United States General Accounting Office

GAO

Report to the Chairman, Select Committee on Indian Affairs
United States Senate

September 1986

INDIAN HEALTH SERVICE

Contracting for Health Services Under the Indian Self-Determination Act

036681

GAO/HRD-86-99

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-222159

September 17, 1986

The Honorable Mark Andrews
Chairman, Select Committee
on Indian Affairs
United States Senate

Dear Mr Chairman.

As requested by your committee, this report presents the results of our efforts to determine problems that exist between the Department of Health and Human Services' Indian Health Service and various Indian tribes in contracting for health services under Public Law 93-638 (the Indian Self-Determination Act).

We are sending copies of this report to interested congressional committees, the Director of the Office of Management and Budget, the Secretary of Health and Human Services, the Indian tribes that participated in this review, and other interested parties and will make copies available to others on request.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

Under Public Law 93-638 (commonly called the Indian Self-Determination Act), Indian tribes are authorized to plan, conduct, and administer (through contracts and grants) programs that have been the responsibility of the Secretaries of the Interior and Health and Human Services.

Senator Mark Andrews, Chairman of the Select Committee on Indian Affairs, has been concerned about problems in contracting between Indian tribes and tribal organizations and the Indian Health Service (IHS) within the Department of Health and Human Services (HHS). In September 1985, Senator Andrews asked GAO to give him information on the contracting process and to determine the problems, if any, that tribal governments and tribal organizations have experienced with the administration of contracts under Public Law 93-638. Also, GAO was asked to review the relationship between IHS and the Health Resources and Services Administration, within HHS's Public Health Service, to determine if the Health Resources and Services Administration was interfering with IHS's approval of Public Law 93-638 contracts.

Background

IHS provides comprehensive health care to about 987,000 Indians and Alaska Natives. It does this at 47 hospitals, 80 health centers, and over 500 health stations and satellite clinics. IHS also contracts with private and public health care facilities. Twelve field offices administer the program.

Public Law 93-638, enacted January 4, 1975, established a policy to permit an effective and meaningful participation by the Indian people in the planning, conduct, and administration of programs and services previously provided by federal agencies. This participation is achieved by Indian tribes operating health care activities through contracts with the federal government. In fiscal year 1985, $162 million or 43 percent of IHS's contracts for its health care system was for contracts awarded under Public Law 93-638. IHS is specifically responsible under Public Law 93-638 for approving all contracts dealing with Indian self-determination. The Health Resources and Services Administration is responsible for overseeing IHS's contracting activities.

As agreed with the committee staff, GAO reviewed the involvement of 12 Indian contractors (tribes or tribal organizations) with four IHS local offices in contracting under Public Law 93-638. GAO also reviewed the involvement of IHS headquarters and the Health Resources and Services

Administration in this contracting process. In addition, GAO sent a questionnaire in November 1985 to all federally recognized Indian tribes and tribal organizations seeking their opinions on contracting under Public Law 93-638 to operate health care programs.

Results in Brief

The majority of Indian tribal contractors GAO visited had problems working with IHS in obtaining and administering contracts under Public Law 93-638. These problems, usually disagreements between IHS and the Indian contractor over the subject matter or the level of funding for the contract, resulted in delays in completing the administrative contract process. According to Indian contractors and IHS officials, however, the delays in contract administration did not result in loss of health care services to Indian tribal members. GAO also determined that the Health Resources and Services Administration's involvement in IHS's contract administration process did not interfere with IHS's approval authority under Public Law 93-638.

Indian self-determination has not been achieved, according to the majority of Indian contractors GAO visited and the majority responding to GAO's questionnaire. Indian contractors perceive the law as giving them the opportunity to determine for themselves the manner in which health care services should be delivered, and they see IHS restricting this freedom by various contract regulations IHS views self-determination as Indian tribes being able to operate IHS activities through contracts as stated in the law. GAO concurs with IHS's views.

Principal Findings

Delays in getting contracts reviewed or approved were attributed by tribal contractors to reasons ranging from difficulties in following contract requirements to disagreements with IHS on the subject matter and/or the amount of funds for the contract. Also, IHS has no procedures for developing a contract for facility construction under Public Law 93-638. Among the reasons given by IHS for delays were the lack of sufficient personnel to review contracts and procedures to follow in the review process.

Equipment Acquistion Sometimes Delayed

Of the 12 contractors GAO visited, 9 expressed concerns about delays in equipment acquisition for items ranging from office computer equipment to X-ray machines Three did not believe there was a problem with equipment acquisition The delays occurred because time was needed to

follow the required review process and/or funds were not available to acquire the equipment

Scope of Work Under Nine Contracts Incomplete

The scope-of-work sections for 9 of the 12 contracts GAO reviewed were incomplete. For example, the contracts did not identify the number of Indian people to be served or the manner in which the contracts were to be evaluated.

Comments from the four local IHS contracting officials indicated that regular visits to the contractor's activity were sufficient to determine contractor performance. GAO did not measure contractor performance because it was beyond the scope of this assignment but believes that a clearly defined scope of work specifying what, when, and by whom services are to be provided needs to be precisely identified along with the intended beneficiaries of this service.

Self-Determination Viewed Differently

To give Indian tribes the greatest possible role in administering health care programs that affect them, Public Law 93-638 allows tribes to contract with IHS for health care activities previously operated by IHS or for new activities not previously provided. Seven of the 12 tribal contractors visited by GAO said that they have little if any say in the health care to be delivered or the funding of their contracts. In addition, they told GAO that IHS has resisted adding new health services, providing services differently than previously provided by IHS, or shifting funds within a contract. A majority (65-78 percent) of the tribal contractors responding to GAO's questionnaire expressed similar views.

Indian contractors and IHS view the law somewhat differently. Tribes generally appear to believe the law allows them to provide health care activities with little intervention from IHS. IHS, however, sees the law as requiring it to assure that adequate health care is provided and that all applicable contract administration procedures are followed. Despite this difference, Indian contractors and IHS officials provided no evidence that Indian tribal members were not receiving health care services.

While Public Law 93-638 attempts to enhance Indian self-determination and increase Indian participation, GAO believes that the contracting process as defined by the law and regulations must be followed and that IHS is responsible for the contracts under the law.

Agency Actions Taken

In April 1986, IHS and the Health Resources and Services Administration developed an initiative paper for review and comment by IHS field offices and tribal entities. This paper proposed to (1) develop procedures for tribes to follow in developing construction contracts under Public Law 93-638, (2) reduce review time for equipment acquisitions, and (3) reduce contract requirements giving tribal contractors more judgment in use of available Public Law 93-638 contract funds.

Recommendations

GAO is making no recommendations.

Agency Comments

HHS stated that the report provides a comprehensive view of contracting under Public Law 93-638 It also stated that the Public Health Service Office of Management had recently completed a study of contracting problems under the act and that HHS had initiated a number of changes discussed in this report.

Contents

Executive Summary		2
Chapter 1 Introduction		8
	Background	8
	Objectives, Scope, and Methodology	9
Chapter 2 Problems in Obtaining and Administering Public Law 93-638 Contracts		14
	Procedures for Obtaining a Contract Under Public Law 93-638	15
	Problems in Working Together	15
	Problems in Equipment Acquisition	19
	Scope of Work Under the Contracts Not Adequately Defined	20
	Agency Actions	21
	Conclusions	22
	Agency Comments and Our Evaluation	22
Chapter 3 Indian Self-Determination Under Public Law 93-638: What Are the Concerns?		24
	Indian Self-Determination—What Does the Law Say?	24
	Most Indian Organizations Contacted Do Not Believe Self-Determination Is Being Achieved	25
	Most Indian Groups Believe Funding for Contracts Is Inadequate	27
	Tribes Would Like to Assume More Responsibility for Managing Their Activities	29
	Lack of Funds Is Predominant Reason for Not Increasing Contracting	31
	Mixed Reasons for Not Contracting	32
	Agency Actions	33
	Conclusions	34
	Agency Comments and Our Evaluation	34
Appendixes	Appendix I: GAO Survey Questionnaire	36
	Appendix II: Analysis Plan for Questions 33 and 34 of Questionnaire	52
	Appendix III: Advance Comments From the Department of Health and Human Services	53

