leaders of compacting tribes cited tribal sovereignty and local control. Other reasons included management flexibility to meet the needs of tribal members and the opportunity to improve the quality of care. Only 7 percent cited maximizing funding.

As the Federal system of Indian health care changes, integration of services is occurring through tribally controlled organizations. While tribes want more local control, many tribes are improving efficiency by entering into multi-tribal agreements for purchasing and delivering services. Multi-tribal agreements are expected to increase in the next 5 years according to the tribal leaders.

Self-governance compacting is not hurting most other tribes. While many tribes in this study said that they were hurting from lack of adequate Federal funding, few reported that they were hurting as a result of other tribes compacting. The direct negative consequences that were reported were the loss of discretionary funds to cover budget shortfalls at the end of the year and the shift of some responsibilities to the Service Unit level. Overall, most of the tribes that were not compacting reported improvements in services, management, and quality of care.

The Federal Government could do more to assure tribes that self-determination contracting and self-governance compacting will not lead to termination. Many tribal leaders who participated in this study would feel more comfortable about the future if there were changes at the Federal level to protect their sovereignty. They types of changes suggested include laws, funding approaches, flexibility in regulations, increased consultation, and more training in Indian law for Congress and Federal employees.

The trend toward increased self-determination contracting and self-governance compacting will make the Indian health system look different in 5 years. If tribes make the changes they predict in this study, the Indian health system will have 6 percent of tribes receiving IHS direct services, 38 percent of tribes contracting, and 56 percent compacting. While these projections are based on the definitions used in this study, the indication by tribes is clear that they plan to exercise more control over their health care delivery systems.

More research is needed on the effects of tribal management on Indian health. Followup studies are needed to more fully explore some of the issues identified in this report. It is important to continue the work begun by the Indian Health Service Baseline Measures Workgroup to further define ways of measuring quality of care indicators so that data may be aggregated nationally, by region and/or by type of tribe for purposes of monitoring trends and comparing performance. While the financial information presented in this report provides a quantitative assessment of the impacts of contracting and compacting, the picture will certainly continue to change and it is necessary to monitor those changes. The changes in the system predicted by the tribal leader's should be monitored in the context of changes in Federal policies that affect barriers and opportunities.

If the Federal Government wants to encourage Tribal management policies could be changed to remove barriers and increase opportunities. According to the findings of this study, these could include:

Full funding for both direct and indirect costs for tribal management of health services;

Remove limits on the number of compacting tribes;

More training available locally to provide entry for Tribal members into health careers;

More training and technical assistance to help tribes acquire and maintain management expertise; and

Changing attitudes in those few IHS Area Offices where tribes perceive that compacting is discouraged.

On behalf of the National Indian Health Board, I thank the committee for considering our testimony on S. 979, which seeks to permanently establish Self-Governance in health care in Indian Country, As you can see, the National Indian Health Board has determined that Self-Determination and Self-Governance is working well, and has identified ways to make it work even better. I urge you to keep these findings in mind as you consider making the Self-Governance program permanent for Indian health, and as you consider the form such legislation will take.

I call upon my American Indian and Alaska Native friends and peers to work together with the Senate Committee on Indian Affairs to help attain the goals our ancestors sought to acquire for us; to ensure that it is possible for all of our tribes to redevelop the ability to take care of their own people. Personally, my own tribe, the Poarch Band of Creek Indians which is located in Alabama, has become a Self-Governance Tribe operating under a compact this year. There are definite advantages and greater flexibility which we have realized this year, as compared to our previous experience operating under a Self-Determination compact. Under either policy framework, our Tribe has been successful and we look forward toward even greater improvements in our health care programs.

PREPARED STATEMENT OF H. SALLY SMITH, CHAIRMAN, ALASKA NATIVE HEALTH BOARD, ANCHORAGE, AK

My name is Sally Smith. I am the president of the Board of Directors of the Bristol Bay Area Corporation (BBAHC) and the Chairman of the Alaska Native Health Board (ANHB). For many years I have had the privilege of representing Alaska Natives and Indians in a number of national, regional and state health-related positions. Among other things, I presently serve as a member of the Board of Directors of the Alaska Native Tribal Health Consortium (ANTHC), the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee, the IHS Steering Committee for the Reauthorization of the Indian Health Care Improvement Act, and the Tribal Title V Permanent Self-Governance Legislative Task Force. In addition, I am an elected Chief of the Native Village of Dillingham and a tribal court judge.

