Expansion of Tribal Self-Governance within the Department of Health and Human Services

The Indian Self-Determination and Education Assistance Act (ISDEAA) authorizes Tribes and Tribal organizations to be funded by the Federal government to provide services that the Federal government would otherwise be obligated to provide due to the trust responsibilities and treaty obligations of the United States. At present, the ISDEAA applies to only one agency within the Department of Health and Human Services (HHS): the Indian Health Service (IHS). But Tribes provide health care services to their communities funded by many non-IHS agencies within HHS, albeit primarily through grant mechanisms that deny Tribes the benefits of the ISDEAA. For over 20 years, Congress has envisioned the expansion of the ISDEAA to non-IHS agencies within HHS. It is time for Congress, HHS, and Tribes to work together on legislation to establish a demonstration project extending the ISDEAA to certain HHS programs that the Department has already determined are feasible to include in Self-Governance Agreements.

Background

When Congress passed the ISDEAA in 1975, it ushered in a new era of Self-Determination for Tribal governments that has greatly improved the lives of American Indians and Alaska Natives. Congressional findings supporting the Act recognized the obligation of the United States to support and assist Indian Tribes in the development of strong and stable Tribal governments capable of administering quality programs and developing the economies of their respective communities.

The success of Indian Self-Determination and a Self-Governance demonstration project within IHS prompted Congress in 2000 to establish permanent Tribal Self-Governance legislation for IHS in Title V of the ISDEAA. Title V authorizes participating Tribes to redesign IHS programs, and redirect funds supporting those programs, in any manner that the Tribes determine is in the best interest of their communities. By coordinating resources across the health system, Tribes have shown that they can successfully operate sophisticated health systems, improve care, and ensure local accountability to their patients. More than 375 of the 574 Federally recognized Tribes, or 65%, participate in Self-Governance within the IHS either directly or through a Tribal organization or intertribal consortium. In FY 2020, $2.6 billion of the IHS budget was transferred to Self-Governance Tribes, roughly 50% of the IHS budget. The inadequacy of Federal health care funding to Tribes is well documented,[1] so Congress should empower Tribes to use this funding most effectively by expanding Self-Governance options.

Despite the successes of Tribes operating IHS programs under Self-Governance compacts and funding agreements, other HHS agencies interact with Tribes through grant agreements, which are discretionary and as such do not uphold the trust responsibilities and treaty obligations of the United States. Grants do not provide Tribal governments the opportunity to redesign programs, effectively leverage resources, or enjoy the other benefits of the ISDEAA. Additionally, smaller Tribes may not have the infrastructure to apply for, manage, and report on grants, leaving those Tribes unable to participate despite demonstrated need. For years, Tribes have asked Congress to expand Self-Governance at HHS to certain grant programs administered by non-IHS agencies. This expansion was first envisioned by Congress back in 2000, when Congress required HHS to study the feasibility of expanding the ISDEAA to include grant programs administered by other HHS agencies. In response to

[1] U.S. Comm'n on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System,* 98 (Sept. 2004). Available at https://www.usccr.gov/pubs/docs/nabroken.pdf.

Congress, a 2003 study conducted by a joint HHS/Tribal group determined that Title VI expansion was feasible. The study identified eleven HHS programs that could be integrated into Self-Governance, and HHS recommended that Congress pass legislation authorizing a demonstration project to expand Self-Governance at HHS.

In 2004, the Senate Committee on Indian Affairs considered legislation, S. 1696, to authorize a five-year demonstration project for programs at HHS. The Committee's report, S. Rep. 108-412, accompanying that bill set forth key components of Self-Governance: "(1) streamlining bureaucracy; (2) increasing program flexibility; and (3) maximizing Indian tribal involvement in decision-making" (p 3). The report noted that Self-Governance can create cost savings for both the Tribe and the Federal government and historically has improved health care services for Indian people.

While S. 1696 ultimately was not enacted, during the Obama Administration efforts were renewed to advance Tribal Self-Governance at HHS. The Department convened the Self-Governance Tribal Federal Workgroup (SGTFW) to prioritize programs that Tribes wish to include in the demonstration project; develop recommendations to overcome logistical barriers to Self-Governance; and identify the benefits that Tribes seek to achieve with the expansion of Self-Governance. Ultimately the SGTFW was unable to reach consensus on whether the demonstration project should be modeled on the ISDEAA, as Tribes proposed, or on a consolidated block grant model, as HHS insisted.[2]

Since 2013, Tribes and Tribal Organizations have continued to make the expansion of Self-Governance at HHS a top priority in their communications to Congress and with the Department. Recently, the Biden Administration and key members of Congress have expressed interest in revitalizing the Title VI expansion effort. Expanding Self-Governance at HHS is the logical next step for the Federal government to promote Tribal sovereignty and Self-Determination and improve services to American Indians and Alaska Natives. The recent pandemic has demonstrated the need for more coordinated funding, better communication and coordination between all Departments and agencies at the Federal level, and more equitable funding for all Tribes. Under Self-Governance, programs and services throughout HHS would be better designed and operated with better results, better health, and better social outcomes for Tribal citizens, their families, and communities. Tribal health programs would reduce administrative costs and eliminate onerous and duplicative reporting requirements.

History demonstrates that Tribal governments are best served and empowered to lead our communities when Federal officials speak with and listen to Tribal leaders in formulating Federal policy that affects Tribal Nations. To move this effort forward, we urge you to support the introduction and enactment of the attached legislation, based closely on S.1696 that would establish a demonstration project in HHS as envisioned in Title VI.

If you have any questions please do not hesitate to contact Jay Spaan, Executive Director, Self-Governance Communication and Education Tribal Consortium at jays@tribalselfgov.org or 918-370-4258.

[2] U.S. Dep't of Health and Human Servs., Self-Governance Tribal Federal Workgroup Final Report (2013), p. 16. Available at: https://www.tribalselfgov.org/wp-content/uploads/2015/05/SGTFWG_FinalReport_2013.pdf.