Tables

Table 1.1: Contracting Activity by 12 IHS Field Offices (Fiscal Year 1985) 10
Table 1.2: Indian Contractors Reviewed for Public Law 93-638 Contracting Activity 11
Table 1.3: Rates of Response From Tribes and Tribal Organizations to Questionnaire 12
Table 2.1: Delays Experienced in Obtaining Contract or Contract Proposal Approval 16
Table 2.2: Time to Obtain IHS Approval to Purchase Equipment 20
Table 3.1: Concerns of Tribes and Tribal Organizations About Changing Health Care Services Under Public Law 93-638 Contracts 27
Table 3.2: Tribal Interest in Changing Service Currently Delivered by IHS 30
Table 3.3: Tribal Interest in Changing Service Currently Delivered in Part or Solely Under Public Law 93-638 31
Table 3.4. Reasons for Not Increasing Contracting to Deliver Health Services Under Public Law 93-638 32
Table 3.5: Reasons for Not Contracting to Deliver Health Services Under Public Law 93-638 33
Table II 1: Grouping of Sources of Health Services 52

Abbreviations

GAO General Accounting Office
HHS Department of Health and Human Services
HRSA Health Resources and Services Administration
IHS Indian Health Service

Introduction

On September 6, 1985, Chairman Mark Andrews of the Senate Select Committee on Indian Affairs requested that we provide his committee with information concerning contracting activities between various Indian tribes and the Department of Health and Human Services' (HHS's) Indian Health Service (IHS). More specifically, he asked that we study the process and determine the problems, if any, that tribal governments and organizations have experienced with the administration of contracts under Public Law 93-638 (commonly called the Indian Self-Determination Act). Also, he requested that we review the relationship between IHS and the Health Resources and Services Administration (HRSA), within the Public Health Service, to determine if HRSA was interfering with IHS's approval of Public Law 93-638 contracts.

Background

The Public Health Service is composed of the Office of the Assistant Secretary for Health and the following agencies—the Alcohol, Drug Abuse, and Mental Health Administration; the Centers for Disease Control; the Food and Drug Administration; the National Institutes of Health; and HRSA. One of the organizational components of HRSA is IHS. HRSA oversees the contracting activities of IHS.

IHS is responsible for providing comprehensive health care to approximately 987,000 Indians and Alaska Natives through its system of 47 hospitals, 80 health centers, and more than 500 smaller health stations and satellite clinics. Also, IHS contracts with private and public health facilities to supplement its direct health care delivery system. In the field, the programs are administered through 12 field offices.

With the passage of Public Law 93-638 on January 4, 1975, the Congress responded to the Indian people's desire for self-determination by assuring maximum Indian participation in deciding on the direction of educational and other federal services to Indian communities. The Congress declared its commitment to the Indians by establishing a policy that would permit an orderly transition from federal domination of programs and services for Indians to an effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services.

The Congress further provided that the Secretary of Health, Education, and Welfare (now HHS), upon the request of any Indian tribe, is to enter into a contract or contracts with any tribal organization to carry out any or all of the Secretary's functions, authorities, and responsibilities under the act. While the Congress allowed Indian tribes and organizations to

enter into contracts for the operation of all or part of the activities performed by the federal government, the federal government still retains responsibility for the quality of services provided to the Indians and for monitoring the activity of the tribes contracting under Public Law 93-638.

Contracts under Public Law 93-638 range from providing a community health service representative for an Indian tribe to operating a hospital for Indian tribal members If an Indian tribe wants to take over the operation of an IHS function, it does so by making a contract proposal to IHS. Acceptance of the proposal by IHS enables the Indian tribe to begin performing the service for IHS The tribe receives funds for the operation based on the amounts IHS would normally allocate for the service in question The services to be performed would be similar to those currently being performed by IHS. The Indian contractor provides the service by using his own people or hiring personnel for that function

If the tribe or organization cannot provide the service required under the contract or decides not to continue contracting under Public Law 93-638, IHS is responsible for delivering the service in question to the Indian tribe. In fiscal year 1985, IHS received about $801 million to operate its health care system and awarded contracts amounting to $380 million, of which $162 million or 43 percent was for contracts developed under Public Law 93-638

Objectives, Scope, and Methodology

The objectives of this assignment were to determine whether:

- Indian tribes and organizations were experiencing problems in obtaining a Public Law 93-638 contract,
- Indian tribes and organizations were having problems in administering a Public Law 93-638 contract,
- Indian tribes and organizations were experiencing difficulties with self-determination under Public Law 93-638, and
- HRSA was interfering with IHS's approval of Public Law 93-638 contracts

We reviewed the involvement of 12 Indian contractors with four IHS field offices. In addition, we sent a questionnaire to all federally recognized Indian tribes and tribal organizations to determine their views on possible contracting and self-determination problems. The questionnaire was developed after we had identified problems by visiting the abovementioned Indian contractors and IHS field offices

By looking at 12 Indian contractors that were extensively involved with Public Law 93-638 contracts, we believed, we could obtain information that would be helpful in describing the difficulties, if any, that the contractors have had with this form of contracting. We chose Indian contractors that had received Public Law 93-638 contracts for different types of activities. For example, we chose contractors that had assumed control of an IHS health care operation, contractors that had contracts for the delivery of health services under a comprehensive health care program, a contractor that was building a hospital with a Public Law 93-638 contract, and contractors that had used Public Law 93-638 as a means of operating small health care activities, for example, a community health representative.

We chose four IHS field offices that ranked high in the relationship between total contracts over $25,000 (contracts for amounts under $25,000 are considered small purchases by the Federal Acquisition Regulation) and the total Public Law 93-638 activity at the IHS field office location. The IHS field offices we selected for our study are shown in table 1.1.

Table 1.1: Contracting Activity by 12 IHS Field Offices (Fiscal Year 1985)

Field office	All contracts over $25,000	Public Law 93-638 contracts	Percent of Public Law 93-638 contracts to all contracts	Percent rank
Sacramento[a]	$27,621,967	$21,280,535	77	3
Bemidji	26,854,779	20,688,921	77	4
Aberdeen	21,388,394	14,346,658	67	7
Albuquerque	7,960,787	2,276,383	29	11
Anchorage[a]	46,356,422	37,311,481	80	2
Billings	9,846,004	5,003,812	51	9
Window Rock	10,077,459	248,800	2	12
Oklahoma	23,861,085	16,979,501	71	5
Phoenix	10,359,018	6,661,748	64	8
Portland[a]	18,807,010	13,323,906	71	6
Tucson	6,896,588	3,128,559	45	10
Nashville[a]	21,981,274	20,273,820	92	1
Total	**$232,010,787**	**$161,524,124**	70	

[a]Field office selected

The selection of Indian tribes and tribal organizations was done in consultation with the requester, but followed the same logic as the selection

of IHS field offices. We chose Indian contractors that had experience contracting under Public Law 93-638. To review Public Law 93-638 contracting activity in the selected IHS field offices, we chose the contractors shown in table 1.2.

Table 1.2: Indian Contractors Reviewed for Public Law 93-638 Contracting Activity

Field office	Contractors selected for review
Sacramento	California Rural Indian Health Board Riverside-San Bernardino County Indian Health, Inc Karuk Tribal Health Program
Anchorage	Bristol Bay Area Health Corporation Cook Inlet Native Association Choggiung Limited
Portland	Yakima Tribe Muckleshoot Tribe Quinault Tribe
Nashville	Mississippi Band of Choctaw Indians Eastern Band of Cherokee Indians Narragansett Indian Tribe

Our review was done at the four field offices and 12 contractors listed in the table and at the IHS and HRSA headquarters in Rockville, Maryland We reviewed pertinent laws, regulations, documents, and agency procedures as they related to Public Law 93-638 contracting. Our review was done from August 1985 to January 1986 in accordance with generally accepted government auditing standards.

In addition to examining 12 contractors' experiences in contracting under the Self-Determination Act, we sent questionnaires to all tribes and tribal organizations, whether or not they were contracting under the act. Our objectives were the same as those for the 12 cases selected for review; however, we also wanted to know why tribes not contracting under Public Law 93-638 had not done so.

To obtain a universe of American Indian and Native Alaska tribes and tribal organizations eligible to contract under the provisions of Public Law 93-638, we requested that the 12 IHS field offices provide us with a list of appropriate tribes and tribal organizations in each jurisdiction. Based on those lists, we sent questionnaires in November 1985 to the universe of 386 tribes and tribal organizations. Subsequently, we identified and removed from our universe six organizations not eligible to contract under the Indian Self-Determination Act because they were urban programs receiving their funding under the Indian Health Care Improvement Act. We received completed questionnaires from 63 percent of the tribes and tribal organizations. Table 1.3 shows the response rates from

tribes and tribal organizations. (See apps. I and II for the questionnaire used for data collection and further detail on interpreting questionnaire results.)

