

TESTIMONY OF ROBERT J. CLARK, PRESIDENT/CEO
BRISTOL BAY AREA HEALTH CORPORATION
SENATE COMMITTEE ON INDIAN AFFAIRS
HEARING ON
H.R. 1833 - TRIBAL SELF-GOVERNANCE AMENDMENTS OF 1998
OCTOBER 7, 1998

Good morning, or Camai in my language, Mr. Chairman and members of the Committee. My name is Robert J. Clark. I am an Yup'ik (Eskimo) and a member of the Village of Clark's Point, a federally recognized tribe in Bristol Bay, Alaska.

I am also a member and shareholder of the Saguyak Corporation and an elected member of the Bristol Bay Native Corporation Board of Directors, both of which are Alaska Native Claims Settlement Act corporations. I sit on the region-wide social services board of the Bristol Bay Native Association, and I am the President and Chief Executive Officer of the Bristol Bay Area Health Corporation.

I am here to talk about BBAHC's experience in the Tribal Self-Governance Program and to express our support for the enactment of H.R. 1833, a bill which will make the Self-Governance Demonstration Program permanent within the Department of Health and Human Services. Let me begin by telling you a little about BBAHC and our experience with the Self-Governance Program.

Under the Indian Self-Determination and Education Assistance Act, BBAHC has contracted for many years with the Indian Health Service to provide health services to 34 Alaska Native Villages in the Bristol Bay, Koniag and Calista regions. BBAHC provides a comprehensive, integrated health care system for this service area that ensures quality health care to Alaska Native and American Indian beneficiaries who live in the region. Among other things, BBAHC manages the 16-bed Kakanak 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 service area.

In 1994 the 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 ("ATHC"). Initially 13 tribes and regional tribal health consortia 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. Today the ATHC has 18 co-signers under which a total of 213 federally recognized tribes in Alaska receive the great majority of the health care services provided to Alaska Native and American Indian beneficiaries who reside in Alaska. Over 95 percent of the IHS programs in Alaska (other than the Alaska Native Medical Center in Anchorage) are currently operated under tribal administration in accordance with the ATHC and the total amount of funding

transferred to co-signers in FY 1998 is approximately \$154.3 million.

An unusual feature of the ATHC is the use of the formal consensus approach. Under this process, negotiations on the tribal side are conducted by a caucus representing Alaska Native co-signers and other interested Alaska Native organizations and tribes. 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. Additionally, 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.

Co-signers have also developed a very cooperative working relationship with the IHS Area Office and have been able to address issues and problems that have arisen as the ATHC has been implemented. The , tribal caucus and the IHS established a Compact Implementation Team and a Technical Assistance Workgroup. The Implementation Team is co-chaired by a tribal representative and an IHS representative and has established several workgroups to assist in addressing specific issues, including information and data gathering, administrative matters, compact language revisions, tribal shares, baseline measures, and Area Office programs.

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 American Indians. By all accounts the Self-Governance Program in Alaska has been a tremendous success.

BENEFITS OF SELF-GOVERNANCE DEMONSTRATION PROGRAM

The legal rights contained in the current Self-Governance statute have gone along way towards 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 BBAHC and other co-signers have derived great benefit from include:

- Consolidation and Redesign. Prior to Self-Governance, BBAHC 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, BBAHC has the flexibility to redesign programs to better address local needs and to transfer funds from one budget category to another without IHS approval to enhance the level of health care services. It is a clear example of reducing bureaucracy and enhancing the effectiveness of a tribally-operated program.

- Negotiated Baseline Measures. Prior to Self-Governance, the IHS unilaterally

determined what standards and measures would be used to annually evaluate BBAHC's programs. Often those standards and measures were burdensome and inapplicable to BBAHC's programs. Under the ATHC, the IHS and BBAHC have jointly developed more relevant and less burdensome baseline measurements which are used for the annual evaluation of BBAHC's programs.

- Less Regulation. Prior to Self-Governance, BBAHC was required to follow the old detailed regulations applicable to Self-Determination contracts that micromanaged every aspect of BBAHC's internal operations. This was before Congress limited IHS authority to issue self-determination regulations to only a few specific areas. Self-Governance has removed some of this regulatory oversight so that BBAHC is now able to more efficiently and effectively operate its internal operations.