I submit this written testimony to express ANHB's strongest support for the enactment of S. 979, the Tribal Self-Governance Amendments of 1999, a bill that will make the Self-Governance Demonstration Program permanent within the Department of Health and Human Services (DHHS). I will begin by briefly telling you how the Tribal Self-Governance Demonstration Program has been implemented by BBAHC and other tribes and tribal organizations in Alaska and will then describe some of the more tangible benefits that have resulted from the program. Finally, I will also discuss certain amendments to S. 979. that we urge you to make before the bill, is enacted.

Under the Indian Self-Determination and Education Assistance Act (ISDEAA or Act), BBAHQ has contracted for many years with the IHS to provide health services to 33 Alaska Native, Villages in the Bristol Bay, Koniag and Calista regions. Today, BBAHC provides a comprehensive and integrated health care system that ensures quality health care to Alaska Native and American Indian beneficiaries who live in the region. BBAHC employs over 350 people and manages the 16-bed-Kanakanak Hospital in Dillingham, Alaska a Federal hospital formerly operated by the IHS. It is the only hospital in the 46,573 square-mile Bristol Bay region and serves approximately 8,000 people in the region. In addition, BBAHC operates 28 clinics in Villages located throughout the region.

In 1994 BBAHC, as a consortium of the Villages in our region entered the Self-Governance Program as a co-signer of the Alaska Tribal Health Compact ("ATAC"). Initially 13 tribes and tribal organizations in Alaska negotiated and signed the ATHC and Annual Funding Agreements authorizing them to operate health programs in Fiscal Year 1995. Since 1994, a number of other tribes and tribal organizations in Alaska have become co-signers of the ATHC. In 1999, the ATHC has 18 co-signers under which a total of 216 federally recognized tribes in Alaska receive the great majority of the health care services provided to Alaska Native and Amer-

ican Indian beneficiaries residing in Alaska. Over 95 percent of the IHS programs in Alaska including the Alaska Native Medical Center in Anchorage are currently operated under tribal administration in accordance with the ATHC., The total amount of funding, transferred to co-signers in fiscal year 1999 is approximately $297 million.

The ATHC is the, culmination of many years of experience by Alaska Native tribes under the ISDEAA. From its inception, the act encouraged self-determination contracting of health services by Alaska Native villages, either directly or through regional health organizations like BBAHC. Starting in 1975 Alaska Native villages aggressively and successfully exercised their rights under the act and by 1994, the first year of the ATHC, most of the state's rural health programs were being operated by health boards authorized by Alaska Native tribes. The negotiation and implementation of the ATHC represented the next logical steps in the process transfer of virtually all of the IHS health delivery system in Alaska to the control of Alaska Native tribes.

An unusual feature of the ATHC is the use of the formal consensus approach. In this process a caucus representing ATHCI co-signers and other interested Alaska Native organizations and tribes represents the tribal side during negotiations. While this approach involves dedicating significant time and resources during the negotiation process it has resulted in a number of very important benefits. Differences among Alaska Native tribes and tribal organizations resulting from different priorities and circumstances have frequently been resolved so that all tribal participants are reasonably satisfied with the outcome. Further sharing information on health needs and other health issues has greatly increased the capacity of Alaska Native tribes and tribal organizations to work on solutions in the health care arena.

Since 1994, co-signers have developed a very cooperative working relationship with the IHS Area Office which has allowed complex and often controversial issues and problems that have arisen as the ATHC has been implemented to be resolved to the satisfaction of all. Early on the tribal caucus and the IHS established an Implementation Team co-chaired by a tribal and IHS representative. The Implementation Team successfully served as a vehicle where disagreements between co-signers and the IHS could be resolved. The consensus approach adopted by the Tribal Caucus during the ATHC negotiations and the work of the Implementation Team has proven to be very successful and is an example of how well the tribal/Federal cooperative framework can work to better enhance the level of health care delivered to Alaska Natives and Indians in Alaska.

By all accounts the Self-Governance Program in Alaska has -been a tremendous success. As a result of Self-Governance tribes in Alaska have been and still are in the forefront of the Act's premise that it is intended to assure Indian and Alaska Native people "an effective voice in the planning and implementation of programs for the benefit of Indians and Alaska Natives which are responsive to the true needs of Indian and Alaska Native communities."