Table 1.3: Rates of Response From Tribes and Tribal Organizations to Questionnaire

	Universe of tribes and tribal organizations	Number of tribes and tribal organizations responding	Percent of tribes and tribal organizations responding
Tribes contracting under Public Law 93-638 as of November 1985	238	158	66
Tribes not contracting under Public Law 93-638	142	80	56
Total	**380**	**238**	**63**

Problems in Obtaining and Administering Public Law 93-638 Contracts

Our review of contracting for health services under Public Law 93-638 disclosed instances where

- self-determination contract approval times were exceeding IHS guidelines,
- delays occurred in acquiring equipment for Indian contractors, and
- the scope of work to be performed by contractors was not clearly defined.

Nine of the 12 contractors we visited indicated they had experienced delays in obtaining IHS approval for Public Law 93-638 contracts The reasons for the delays related to both parties in the contract review process, i.e.:

- Tribal contractors indicated that reasons ranged from difficulties in following contract requirements to disagreements with IHS on the subject matter or amount of funds for the contract.
- IHS contracting officials indicated the reasons ranged from lack of sufficient personnel to review contracts to not having specific procedures to follow in the review process.

But, according to both Indian contractors and IHS officials, delays in contract administration have not resulted in loss of services to tribal members.

Also, 9 of the 12 tribal contract representatives indicated they were experiencing delays in obtaining IHS approval for equipment acquisition because of the IHS review process. Almost half of the tribes responding to our questionnaire said they had problems understanding IHS's procedures for purchasing equipment.

The scope-of-work section of 9 of the 12 contracts for health care services did not always precisely define such matters as the services to be provided, the population to be served, or the facilities or staff to be used. Without such information, it is difficult to measure a contractor's performance or determine the extent to which the contractor has fulfilled the terms of the contract

After we brought the above matters to the attention of IHS and HRSA, they initiated actions to improve and streamline the working relationship between Indian contractors and IHS by reducing administrative requirements, using longer contracting periods, and encouraging tribes to initiate equipment requests sooner (See p 21.)

Regarding the relationship that exists between IHS and HRSA as it relates to the administration of Indian self-determination contracts, we found that (1) current law provides that IHS has final approval of all Public Law 93-638 contracts and (2) the involvement of HRSA does not seem to interfere with IHS in administering these contracts

Procedures for Obtaining a Contract Under Public Law 93-638

IHS has published procedures that supplement the procurement regulations for Public Law 93-638. These procedures establish a step-by-step process for developing a contract proposal, including the scope-of-work section and the budget for expenditure of contract funds, and certain time frames for review and approval by IHS. HRSA oversees operational contracting activities including those of IHS. HRSA has delegated to IHS authority to review and approve contracts under $500,000 (under $300,000 for certain IHS field offices). However, since Public Law 93-638 gives contract approval authority to the director of IHS, all contracts under the act are approved by IHS HRSA reviews Public Law 93-638 contracts to determine adherence to procurement regulations and makes recommendations to IHS, but IHS has final authority for approving the contract Public Law 93-638 contracts under $500,000 are approved at most IHS field offices, while contracts of $500,000 or greater are reviewed at the IHS area office, IHS headquarters, and HRSA, with final approval by IHS headquarters.

IHS contract regulations set a time frame of 60 days for IHS field office directors to approve or disapprove contract proposals under Public Law 93-638. This time frame can be extended by mutual agreement to obtain clarification of programmatic issues. For renewing an existing contract, IHS allows 120 days for tribes to indicate an interest in continuing the contract before it expires. If the contract expires, it can be extended by mutual agreement for limited periods of time

Problems in Working Together

The relationship between IHS and an Indian contractor is unique under Public Law 93-638 because the Indian contractors provide health services to its tribal members in place of IHS IHS, however, is still responsible for seeing that the contractor delivers these services in a satisfactory manner, until such time as the quality of services becomes unsatisfactory or the contractor requests to be released from the contract, in which cases IHS must provide the service. The parties involved in the contract process have experienced problems working together, which has resulted in delays in approving or disapproving contract proposals and delays in approving renewals of existing contracts

Of the 12 Indian contractors we visited, 9 experienced delays in contract approval. The delays ranged as shown in table 2.1, depending on the IHS proposed time frame for contract proposal (60 days) and renewal of existing contracts (120 days).

Table 2.1: Delays Experienced in Obtaining Contract or Contract Proposal Approval

Contractor	IHS time frame	Days required to obtain contract or contract proposal approval
1[a]	60	143
2	120	190
3	120	189
4	[b]	[c]
5	120	166
6	120	179
7	120	304[d]
8	120	246
9	120	212

[a]Contract proposal

[b]None established

[c]Over 1 year

[d]Contract was extended 3 months during review process

Many of the tribal contractors had disagreements with IHS as to the meaning of Indian "self-determination" under the law (as discussed in ch. 3), and this delayed the process of completing the contract. Others indicated that the amount of funds available from IHS was insufficient for the services to be contracted, while still others had difficulty following the review process.

The following examples relate to the first four contracts indicated above. They illustrate the problems experienced by IHS and the Indian contractors.

- The first Indian contractor asked to take over the operation of an IHS hospital and service unit. The IHS area office approved the contractor's proposal 143 days later or 83 days after the prescribed 60-day time period for approving a new Public Law 93-638 contract proposal. The additional time was needed, according to the IHS area office, to (1) resolve contract proposal deficiencies (i.e., functional statements for activities to be operated by the contractor were not included in the contract proposal) and (2) reach agreement on the amount of funds made

available for the contract According to the Indian contractor, the area office provided neither sufficient technical assistance in developing the contract proposal nor sufficient funds for the operation of the hospital and service unit by the contractor Once agreement on the proposal and the amount of funding was obtained, a contract was signed

- For the second Indian contractor, the contract renewal process took 190 days, 70 longer than the 120-day time frame that was IHS's goal for renewing contracts The contract proposal was for medical, dental, optometric, and community health services provided by the Indian contractor The Indian contractor took 119 days to submit its proposal to renew the contract. That length of time was needed to meet new IHS area office contract requirements, the contractor indicated, and the area office did not provide sufficient guidance concerning the changes. The IHS area office agreed that contract proposal requirements were changed to make scope-of-work sections more specific. However, according to IHS officials, technical assistance would have been provided if requested by the contractor. The length of time taken by the Indian contractor to present the proposal plus the time needed by IHS to review the contract proposal accounted for the total time needed to reach agreement on renewal of the contract.
- The third Indian contractor, providing inpatient care, outpatient care, eye care, dental care, audiology services, and community health services, received notification from IHS to begin contract renewal on March 3, 1984. IHS agreed to the new contract on September 11, 1984—189 days later or 69 days over the 120-day goal for this process to obtain approval. The delays were mainly attributable to the Indian contractor not providing the contract proposal to IHS. Within the 120-day guideline for contract renewal, the contractor has 40 days to present its proposal, but the contractor took 70 days with no explanation for the delay IHS area office personnel experienced delays in reviewing the contract proposal, once received, which added to the time needed to approve the contract. The reason for the IHS delays was that certain key people were not available to review the contract. Comments from the Indian contractors indicated additional technical assistance was needed from IHS However, comments from the area office officials responsible for this contract indicated that the assistance would have been provided if it had been requested.
- The fourth Indian contractor experienced delays of over a year because IHS has no construction contracting guidelines for tribes or IHS area offices to follow in identifying who is responsible for processing, approving, and administering construction contracts under Public Law

93-638. As a result, the contract proposal for the replacement of a hospital in Alaska was delayed in the review process. According to IHS officials, $400,000 in increased construction costs were incurred by the government because the hospital had to be built the next year, following the winter season. The construction season is short in Alaska. According to the Indian contractor, delays occurred in approving the proposal because no one at the IHS field office knew what was needed for a complete construction proposal. In addition, the contractor said it was unclear who in IHS or HHS was responsible for processing and administering Public Law 93-638 construction contracts IHS area office officials stated that the review period was extended because (1) IHS had no construction contract review procedures, (2) there were disagreements within HHS over responsibility for contract review and administration, and (3) the contract contained new and unique features This was the IHS area office's first construction contract under Public Law 93-638.

The involvement of HRSA in the review process for the Public Law 93-638 contracts we looked at did not cause delays in completing the contracts. HRSA's involvement was directed at reviewing the contracts to determine adherence to procurement regulations and providing recommendations to IHS. According to IHS contracting officials in field offices we visited, the recommendations made by HRSA were helpful in developing the contracts.

Our questionnaire results showed that, during the stages of obtaining a Public Law 93-638 contract, 67 percent of the respondents receiving information from IHS on health services available for contracting stated that the information was adequate or better, while 32 percent thought the information was less than adequate and 1 percent did not respond. Eighty-five percent of the respondents requesting assistance from IHS in developing their proposals said they received that assistance. Seventy percent of the respondents stated that the assistance provided to them by IHS in developing their proposal for delivering health care services was adequate or better, while 30 percent stated the information was not adequate. Regarding the administration of the contract, 91 percent of the responding tribes and tribal organizations asking for technical assistance said they received it, 25 percent thought that the technical assistance they received was very useful, and 36 percent thought it was useful, while 38 percent thought it was of little use, and 1 percent did not respond.

