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RE: Self-Governance

Please find for your review the following analysis of self-governance as provided by the Indian Self Determination and Education Assistance Act P.L. 93-638. Self-governance is being directed by the participating Tribes in cooperation with Congress and the Executive Branch. Under this program, each tribal government is allowed to determine how they will define their relationship with the federal government which may include Federal service delivery, Self-Determination Contracts, Self-governance Compacts, or a combination of the foregoing. Self-Governance returns decision-making authority and management responsibilities to Tribal governments. Self-Governance transfers federal funding available for programs, services, functions, and activities to Tribal control.

Self-Governance is not about termination of federal responsibility. Safeguards protecting the trust responsibility are contained in the enabling legislation, as well as in each negotiated Compact. Self-Governance does not solve all problems, but it does allow for tribes to develop solutions to those problems which affect their tribal members. It is designed to provide Tribes with the flexibility to re-design and re-prioritize federal programs and to reallocate federally-appropriated funds to whatever programs the tribe chooses. When a subject area includes Federal concerns as well as tribal concerns, specific agreements will need to be developed between the federal government and the affected Indian tribe.

Self-Governance tribes will no longer be allowed to request assistance from the Bureau of Indian Affairs as they can if they are a 638 tribe. The self-government tribes are expected to perform all obligations for which they have compacted. However, when legitimate policy and administrative concerns arise which are important to carrying out the contractual duties, federal agencies can be contacted for assistance.

BRIEF HISTORY OF SELF-GOVERNANCE

In 1975 the Indian Self Determination and Education Assistance Act P.L. 93-638, was passed to provide maximum Indian participation in the Government and education of the Indian peoples; to provide for the full participation of Indian tribes in programs and services conducted by the Federal Government for Indians and to encourage the development of human resources of the Indian people; to establish a program of assistance to upgrade Indian education; to support the right of Indian tribes to control their own education activities; and for other purposes. (January 4, 1975).

It was not until 1990, Congress enacted legislation that provided for the Self-Governance Demonstration Project. Approximately 20 tribes were chosen to participate in the project. The BIA and Indian Health Services secretly fought the project by delaying negotiations with the individual tribes. The Interior Department had proposed an addition to the Self-Determination Act which provided for a direct transfer of funds currently contracted by Tribes with a waiver of the trust responsibility of the United States for programs assumed by the Tribes. This proposal was vehemently opposed.

The Self-Governance Tribes countered the proposal with an explicit amendment that clearly protects the trust and treaty relationship. Title III was designed by the tribes to increase participation for the Demonstration Project from 20 to 30 tribes and include in the project programs, services, and functions of the BIA at all levels.

In 1991, Congress provided funding for an Office of Self-Governance at the request of the tribes. The Office was given the responsibility of working with tribes to implement ways of transferring decision-making powers over Tribal government functions from the Department to the Tribes.

In 1994, President Clinton signed Self-Governance Permanent Authorizations as an amendment to the Self-Determination Act. Many elements of Title III were carried over into the new legislation, but included negotiated rule-making, access to Central Office Tribal shares and the development of a list of non-BIA programs eligible for Tribal Compacting. The act also provided for up to twenty new tribes per year to negotiate compacts with the Department of the Interior. The Act specifically includes trust responsibility language:

> The Secretary shall negotiate and enter into an annual written funding agreement with a governing body of each participating tribal government in a manner consistent with the Federal Government's laws and trust relationship to and responsibility for the Indian people.

On August 8, 2000, Public Law 106-260 was enacted repealing Title III of the Indian Self-Determination Act. It enacted Title V "permanent Self-Governance in the Department of Health and Human Services." The Act mandated negotiated rule-making. On February 14, 2002, the Department published the final rule on the Federal Register. 42 CFR Part 36. Thirty-six tribes participated. The rules provide for recognition of the present self-governing tribes and the addition of 50 extra tribes per year.

To be eligible for participation, an Indian tribe must meet certain criteria:

1. The Tribe must have successfully completed the planning phase which includes legal and budgetary research and internal tribal government planning and organization preparation relating to the administration of health programs.

2. The tribe must have requested participation in self-governance by resolution or other official action of the governing body.