As illustrated by the Alaska experience, the legal rights contained in title III of the act, the current Self-Governance Demonstration Program have gone a long way toward implementing Congress' policy of enhancing tribal control over health programs for American Indians and Alaska Natives provided by the Federal Government. Some of the most important new self-governance authorities that co-signers of the ATHC have derived great benefit from include:

Consolidation and Redesign. Prior to Self-Governance, co-signers could only redesign programs and reallocate funds from one budget category to another after seeking and obtaining IHS approval to do so. Under Self-Governance, co-signers have, had the flexibility to redesign programs to better address local needs and to transfer funds from one budget category to another without IHS approval. This is a clear example of successfully, reducing bureaucracy and transferring control over programs to local control.

Negotiated Baseline Measures. Prior to Self-Governance, the IHS unilaterally determined what standards and measures would be used to annually evaluate co-signers programs. Often those standards and measures were burdensome and inapplicable to co-signers' programs. Under the ATHC, the IHS and co-signers have jointly developed relevant and less burdensome baseline measurements, which are used for the annual evaluation of the co-signers programs.

Less Regulation. Prior to Self-Governance, co-signers were required to comply with detailed regulations applicable to Self-Determination contracts that unnecessarily micromanaged every aspect of the co-signers internal operations. Self-Governance has removed some of this regulatory oversight so that co-signers are now able to more efficiently and effectively operates their internal operations.

Increased Financial Flexibility. Prior to Self-Governance co-signers had to seek approval from IHS for payment of contract funds during the contract year. Often

this resulted in late payments to co-signers. Under Self-Governance, co-signers have been able to receive funds from the IHS at the beginning of the contract year. This has reduced the co-signers administrative burdens and given co-signers the ability to deposit funds and generate interest revenues that have been used to enhance the level of health care services.

Access to New Responsibilities and Funds. Self-Governance has given co-signers the right to assume responsibilities and funds (called "tribal shares") from the Area Office and IHS Headquarters that were unavailable previously. To assist the IHS in its efforts to downsize its operation in the Area Office, co-signers agreed in 1994 to a 3-year transition period. Fiscal Year 1998 was the first year that co-signers received 100 percent of all tribal shares that they had decided to take from the Area Office. These new funds and responsibilities have greatly increased the scope of responsibilities that co-signers have assumed responsibility for and control over.

The results of these new Self-Governance authorities, coupled with the cooperative effort that has occurred statewide in Alaska under the ATHC, have been dramatic. Today, Alaska Natives and Indians operate almost the entire IHS health care delivery system in Alaska. It is unquestionable that tribes and tribal organizations have been able to manage the system with more efficiency, effectiveness and creativity than the IHS ever could. Based on this track record of success, it is critical that Self-Governance becomes a permanent program within the DHHS so that tribes and tribal organizations can continue to improve the health care delivery system in Alaska.

On behalf of tribes in Alaska I have for close to 3 years participated in the national tribal effort to develop legislation that will make the Self-Governance program permanent. This effort involved extensive consultation with tribes throughout the country as well as with representatives from the, IHS and DHHS. These tribal efforts culminated in a bill supported by tribes and DHHS implementing a permanent self-governance program within DHHS that was passed by House (H.R. 1833) in the final days of the 105th Congress.

A bill similar to H.R. 1833 did not pass the Senate in the 105th Congress because concerns were raised about the bill's impact on the growing backlog of unpaid contract support costs. We note, however, S. 979 will have no impact whatsoever on the contract support problem because it extends to tribes and tribal organizations exactly the same rights to contract support costs as they are entitled to receive under title I of the act. In other words, the tribes entering into self-governance compacts were previously contracting the health program under Title I and therefore were receiving, or on the queue to receive, CSC. We hope that the contract support problems will be resolved without delay but urge that resolution of those issues should not serve, as a barrier to the enactment of S. 979 this legislative session.

The version of S. 979 introduced by Senate Committee on Indian Affairs Chairman Campbell on May 6, 1999, closely tracks the House version (H.R. 1167) introduced by Representative Miller and others on March 17. Both versions are very similar to the bills that were introduced during the 105th Congress. BBAHC fully supports the enactment of S. 979 but urges the committee to consider amending it to address a number of substantive differences between S. 979 and H.R. 1167 as well as include a number of tribally recommended changes to the bill. BBAHC and ANHB support all of the recommendations proposed by the Tribal Title V Legislative Drafting Task Force. In particular, we ask that the committee consider the following proposed amendments to S. 979:

Definition of "Intertribal Consortium". Section 501(a)(4) of S. 979 contains a definition of the term "intertribal consortium" that is unclear. It explains that coalitions of two or more tribes that join together for the purpose of participating in Self-Governance are eligible to do so, and states that tribal organizations satisfy this definition. The definition should be revised to make clear that organizations other than tribal organizations (such as the co-signers of the ATHC) can also satisfy the definition.