Problems in Equipment Acquisition

Of the 12 contractors we visited, 9 expressed concerns because of delays in equipment acquisition, while 3 did not believe this was a problem. For the contracts we reviewed, the amount and type of equipment requested by the Indian contractor varied depending upon the purpose of the particular contract. For example, equipment acquired ranged from office computer equipment to hospital X-ray machines.

The reasons for the delays stemmed from time needed to fulfill the requirements of the review process and/or funds not being available to acquire the equipment. For example, one Indian contractor submitted three requests to purchase equipment under its contract. IHS/HRSA approval time for the three requests was an average of 119 days, ranging from a low of 71 to a high of 150 days The contractor said IHS did not have funds set aside to replace major items of equipment, such as an X-ray machine. The contractor had to buy equipment items out of operating funds. The area office officials stated that lack of equipment replacement funds and determining the justifications for equipment acquisitions were problems. The reasons for delays in obtaining equipment experienced by other contractors expressing such concerns were similar.

Prior to purchasing new or replacement equipment, a Public Law 93-638 contractor must obtain approval from IHS and/or HRSA HRSA approval is required for all nonexpendable property (property not easily used up) with a cost of $1,000 or more per item or $5,000 or more per procurement action and for certain types of property regardless of dollar value (e.g , computer equipment). IHS contracting officers can approve purchases for less than the $1,000/$5,000 standard. The review process begins with a justification for the equipment and a determination of appropriate sources (e g., the General Services Administration, other locations within IHS, or other governmental sources). Once the justification is developed and the source determined, approval is obtained from IHS or HRSA depending on the amount of the procurement action HRSA guidelines for processing equipment acquisition requests state that the IHS regional contracting officer should respond to the Indian contractor's request for equipment within 15 days of the receipt of the purchase request.

The most important delay factor in equipment acquisition for the contracts we reviewed was lack of funding for the items. If funds for the equipment items are included in the Public Law 93-638 contract, the item needs only to be approved by IHS and/or HRSA If the funds are not budgeted, delays may occur while the contractor, IHS area office, and

headquarters office determine a source of funds. According to IHS officials, IHS funds budgeted for another purpose sometimes are changed so that equipment can be acquired. IHS lacks a budget line item for equipment acquisition and replacement; consequently, funds for equipment must be obtained from general operating funds. Determining a source of funds can extend the time needed to obtain equipment.

Concerning delays in equipment acquisition, we asked tribes and tribal organizations through our questionnaire if they were satisfied with IHS's procedures for purchasing equipment under a Public Law 93-638 contract. Of the responding tribes and tribal organizations, 29 percent said they had major difficulty understanding the procedures when purchasing equipment, 18 percent considered the procedures to be of some problem, 47 percent did not consider them to be a problem, and 6 percent provided no response. When purchasing equipment for $1,000 or more, some of the responding tribes and tribal organizations experienced lengthy delays in obtaining purchase approvals. Based on their reported experiences since October 1, 1983, table 2.2 shows the average time required to obtain IHS approval

Table 2.2: Time to Obtain IHS Approval to Purchase Equipment

Length of time	Percent of respondents
1 to 30 days	11
31 to 60 days	17
61 to 90 days	23
91 or more days	31
No response	18

Scope of Work Under the Contracts Not Adequately Defined

Requirements for the scope-of-work section of the contracts we reviewed were not followed in 9 of 12 cases. The purpose of the scope-of-work section of a contract, according to IHS, is to specify the performance of the contractor and provide a basis for IHS to evaluate the contractor's performance at the end of the contract. IHS requires that the following be included in the scope-of-work section of a contract for health care services:

- goals and objectives,
- estimated number of Indians to be served,
- timetable for delivery of service,
- identification of facilities, equipment, and staff to be used,

- identification of health program and professional standards to be used, and
- evaluation plans

We did not attempt to determine the quality of the information in the contracts, only whether the items were included. Our review showed that three contracts contained information on all items, while nine contracts did not contain information on one or more items, such as the number of Indians to be served, the timetable for delivery of service, the health program and professional standards to be used, and the method to be followed in evaluating the contract. Comments from local IHS contracting officials indicated that they believed that regular visits to the contractor's activity were sufficient to determine contractor performance. Other contracting officers stated that contractors did not have the capability, in some cases, to provide the needed information, and the contracting officers did not pursue the issue. Because it was beyond the scope of this assignment, we did not determine the adequacy of the contractor's performance, but incomplete information concerning scope-of-work sections of the contract in our opinion would make evaluating contractors' performance difficult.

Agency Actions

On April 1, 1986, IHS and HRSA in a joint memorandum to IHS field offices and tribal entities proposed changes to the Public Law 93-638 contracting process. The IHS field offices were instructed to discuss these proposals with Indian contractors interested in contracting under Public Law 93-638. In commenting on a draft of this report, HHS stated that the Public Health Service Office of Management had recently completed a study of contracting problems under the act and that HHS had initiated a number of changes discussed in this report. According to agency officials, our work played a part in the development of these initiatives.

The purpose of the initiatives is to streamline the Indian self-determination contracting process by reducing administrative restrictions and improving the partnership between the Indian contractor and IHS. Being discussed with Indian tribal contractors are such subjects as reductions in contract documents needed for reviewing contracts that are substantially the same as previous contracts; the use of 3-year contracts to reduce annual contract reviews, and encouraging contractors to include equipment requirement justifications with the proposed contract. The latter would mean that, once the equipment requests and proposed contract were reviewed and approved, the contractor would be free to obtain equipment items without further processing

In addition, IHS advised us that it was currently developing procedures directed at helping Indian contractors develop improved contract proposals, including more specific scope-of-work sections for the construction of facilities. According to IHS, the new procedures will also specify the various processing steps tribes need to take to obtain IHS approval of the contract proposal.

Conclusions

Both IHS and Indian contractors have contributed to the delays in obtaining approval of Public Law 93-638 contracts. Disagreements over the services to be provided and the level of funding for the contracts cannot be resolved by writing more guidelines or making procedural changes in the contracting process but must be individually negotiated and resolved. Other delays attributable to a lack of understanding of IHS requirements can be minimized by better IHS guidelines and improved technical assistance to the tribes—matters that IHS advised us it is attempting to improve. Future delays in equipment acquisition can also be minimized if contractors specify equipment requirements in the proposed contracts—this is being discussed currently between IHS and the tribes.

In our opinion, IHS should not approve contracts whose scopes of work are not clearly defined. We believe a clearly defined scope of work specifying what, when, and by whom services are to be provided and who is to be served is critical to an effective contracting process Without this information, it is not possible to precisely determine the level of funding needed or whether the contractor fulfilled his responsibilities. The new procedures being developed by IHS to help Indian contractors improve contract proposals, including the scope-of-work sections for the construction of new facilities, should help this situation.

Agency Comments and Our Evaluation

In its August 1, 1986, comments on a draft of this report (see app. III), HHS said that our report provides a comprehensive view of contracting under Public Law 93-638. HHS officials stated that the following changes are being initiated:

- Contractors will be encouraged to submit requests for property acquisitions with the submission of their cost proposals. Required approval for most items can then be made concurrent with contract awards, and items can be obtained without further review.
- Contractors will be encouraged to use the Federal Acquisition Regulation dealing with subcontracting. This would substantially reduce the

need for seeking contracting office prior approval for only those subcontracts in excess of $25,000 or 5 percent of the total estimated cost of the contract.

- Contractors will be encouraged to continue use and expansion of 3-year contracts as an indication of the government's partnership with Indian tribes in providing continuing health care services.
- Renewal contracts for substantially the same services will be required only to update the changed services instead of a complete contract resubmission.
- Guidance for Public Law 93-638 contracts for facilities construction is being developed by HRSA.

If properly implemented, the proposed changes should help streamline the Public Law 93-638 contracting process by reducing administration restrictions. Additional actions mentioned by HHS are discussed on page 34.

Indian Self-Determination Under Public Law 93-638: What Are the Concerns?

Seven of the 12 Indian contractors we visited did not believe that self-determination was being achieved under Public Law 93-638 The seven contractors believed that they had little say in the services to be delivered or in the funding of such contracts In addition, between 65 and 78 percent of the contractors responding to our questionnaire indicated that they wanted to change an aspect of health service delivery under their Public Law 93-638 contract; however, between 38 and 55 percent told us they had major difficulty making the change because of IHS program requirements. On the other hand, IHS is responsible under the law for the quality of health care provided to Indian tribal members through Public Law 93-638 contracts, and it attempts to administer contracts to assure that high-quality services are provided and funds prudently spent. As indicated in chapter 2, IHS and HRSA have initiated actions to streamline the Public Law 93-638 contracting process and improve the involvement of the Indian contractors in the management of funds under the contracts.