- Increased Flexibility. Prior to Self-Governance, BBAHC had to seek approval from IHS for payment of contract funds during the contract year. Often this resulted in late payments to BBAHC. Under Self-Governance, BBAHC has been able to receive most of its annual funding funds from the IHS in a lump sum at the beginning of the contract year. This has reduced BBAHC's administrative burden and given BBAHC the ability to deposit funds and generate interest revenues which have been used to enhance the level of health care services.

- Access to New Programs and Funds. Self-Governance has given BBAHC the right to assume more programs and funds (called "tribal shares") from the Area Office and IHS Headquarters. To assist the IHS in its efforts to downsize its operation in the Area Office, co-signers agreed in 1994 to a three-year transition period. Fiscal Year 1998 was the first year that co-signers received one hundred percent of all tribal shares that they had decided to take from the Area Office.

The results of these new Self-Governance rights, coupled with the cooperative effort that has occurred statewide in Alaska under the ATHC, have been dramatic. Today, almost the entire IHS health care delivery system in Alaska is operated by Alaska Natives and American Indians. Only the Alaska Native Health Center is still operated by the IHS, and it too will soon be run by a statewide consortium of tribes and tribal organizations as directed in Section 325 of the FY 1998 Interior and Related Agencies Appropriations Act. Tribes and tribal organizations have been able to run 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 become a permanent program within the Department of Health and Human Services so that tribes and tribal organizations can continue to improve the health care delivery system in Alaska. For the past year and a half, BBAHC has participated in a national tribal effort to develop legislation that will make the program permanent. This effort has involved extensive consultation with tribes throughout the country, and with representatives from the IHS and DHHS. The effort concluded late last summer with the completion of a draft bill which would implement a permanent self-governance program within DHHS.

In June of last year, Representatives Young (R-AK), Miller (D-CA), Kildee (D-MI), Kennedy (D-RI) and Faleomavaega (D-AS) introduced H.R. 1833, a bill that closely tracks the tribal version of the bill. The bill is detailed and provides helpful guidance for tribes and DHHS to work together in the upcoming years to ensure that it is implemented in a manner that builds on the successes of the Self-Governance Demonstration Program and improves on them.

Since H.R. 1833 was initially introduced, representatives from tribes, DHHS, IHS and House Committee members have in good faith worked to resolve a number of differences over Bill language in a mutually satisfactory manner. BBAHC submitted testimony to the House Resources Committee on March 17, 1998, and proposed a number of amendments to the Bill. Most of these concerns have been resolved, but a few remain to be addressed. BBAHC, along with other tribal representatives, will be submitting to the Committee recommendations for amendments to H.R. 1833.

BBAHC has recently become aware of an issue relating to the storage of medical records that has not been discussed previously in connection with H.R. 1833, but should be addressed through an amendment to the Bill. In 1996, the National Archives and Records Administration (NARA) General Counsel issued an opinion that tribes and tribal organizations are not "agencies" for purposes of the Federal Records Act (FRA) and thus are *not automatically* eligible for Federal Records Center (FRC) services. Instead, record storage is at the discretion of FRCS. While BBAHC believes that tribal records should not automatically be considered federal records under the FRA for all purposes, FRCs should be required to store records, on the same basis as the Department of Health and Human Services, if a tribe or tribal organization so requests.

To address this issue, BBAHC proposes that the following new provision be added as Section 6(3) of H.R. 1833:

"(3) by adding at the end thereof the following:

At the option of an Indian tribe or tribal organization, patient records may be deemed federal records under the Federal Records Act for the limited purpose of making them eligible for storage by Federal Record Centers to the same extent and in the same manner as other Department of Health and Human Services patient records."

This language would ensure 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.

CONCLUSION

In summary, BBAHC fully supports the enactment of H.R. 1833, with changes.

Thank you for the opportunity to provide our comments on a bill that is of great importance to BBAHC and the rest of the tribes and tribal organizations in Alaska.