Expanded Criteria for Selection to Applicant Pool. S. 979 would require that a qualified tribe for the applicant pool demonstrate financial stability and financial management for the preceding 3 full fiscal years (Sec. 503(c)(1)(C)); and (c)(2) would expand the "no uncorrected significant and material audit exceptions" for determining such stability and capability in the annual audit of a tribe's self-determination contract or self-governance funding agreement with any Federal agency. We urge the committee to remove these additional and unnecessary impediments to the continued success in the implementation of the Self-Governance program.

Protection Against Funding Reductions. Section 516(a) of S. 979 drops cross-references to sections 106(a) and (b) that are included in the same provision of H.R. 1167. These provisions require that funding, provided under a self-determination contract be no less than the amount the Secretary would have otherwise provided

for the operation of the program (including contract, support), and prohibits the Secretary from reducing contract amounts except, under specified circumstances. We do note, however, that the provision regarding the funding of contract support is covered in Sec. 508(c) of S. 979 which addresses the amount of funding to be included in an AFA. The omission of a cross-reference to sections 106(a) and (b) would be a significant curtailment of tribal rights. We urge the committee to reinstate the missing language.

Treatment of Patient Records. We urge the committee to include language in the bill that ensures that patient records in the possession of tribes and tribal organizations are treated by the National Archives and Records Administration in the same manner as patient records in the possession of the Department of Health and Human Services, if requested by a tribe or tribal organization. Section 7 of the House version of the bill (H.R. 1167), as passed by the Resources Committee, contains such a provision that was modified to clarify that such records are not made subject to the provisions of the Freedom of Information Act. We urge the committee to include the same provision in S. 979.

Annual Reports. Section 106(c) of the ISDEEA formerly required the Secretaries of the Interior and the DHHS to report to Congress annually the direct program and contract support deficiencies and indirect cost rates for tribes and tribal organization. Unfortunately, the Federal Reports Elimination Act of 1998 eliminated these reporting requirements, which are critical to ensuring that Congress is apprised of these vital funding issues. We urge the committee to adopt the new section 10 to S. 979 proposed by the tribal task force that will reinstate the language from Section 106(c).

Waiver of Regulations. Section 512 of S. 979 explains the process and standards that apply when a tribe identifies a regulation that it determines should be waived by the Secretary in order to better implement a program that it has assumed in a self-governance compact and annual funding agreement. Presently section 512(b)(2) requires the IHS to approve a waiver request unless the request is prohibited by Federal law. We understand that the IHS believes that this standard is too high because it eliminates the agency's discretion to decide if waiver requests are in the best interest of the Indians served by the program and that the IHS will urge the committee to weaken this standard. We strongly disagree that this standard should be weakened in any way. A key concept in self-governance is that tribes are better placed to decide what is best for Indian people—IHS's position would shift this decisionmaking authority back to the IHS.

Amendments Clarifying Civil, Proceedings. Section 6 of S. 979 presently contains provisions that clarify what burden of proof apply to civil actions conducted pursuant to section 110(a) of the act. In previous tribal versions of the bill this section also included a provision making clear that the *de novo* judicial review standard applies to actions under the act for actions brought before the Federal district courts. We understand that the IRS strongly objects to these provisions because it does not want the bill to affect pending litigation. We urge the committee to include these provisions in the bill with prospective application at a minimum.

Davis-Bacon. Finally, we strongly support the committee's position reflected in section 509(g) that in matters regarding construction projects, tribes or tribal organizations should determine the prevailing wages as opposed to the Secretary of Labor in accordance with the Davis-Bacon Act. The same provision in the House bill would require the application of Davis-Bacon to construction projects. We fully support the language proposed in S. 979 on this issue as it is the version that was proposed by the tribes during discussions in the 105th Congress and it is consistent with existing Davis-Bacon provisions in title I of the act.

In summary, BBAHC and AHNB fully support the enactment of S. 979—with certain amendments. We urge the committee to amend the bill to include the changes that are identified in the strikeout/underline draft provided to committee staff by tribal representatives, which include, among others the provisions discussed above. Thank you for the opportunity to provide input on a bill that is of great importance to all tribes in Alaska.