Indian Self-Determination—What Does the Law Say?

The law authorizes IHS to contract with any tribal organization that wants to take over in whole or part the operation of an IHS activity. IHS can decline to contract if it can demonstrate that the proposing contractor cannot perform the work required or that the services to be provided will not be satisfactory. IHS must, however, help the tribe correct the deficiencies for which the contract was not approved. If IHS cannot support the conclusion to decline to contract, it must approve the proposal and proceed to negotiate the contract. Under Public Law 93-638, however, IHS is responsible for contract administration and the quality of services being provided to Indian tribal members. Also, if an Indian contractor no longer wants to contract, under the law IHS must provide the services that were being provided by the contractor.

Under Public Law 93-638, an Indian tribe or organization makes a contract proposal to IHS for the operation of a health care activity The contract represents the agreement of the two parties. The parties agree on the funds for the contract and the services to be delivered. IHS contract requirements provide for a detailed contract budget to be developed for the expenditure of funds under the contract and a scope-of-work section indicating the manner in which services will be provided. Public Health Service standards are used as guides for health care delivery by IHS. Changes to the contract budget and scope-of-work section of the contract require a written change to the contract. The Indian contractor can request a change to the contract; IHS then decides on the merits of the request

Most Indian Organizations Contacted Do Not Believe Self-Determination Is Being Achieved

Our discussions with 7 of the 12 Indian contractors disclosed that Indian tribes believe self-determination means the ability to direct contract funds to areas they believe are important without having to provide justification for changes in contract language or budgets for additional approval by IHS and to change the pattern of health service delivery from the way IHS has approved. More specifically, tribes and tribal organizations advised us that they would like to be free to mix staffing patterns and change budget levels in any way they feel is appropriate Tribal representatives we talked to stated that IHS is too inflexible in approving contract changes, such as adding new health services, providing services differently from the way IHS previously provided them, or using funds in a different manner than specified in the contract but for the same overall purpose.

Following are comments from six of the seven tribal officials we visited (the remaining one had similar views) who indicated their concerns with Public Law 93-638. The remaining five Indian contractors we visited said they were satisfied with the implementation of the law by IHS

- According to one tribal official, the purpose of the Indian Self-Determination Act (Public Law 93-638) is to move responsibility for Indian health away from IHS while increasing tribal control He said that the purpose has not been achieved because IHS has viewed its role as more than a program monitor, resulting in an adversarial contracting process with the burden of proof on the contractor to show IHS its capability.
- Another tribal official said that many obstacles remain that prevent the total implementation of Public Law 93-638 He said that the major obstacle preventing them from becoming a self-determining sovereign nation that they are allowed limited responsibility and no authority to manage contracted programs based on tribal management systems, goals, and objectives For example, he said that he has limited authority to manage (Public Law 93-638 contract) program budgets to fit tribal needs and no participation in determining program budgets. He said that IHS directs the tribe on how to spend program funds, which he feels defeats the purpose of the Self-Determination Act.
- Officials from a different tribe said that IHS is not administering Public Law 93-638 as a self-determination program, since IHS contracting officers frequently veto tribal health organization program proposals. These vetoes have limited the tribe's ability to add health services different from those normally provided by IHS These officials said there is less self-determination under their Public Law 93-638 contract than

under "Buy Indian" contracts (contracts with tribes for delivery of prescribed services). They believe IHS overregulates Public Law 93-638 programs, especially in restricting the health services the tribe can provide.

- Another contractor we visited does not believe that self-determination is being achieved because, among other reasons, the tribe is being directed on how to spend program funds. For example, the tribal officials wanted to give pay increases to staff under the contract. In order to give the increases, they had to seek approval from IHS. Tribal officials stated that it took 90 days to get the pay increases approved even though the increases were negotiated in the contract's scope-of-work section This contractor also expressed concern over IHS's qualification requirements for the contractor staff. The tribal officials believe that they should be able to set staff qualifications to meet their needs. However, IHS guidelines require tribes hiring staff to meet IHS qualifications
- Another tribe we visited also expressed concern with IHS's involvement in the contract's budget. The tribal official told us that once a contract budget is accepted by IHS, the tribe and not IHS should be responsible for assuring that the program operates within the budget As an example, the official said that if the contractor needs another staff person to provide the contracted services, the tribe should be able to make that change without prior IHS approval.
- Officials in another tribe expressed concern that they have no input in determining program budgets, and they do not know on what they are based. The tribal contract manager said that the tribe wants input in the budget process to ensure, as much as possible, that program budgets are based on tribal-specific needs. In addition, he felt that it was a violation of the tribe's self-determination rights to prohibit tribal input in the budget process.

The tribes and tribal organizations responding to our questionnaire indicate that IHS is limiting the Indian tribes' control over these programs Responses from these tribes and tribal organizations indicate that they have concerns similar to those of the Indian contractors we visited and that they had major difficulty changing the way health services are being delivered under Public Law 93-638 contracts

Contractors' concerns about difficulties in changing health services under a Public Law 93-638 contract are outlined in table 3 1.

Table 3.1: Concerns of Tribes and Tribal Organizations About Changing Health Care Services Under Public Law 93-638 Contracts

Figures in percents

Change desired	Respondents wanting to make change	Respondents who had difficulty with IHS in making the change
Alter staffing patterns within a project	71	41
Shift funds from project to project within a contract	65	41
Add health services not provided earlier by IHS	78	38
Provide health services different from those of IHS	67	55

IHS advised us that its responsibility is to administer the contract in a manner that would assure that adequate health care is provided and funds spent prudently. IHS uses as its guide for health care delivery the various standards followed by the Public Health Service IHS also requires submission of detailed cost budgets and detailed change justifications if changes are requested from the originally approved budget

The term "self-determination" mentioned in the title of Public Law 93-638 is in our opinion viewed differently by Indian contractors and IHS. It is clear that the law attempts to enhance Indian self-determination and increase Indian participation but within the context of the law and IHS regulations. The law and regulations state the manner and extent to which self-determination is to be achieved through the contracting process. For example, the regulations and related IHS guidance discuss such items as (1) how services should be delivered, (2) how funds will be allocated in the contract, and (3) the roles and responsibilities of each party. The law also makes IHS responsible for monitoring these contracts In addition, IHS is responsible for assuring that Indian tribal people receive adequate health care, whether provided through a contract or directly by IHS. Thus, the law and regulations deal with self-determination but also delineate specific IHS responsibilities

Most Indian Groups Believe Funding for Contracts Is Inadequate

Seventy-two percent of the tribes and organizations responding to our questionnaire said IHS funding was inadequate for the contract services to be provided Also, 85 percent of the respondents who now contract under Public Law 93-638 thought that the number of contract awards would decrease in the future. Some Indian contractors we visited were uncertain as to how IHS allocates funds and therefore distrusted IHS According to some contractors, funds are made available to them in a manner not reflective of their needs Because it was beyond the scope of

this review, we did not determine the adequacy of funding for the Public Law 93-638 contractors.

The funding of a Public Law 93-638 contract, according to IHS officials, is based on estimates of the costs IHS was incurring for the activity when it was providing the service directly—the "base recurring amount" of the contract. The base the contractor receives can be increased if the Congress provides funds to the specific tribe or tribal organization (the tribe makes a specific appeal and receives funds) or if IHS receives additional funding (funds provided by the Congress for all tribes) and distributes it among the tribes and organizations.

But for Indian contractors that want to provide health services not previously provided by IHS, the funding is different. IHS performs a needs assessment and determines the cost to provide the service, then asks the Congress for the funds. Once funded by the Congress, this amount becomes the base recurring amount for that contract.

Our questionnaire results indicate 72 percent of the respondents believe that the funds provided by IHS for direct contracting costs are inadequate to deliver the services required under their contract, while 25 percent viewed the funds as adequate or better and 3 percent did not respond. Additionally, 59 percent stated that the funds provided for indirect contracting costs (tribal-related) were inadequate, 33 percent thought the funds were adequate, and 8 percent did not respond. Of those tribes and tribal organizations responding to our questionnaire who were also contracting to deliver health care services, 73 percent cited lack of funds from IHS as a major reason for not expanding their current Public Law 93-638 contract to provide more health services to tribal members. However, the amount of funds available for increasing contract amounts is related to the funds appropriated to IHS, and since IHS's budget has remained relatively constant for the past 3 fiscal years, the level of funds available for contracting has remained about the same.