3. The tribe must have demonstrated for three (3) fiscal years, financial stability and financial management capability.

RIGHTS UNDER SELF-GOVERNANCE

Although the Act specifically pledges its trust responsibility, the tribes have the full authority, subject to any statutory requirements, to manage tribal property and assets. The Compacts provide for an annual Trust Evaluation which allows the United States to exercise the necessary supervision or oversight relative to its obligations. A clause is included in the Compact, whereby the United States may assume direct management of the physical Trust assets, upon proper notice to the tribe, if the trust assets are in imminent jeopardy. The Compact defines "imminent jeopardy" as significant loss of devaluation of the physical trust asset, caused by the Tribe's action or inaction. The individual tribe negotiates what it wants included in the compact.

Tribe's can compact to assume control over any service or program the BIA or IHS is currently providing. When these agencies provide direct services or manage Self-Determination grants or contracts, the program design and funding level decisions are made by a federal bureaucracy. Most of the BIA/IHS guidelines, policies, and regulations are prepared for national application and are not tailored to the individual needs of each tribe.

The Quinault Tribe in Washington was among the first tribes in the demonstration project. They distribute Food Stamps, TANF, WIC, and child care. They chose to distribute only these benefits. The Self-Governance Coordinator at Quinault stated they have very minimal contact with state government and have no contact with the BIA or the IHS. After taking over BIA programs, the Quinault Tribe discovered they were receiving a mere 7¢ cents on the dollar. Since their involvement with the program, the Quinalt Tribe has built a clinic and are one of the largest employers in the area. The Tribe has approximately 2,500 tribal members. In 2000 they sent 200 teenagers to college with full scholarships whereas before the project they could only send 21. With the excess money, the Quinault tribe was able to purchase land that was taken years ago. They have increased their respective land base up to 60% Indian ownership. Money received from BIA for law enforcement services was barely enough to keep the agency operating. The Quinaults now set aside 60% of money previously allocated to law enforcement for other purposes. Law Enforcement needs are met as are the needs of other programs.

One reason that tribes are *not* adopting Self-Governance is the fact that tribes in each region are pooled and the participating tribe would be given their share of the money based on their population. Oppositionists do not understand the government is already distributing funds in this manner without tribal involvement. Tribal involvement disposes of the middlemen who are receiving the lump sum of the disbursements.

INDIAN HEALTH SERVICE

Tribes taking over IHS programs and facilities face new challenges. The IHS budget is neither growing nor keeping up with the increasing costs of delivering health care. Moreover, IHS receives insufficient funds from its annual appropriation from Congress to serve its total beneficiary population. Faced with this serious funding shortfall, some tribes have chosen to limit the services provided to their own tribal members. Others have opted to serve non-Indians in order to generate revenue to support the basic health program for their members.

Previously, tribes could assume responsibility gradually. First, tribes could take over community health representative programs, followed by community health nursing, dental, mental health, and other program components. But market realities of the 1990's meant that tribes must approach health care more as a business than as a government program. Tribes faced

competition, not only for funds, but also for patients, especially since the advent of managed care.

Tribes that have decided to run their own program, that have operated two or more mature contracts and that have had three years of audits without material audit exceptions can choose between contracting or compacting. Otherwise, a tribe can contract for tribal healthcare, selecting programs, function, services, and activities they wish to take over. With a contract a tribe can also redesign the health care program tailoring it to meet community needs.

In general, tribes have found that the quality of health care improves after they take over their program from IHS. Often, compared with IHS, tribes can provide more services, including specialty and preventive care. That is because they have more operating flexibility than IHS. Frequently, tribes can shorten the waiting time for receipt of services because of their ability to meet local needs. It is also easer for tribes to align their priorities for care with the needs of their members since they are not constrained by a national system of priorities that often fails to reflect local conditions.

Because a tribe is not constrained by the federal bureaucracy, when it comes to meeting local needs a tribal health program faces fewer hurdles. This freedom plays out in many ways. Flexibility promotes creative problem solving, permitting a tribe to consolidate and redesign programs tailored to its members. Similarly, a tribe can use resources more efficiently, since it can base decisions entirely on local needs rather than on area-wide or nation-wide considerations.

Compared with IHS, tribes are more free to develop more attractive compensation packages for health professionals. Whether these packages include higher salaries, more generous vacation benefits, better retirement plans, or simply more desirable and stable working conditions, tribes have an edge over IHS because of this flexibility.

Because the tribe is better able to assess and meet community needs, it is in a better position to fulfill those needs. The tribe itself can set priorities and policies for care based on community input, rather than following national IHS priorities and standards. Thus, when their needs are being met, tribal members are more satisfied with the services provided. Further, the care furnished under tribal governance is generally more culturally sensitive than that provided by IHS.