PREPARED STATEMENT OF MICHEL E. LINCOLN, DEPUTY DIRECTOR, 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 percent of the federally recognized tribes and they collectively serve over 32 percent 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 Section 512(b)—Facilitation: requlation 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 unforseen 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 noncompacting 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.

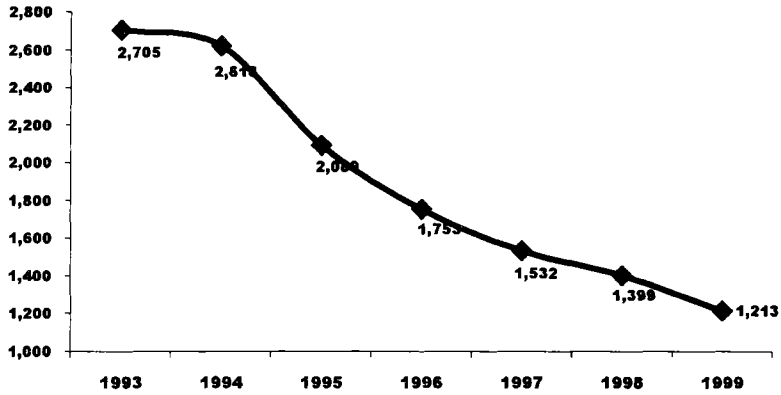
Competitive grant programs such as the Indian Health Professions Scholarships and the Tribal Management Grant Program have been established for specific public purposes. Likewise, the Department and IHS have agency-wide initiatives that address national concerns and are carried out under general grant 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.

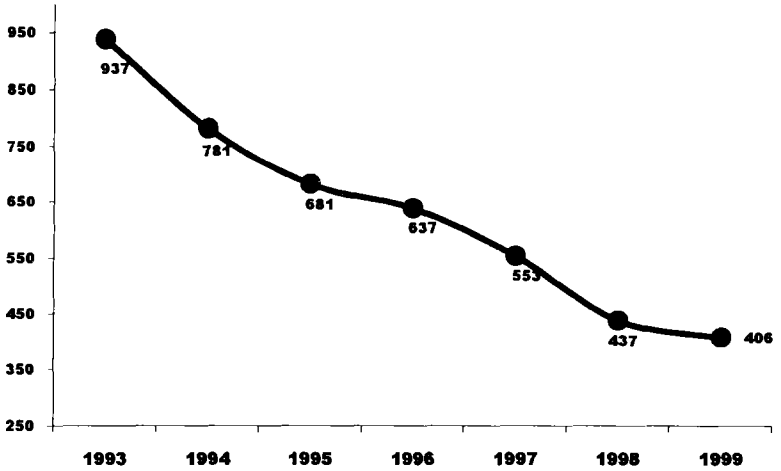
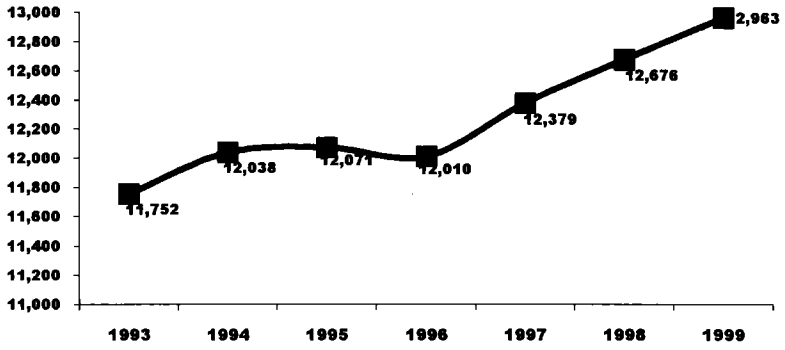
9 I commend you for your commitment to rights of the Nation's Indian Tribes and to providing them opportunities to administer those Federal programs affecting the health and welfare of their people. The Indian Health Service and the Department of Health and Human Services stand ready to work collaboratively 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.

Indian Health Service Employment: 1993 - 1999
Area Offices Declined by 1,492 FTE (-55%)



Indian Health Service Employment: 1993 - 1999
Headquarters decreased by 531 FTE (-57%)



Indian Health Service Employment: 1993 - 1999
Service Units increased by 1,211 FTE (+10%)