Tribes and tribal organizations expressed concern that future funding under Public Law 93-638 would decrease Eighty percent of those responding to our questionnaire thought that the dollar amounts of IHS contract awards for health services would decrease over the next several years, 49 percent thought that the decrease would be substantial. Only 13 percent thought contract award amounts would stay the same or increase.

Tribes Would Like to Assume More Responsibility for Managing Their Activities

We asked tribes and tribal organizations through what sources they were currently receiving 14 different health care services, such as inpatient, outpatient, and dental care For each service, we categorized the tribes into those currently having the service delivered solely by IHS and those that participated in the delivery of the service partly or solely through contracting under Public Law 93-638. We further asked the tribes and tribal organizations how they felt the service should be made available 5 years from now The percentage of tribes and tribal organizations currently receiving each service solely through IHS that felt they should participate in the service delivery 5 years from now ranged from 44 to 79. For tribes and tribal organizations currently participating in delivery of the 14 services, from 78 to 93 percent said they should participate in the delivery 5 years from now

Tables 3.2 and 3 3 present information for the 14 health care services for which information was obtained.

Table 3.2: Tribal Interest in Changing Service Currently Delivered by IHS

Service	No. of tribes currently getting service solely through IHS	Percent wanting IHS to continue providing service 5 years from now[a]	Percent wanting to participate in service delivery through Public Law 93-638[a]
Inpatient	83[b]	51	44
Outpatient	62	44	50
Dental	72	38	58
Eye care	67	42	52
Mental health	55	29	69
Alcoholism	19	5	79
Community health	11	27	55
Public health nursing	62	27	65
Emergency medical	23	35	61
Evaluation and planning	23	29	71
Health education	•	26	72
Sanitation facility construction	80	41	53
Health facility construction	36	31	61
Maintenance and repair	36	42	55

[a]Percents do not equal 100 because some tribes and organizations (1) did not respond to our question about the delivery of a particular service or (2) received the service from a source other than IHS or through Public Law 93-638 (i e , the tribe or organization's own funds or other non-Indian sources, such as state or local governments)

[b]The number of tribes and organizations that responded that they were receiving a health service through a particular source For example, 83 of the respondents said that they were getting inpatient care through IHS

Table 3.3: Tribal Interest in Changing Service Currently Delivered in Part or Solely Under Public Law 93-638

Service	No. of tribes currently getting service in part or solely under Public Law 93-638	Percent wanting to have service delivered solely by IHS[a]	Percent wanting to participate in delivery through Public Law 93-638[a]
Inpatient	64[b]	9	88
Outpatient	99	7	89
Dental	91	8	87
Eye care	90	8	88
Mental health	82	6	88
Alcoholism	120	3	93
Community health	142	4	90
Public health nursing	64	3	92
Emergency medical	89	8	87
Evaluation and planning	73	4	90
Health education	100	6	91
Sanitation facility construction	38	11	87
Health facility construction	31	16	81
Maintenance and repair	49	12	78

[a]Percents do not equal 100 because some tribes and organizations (1) did not respond to our question about the delivery of a particular service or (2) received the service from a source other than IHS or through Public Law 93-638 (i e , the tribe or organization's own funds or other non-Indian sources, such as state or local governments)

[b]The number of tribes and organizations that responded that they were receiving a health service through a particular source For example, 64 respondents said they were participating in the delivery of inpatient care

Lack of Funds Is Predominant Reason for Not Increasing Contracting

Through our questionnaire, we attempted to determine the reasons why some tribes and tribal organizations currently contracting under the provisions of Public Law 93-638 were not interested in increasing their level of contracting. Table 3.4 indicates the prevalence of various reasons a tribe or tribal organization might choose not to increase its contracting responsibility. As indicated earlier, lack of IHS funds to expand projects is a major reason for not increasing Public Law 93-638 contracting.

Table 3.4: Reasons for Not Increasing Contracting to Deliver Health Services Under Public Law 93-638

	Percent of contracting tribes agreeing with reason to a			
Reason	Great extent	Moderate extent	Little or no extent	No response
Tribe/organization could not agree on subject of proposal	8	6	73	13
Tribes to be served could not reach agreement as to which tribe should deliver service	10	6	72	12
Lack of IHS funds to increase size of project	73	6	12	9
Lack of tribal staff to take on more responsibility	50	16	23	11
Lack of assistance from IHS	33	19	36	12
Uncertainty of IHS services available for contracting	39	21	28	12
IHS did not accept contract proposals	27	14	46	13
IHS provided the services of interest in a satisfactory manner	11	22	52	15
Generally poor experience with contracting	11	11	66	12

Mixed Reasons for Not Contracting

We also attempted to obtain information concerning why certain tribes and tribal organizations eligible to contract under the provisions of the Indian Self-Determination Act chose not to do so. Based on the responses received, there is no predominant reason for not participating. Table 3.5 shows the prevalence of reasons given by tribes or tribal organizations for choosing not to contract.

Table 3.5: Reasons for Not Contracting to Deliver Health Services Under Public Law 93-638

	Percent of noncontracting tribes agreeing with reason to a			
Reason	Great extent	Moderate extent	Little or no extent	No response
Tribe/organization could not agree on subject of proposal	2	7	50	41
Tribes to be served could not reach agreement among themselves on who would deliver the service	2	5	53	40
It was IHS's responsibility to deliver services	26	9	31	34
Tribe/organization felt that IHS did not have funds adequate for contracting	14	10	40	36
IHS did not tell tribes/ organizations what services were available for contracting	22	9	33	36
IHS did not provide guidance on how to submit a proposal	22	7	34	36
Tribe/organization lacked expertise to provide health care services	26	9	30	36

Agency Actions

As indicated in chapter 2, IHS and HRSA have taken several initiatives to improve the Public Law 93-638 contracting process. One proposed change suggested by IHS and HRSA is to allow the contractor more latitude to manage contract funds Contractors will continue to be required to submit detailed cost budgets indicating the various categories of expenditures for their proposed contract under Public Law 93-638, and this budget will be used to arrive at the total contract figure. However, according to IHS, the detailed budget will not become part of the contract, only the total agreed-upon contract figure Deleting the detailed cost budget from the contract is intended to eliminate the need for submitting justifications to IHS for moving funds between line items of the cost budget. According to IHS, this should increase the flexibility of the Indian contractors to manage their contract funds.

On April 22, 1986, the Director of IHS informed the IHS field offices of a pilot project to develop a more rational, equitable, and consistent policy for determining the level of funding for IHS and Public Law 93-638 tribal contractors. The purpose of the project is to identify indirect costs such as Indian contractor administration and executive director costs and to develop a process of allocation to Indian contractors that is more reflective of health needs at the tribal level.

Conclusions

There is a difference in how some Indian tribes and IHS interpret the meaning of "self-determination" as it applies to Public Law 93-638. Some tribes view this term as giving them the authority to make decisions autonomously concerning the manner in which health care is to be delivered to them with minimal involvement or interference by IHS.

IHS, on the other hand, views the term somewhat differently and sees its role as requiring it to ensure that self-determination contracts specifically define what service is to be provided and how and by whom it will be delivered. Moreover, IHS sees its role as requiring it to ensure that tribes adhere to all applicable contracting rules and regulations. We agree with IHS that it has a responsibility under Public Law 93-638 to ensure that contracts are clearly written and administered in accordance with applicable contracting procedures.

Agency Comments and Our Evaluation

In commenting on this report (see app III), HHS officials indicated that the following changes are being initiated to streamline the contracting process.

- Detailed cost budgets will be discontinued as part of the contract document, thus reducing the need to modify the contract for changes in the budget.
- Contract modifications will no longer be issued for certain changes under the contract, for example rebudgeting and domestic travel estimates.
- Contracts will be funded on an annual basis for the full estimated amounts negotiated when the Appropriation Act becomes effective.
- Funding allocation will be based on a new allocation methodology reflecting need and providing for a rational and equitable distribution of funds.

The proposed changes, if properly implemented, should resolve some of the concerns raised by the Public Law 93-638 contractors. The improvements in the contracting process under Public Law 93-638 discussed above and on page 22 and the allocation of funds to tribal contractors in a manner more reflective of tribal need are steps in the right direction and should improve the working relationship between the Indian contractors and IHS

GAO Survey Questionnaire

U.S. GENERAL ACCOUNTING OFFICE

SURVEY OF AMERICAN INDIAN AND ALASKA NATIVE TRIBES
CONCERNING THE OPERATION OF HEALTH PROGRAMS UNDER P.L. 93-638

CORRECTIONS

LABEL

ID (1-5)
CARD1 (6)

The label above should contain the name and address of your tribe or tribal organization. If corrections need to be made please do so to the right of the label.

Some of the questions have instructions associated with each possible answer which tell you to "GO TO" a given question if you choose that answer. Following these instructions will allow you to skip questions for which you will not have an answer.

If you wish to add comments about any of the questions please do so in the space provided for answers to the last question.

1. Please provide the name, title and telephone number of the individual we should contact if additional information about your response is required.

   Name ______________________________

   Title ______________________________

   Telephone number ( ) ______________________

2. Has your tribe/organization ever contracted under the provisions of P.L. 93-638, the Indian Self Determination Act, to operate health programs? (CHECK ONE.) (7)

   1. [ ] Yes (GO TO QUESTION 3.)

   2. [ ] No (GO TO QUESTION 37 on page 14.)

3. For about how many years has your tribe/organization been operating health programs under P.L. 93-638? (8-9)

   ________ years

* *
* If your tribe/organization has gone through the process of getting and carrying out more than one P.L. 93-638 contract to operate health programs, your experiences may vary. In answering the following questions, please relate your experiences from October 1, 1983 to the present. *
* *

In discussing the results of the questionnaire in the report, the response labels have been combined or revised The revised question labels are identified next to the appropriate question in this questionnaire.

PREAWARD STAGES

This section concerns your experiences in the preaward stages of obtaining a P.L. 93-638 contract(s) to operate health programs. The preaward stage includes any actions prior to the time the contract was signed.

4. Since October 1, 1983, did you request the Indian Health Service (IHS) to provide you with information on health services available for contracting? (CHECK ONE.) (10)

1. [ ] Yes

2. [ ] No

5. Since October 1, 1983, did IHS provide information on health services available for contracting? (CHECK ONE.) (11)

1. [ ] Yes (GO TO QUESTION 6.)

2. [ ] No (GO TO QUESTION 9.)

6. How adequate was the information on the health services available for contracting which IHS provided to you? (CHECK ONE.) (12)

1. [ ] Much more than adequate

2. [ ] More than adequate

3. [ ] Adequate

4. [ ] Less than adequate

5. [ ] Much less than adequate

7. Since October 1, 1983, when IHS provided health services information did they also provide information on funds available for health services contracting? (CHECK ONE.) (13)

1. [ ] Yes (GO TO QUESTION 8.)

2. [ ] No (GO TO QUESTION 9.)

8. How adequate was the information on funds available for health services contracting which IHS provided to you? (CHECK ONE.) (14)

1. [ ] Much more than adequate

2. [ ] More than adequate

3. [ ] Adequate

4. [ ] Less than adequate

5. [ ] Much less than adequate

9. Since October 1, 1983, did you request IHS to provide you with assistance in developing your proposal for operating a health care program? (CHECK ONE.) (15)

1. [ ] Yes

2. [ ] No

10. Since October 1, 1983, did IHS provide assistance to you in developing your proposal for operating a health care program? (CHECK ONE.) (16)

1. [ ] Yes (GO TO QUESTION 11.)

2. [ ] No (GO TO QUESTION 12.)

11. How adequate was the assistance provided by IHS in developing your proposal for operating a health care program? (CHECK ONE.) (17)

1. [ ] Much more than adequate
2. [ ] More than adequate
3. [ ] Adequate
4. [ ] Less than adequate
5. [ ] Much less than adequate

much more than adequate and more than adequate = very useful

adequate = useful

less and much less than adequate = little value

12. Consider the services required under the scope of work section of your contract. Since October 1, 1983, how adequate have the funds been that were provided by IHS for direct contracting costs? (CHECK ONE.) (18)

1. [ ] Much more than adequate
2. [ ] More than adequate
3. [ ] Adequate
4. [ ] Less than adequate
5. [ ] Much less than adequate

13. Since October 1, 1983, how adequate have the funds been that were provided by IHS for indirect contracting costs? (CHECK ONE.) (19)

1. [ ] Much more than adequate
2. [ ] More than adequate
3. [ ] Adequate
4. [ ] Less than adequate
5. [ ] Much less than adequate

3

CARRYING OUT THE CONTRACT(S)

--TECHNICAL ASSISTANCE

14. Since October 1, 1983, did you request IHS to provide you with technical assistance after your contract was signed? (CHECK ONE.) (20)

1. [ ] Yes

2. [ ] No

15. Since October 1, 1983, did you receive technical assistance from IHS after your contract was signed? (CHECK ONE.) (21)

1. [ ] Yes (GO TO QUESTION 16.)

2. [ ] No (GO TO QUESTION 17.)

16. Of how much use was the technical assistance provided by IHS after your contract was signed? (CHECK ONE.) (22)

1. [ ] Very great use — very great use and great use = very useful
2. [ ] Great use
3. [ ] Moderate use — moderate use = useful
4. [ ] Some use — some use and little or no use = little or no use
5. [ ] Little or no use

-- PAYMENT OF VOUCHERS

17. P.L. 93-638 contracts require the monthly submission of vouchers and certain supporting documents for payment purposes.

Since October 1, 1983, how much of a problem has the requirement been to submit vouchers each month? (CHECK ONE.) (23)

1. [ ] Little or no problem — little or no problem and some problem = not a problem
2. [ ] Some problem
3. [ ] Moderate problem — moderate problem = some difficulty
4. [ ] Great problem — great problem and very great problem = major problem
5. [ ] Very great problem

18. Since October 1, 1983, how much of a problem has it been to determine what documentation is required to support a voucher for payment purposes? (CHECK ONE.) (24)

1. [ ] Little or no problem

2. [ ] Some problem

3. [ ] Moderate problem

4. [ ] Great problem

5. [ ] Very great problem

19. Since October 1, 1983, how quickly or slowly has your tribe/organization received payment for the vouchers submitted? (CHECK ONE.) (25)

1. [ ] Very quickly — very quickly and somewhat quickly = quickly
2. [ ] Somewhat quickly
3. [ ] Not quickly but not slowly
4. [ ] Somewhat slowly — somewhat and very slowly = slowly
5. [ ] Very slowly

20. As of September 30, 1985, how were payments from the federal government made to your tribe/organization? (CHECK ONE.) (26)

1. [ ] Through a letter of credit

2. [ ] Payment for vouchers submitted

3. [ ] Other (SPECIFY) ____________________

____

4

-- PURCHASING EQUIPMENT

21. Since October 1, 1983, how much of a problem have you had in understanding what you have to do when trying to purchase equipment? (CHECK ONE.) (27)

1. [ ] Little or no problem
2. [ ] Some problem
3. [ ] Moderate problem
4. [ ] Great problem
5. [ ] Very great problem

little or no problem and some problem = not a problem
moderate problem = some problem
great problem and very great problem = major problem

22. On the average, since October 1, 1983, how long do you feel it has taken to get federal approval for the purchase of health equipment costing $1,000 or more? (CHECK ONE.) (28)

1. [ ] Between 1 and 30 days
2. [ ] Between 31 and 60 days
3. [ ] Between 61 and 90 days
4. [ ] 91 or more days

-- SAFEGUARDING FEDERAL EQUIPMENT

23. Do you have procedures for safeguarding federal equipment? (CHECK ONE.) (29)

1. [ ] Yes (GO TO QUESTION 24.)
2. [ ] No (GO TO QUESTION 26.)

24. Did IHS help you set up your procedures for safeguarding federal equipment? (CHECK ONE.) (30)

1. [ ] Yes
2. [ ] No

25. How adequate do you feel your procedures for safeguarding federal equipment are? (CHECK ONE.) (31)

1. [ ] Much more than adequate
2. [ ] More than adequate
3. [ ] Adequate
4. [ ] Less than adequate
5. [ ] Much less than adequate

26. Between October 1, 1983 and September 30, 1985, about how many times did IHS make site visits to monitor or check on the safeguarding of federal equipment. (CHECK ONE.) (32)

1. [ ] Never
2. [ ] 1 to 3 times
3. [ ] 4 to 6 times
4. [ ] 7 or more times

-- SITE VISITS

27. Between October 1, 1984 and September 30, 1985 about how many times did IHS officials make site visits to assist you or to determine how well your health program was operating? (CHECK ONE.) (33)

1. [ ] Never
2. [ ] 1 to 3 times
3. [ ] 4 to 6 times
4. [ ] 7 or more times

5

IHS MEMORANDA AND ADVISORIES

28. IHS has developed Indian Self Determination Memoranda (ISDMs) and Indian Self Determination Advisories (ISDAs) to inform tribes of P.L. 93-638 policy.

Has your tribe/organization received any of this information (ISDMs or ISDAs) from IHS since October 1, 1983? (CHECK ONE.) (34)

1. [ ] Yes (GO TO QUESTION 29.)
2. [ ] No (GO TO QUESTION 31.)
3. [ ] Can't recall (GO TO QUESTION 31.)

29. How often did IHS give you help in understanding the ISDAs and ISDMs they sent to you? (CHECK ONE.) (35)

1. [ ] Always or almost always
2. [ ] More than half the time
3. [ ] About half the time
4. [ ] Less than half the time
5. [ ] Never or hardly ever

30. How much help was the combined information derived from the ISDMs and ISDAs and any assistance provided by IHS staff in guiding you in obtaining and carrying out contracting under P.L. 98-638? (CHECK ONE.) (36)

1. [ ] Very great help
2. [ ] Great help
3. [ ] Moderate help
4. [ ] Some help
5. [ ] Little or no help

6

TRIBAL/ORGANIZATIONAL INFLUENCE

31. To what extent do you feel your tribe/organization has participated in the planning of health care services delivered under your P.L. 93-638 contract? (CHECK ONE.) (37)

1. [ ] Very great extent

2. [ ] Great extent

3. [ ] Moderate extent

4. [ ] Some extent

5. [ ] Little or no extent

32. Listed below are a number of changes a tribe/organization might like to make under a contract arrangement with IHS. For each indicate (A) whether you ever wanted to make the change and (B) if so, to what extent you feel IHS program requirements prevented your tribe/organization from doing so.

	(A) Wanted to make change? (CHECK ONE.)		(B) Extent prevented by IHS program requirements (CHECK ONE FOR EACH, IF APPLICABLE.)					
	YES	NO	Little or no extent	Some extent	Moderate extent	Great extent	Very great extent	
Change	1	2	1	2	3	4	5	
(1) Alter staffing patterns within a project								(38-39)
(2) Shift funds from project to project within a contract								(40-41)
(3) Add health services not earlier provided by IHS								(42-43)
(4) Provide health services different than IHS would								(44-45)

Little or no extent and some extent = little or no difficulty
Moderate extent = somewhat difficult
Great extent and very great extent = major difficulty

7

--PROVIDERS OF HEALTH SERVICES

33. Listed below and on the next page are a number of health services that could be available to your tribe/organization. For each indicate (A) whether it is currently available to your tribe/organization and (B) if so, how it is made available.

Analysis Plan for questions 33 and 34 see appendix II

Type of Health Service	(A) Available to tribe/organization? (CHECK ONE.) Yes	No	(B) Health service is made available by (CHECK ALL THAT APPLY FOR EACH SERVICE.) IHS directly	IHS through contracts (Non-P.L. 93-638)	Tribe/organization through: P.L. 93-638 contracts	grants from U.S. Government	its own funds	Inter-governmental agreement (U.S. Government and Tribe/Organization)	Other Non-Indian Sources of funds or services	
	(1)	(2)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
1) Inpatient care										(46-53)
2) Outpatient care										(54-61)
3) Dental services										(62-69)
4) Eye care										(70-77)
5) Mental health services (excluding alcoholism)										*2 (7-14)
6) Alcoholism										(15-22)
7) Community Health Representative (CHR)										(23-30)
8) Public health nursing										(31-38)
9) Emergency Medical Services (EMS)										(39-46)

8

33. (Continued)

	(A)		(B)							
	Available to tribe/organization? (CHECK ONE.)		Health service is made available by. (CHECK ALL THAT APPLY FOR EACH SERVICE.)							
					Tribe/organization through.					
	Yes	No	IHS directly	IHS through contracts (Non-P.L. 93-638)	P.L. 93-638 contracts	grants from U.S. Government	its own funds	Inter-governmental agreement (U.S. Government and Tribe/Organization)	Other Non-Indian Sources of funds or services	
Type of Health Service	(1)	(2)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
10) Health evaluation and planning										(47-54)
11) Health education										(55-62)
12) Sanitation facility construction										(63-70)
13) Health facilities construction										(71-78)
14) Maintenance and repair of health facilities										*3 (7-14)
15) Other direct health services (SPECIFY)										(15-22)

34. The list of health services is presented below and on the next page once again. This time indicate how you feel each health service should be made available five years from now.

	Health service should be made available by (CHECK ALL THAT APPLY FOR EACH SERVICE.)							
			Tribe/organization through					
Type of Health Service	IHS directly (1)	IHS through contracts (Non-P.L. 93-638) (2)	P.L. 93-638 contracts (3)	grants from U.S. Government (4)	Its own funds (5)	Inter-governmental agreement (U.S. Government and Tribe/Organization) (6)	Other Non-Indian Sources of funds or services (7)	
1) Inpatient care								(23-29)
2) Outpatient care								(30-36)
3) Dental services								(37-43)
4) Eye care								(44-50)
5) Mental health services (excluding alcoholism)								(51-57)
6) Alcoholism								(58-64)
7) Community Health Representative (CHR)								(65-71)
8) Public health nursing								(72-78) *4
9) Emergency Medical Services (EMS)								(7-13)

10

34. (Continued)

Type of Health Service	Health service should be made available by (CHECK ALL THAT APPLY FOR EACH SERVICE.)							
	IHS directly	IHS through contracts (Non-P.L. 93-638)	Tribe/organization through: P.L. 93-638 contracts	Tribe/organization through: grants from U.S. Government	Tribe/organization through: Its own funds	Inter-governmental agreement (U.S. Government and Tribe/Organization)	Other Non-Indian Sources of funds or services	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	
10) Health evaluation and planning								(14-20)
11) Health education								(21-27)
12) Sanitation facility construction								(28-34)
13) Health facilities construction								(35-41)
14) Maintenance and repair of health facilities								(42-48)
15) Other direct health services (SPECIFY)								(49-55)

11

35. Listed below are a number of reasons why your tribe/organization is not providing more of its own health services through contracting under P.L. 93-638. For each indicate the extent to which it contributed to your decision not to contract more. (CHECK ONE BOX FOR EACH REASON.)

Reason	Very great extent (1)	Great extent (2)	Moderate extent (3)	Some extent (4)	Little or no extent (5)	
(1) Tribe/organization could not agree on subject of proposal						(56)
(2) Tribes to be served could not reach agreement to allow delivery of services						(57)
(3) Lack of funds to take on more responsibilities						(58)
(4) Lack of staff to take on more responsibilities						(59)
(5) Lack of assistance from IHS						(60)
(6) Uncertainty of IHS services available for contracting						(61)
(7) IHS will not allow us to contract for the services of interest to us						(62)
(8) IHS provides good direct services						(63)
(9) Generally poor experience with contracting						(64)
(10) Other (SPECIFY)						(65)

Very great extent and great extent = great extent

Moderate extent = moderate extent

Some and little or no extent = little or no extent

12

36. The management functions for the health services provided to your tribe/organization are operated by three IHS entities outside your tribe/organization, namely, (1) the service unit, (2) the area office and (3) headquarters. Indicate how you feel these health management functions should be operated. (CHECK ALL THAT APPLY FOR EACH MANAGEMENT FUNCTION.)

Management Function	IHS directly (1)	Tribe/ Organization through contracts (P.L. 93-638) (2)	Tribe/ Organization through grants from U.S. Government (3)	Inter-governmental agreement (U.S. Government and Tribe/ Organization (4)	
(1) Some or all of the functions of the service unit					(66-69)
(2) Some or all of the functions of the area office					(70-73)
(3) Some or all of the function of headquarters					(74-77)

IF YOU ANSWERED QUESTION 36,
GO TO QUESTION 38.

ON PAGE 15.

13

THIS QUESTION SHOULD BE ANSWERED ONLY IF YOU ANSWERED "NO" TO QUESTION 2.

37. Listed below are a number of reasons why a tribe/organization might have decided not to contract to operate a health program under P.L. 93-638. For each indicate the extent to which it contributed to your decision not to contract. (CHECK ONE BOX FOR EACH REASON.)

Reason	Very great extent (1)	Great extent (2)	Moderate extent (3)	Some extent (4)	Little or no extent (5)	
(1) Tribe/organization could not agree on subject of proposal						*5 (7)
(2) Tribes to be served could not reach agreement to allow delivery of services						(8)
(3) It is IHS's responsibility to deliver services						(9)
(4) Tribe/organization feels that IHS did not have funds adequate for contracting						(10)
(5) IHS did not tell tribe/organization what services were available for contracting						(11)
(6) IHS did not provide guidance on how to submit a proposal						(12)
(7) Tribe/organization lacks expertise to provide health care services						(13)
(8) Other (SPECIFY)						(14)

Very great extent and great extent = great extent

Moderate extent = moderate extent

Some and little or no extent = little or no extent

14

38. What does your tribe/organization feel will happen to the dollar amounts of IHS contract awards for health services over the next several years? (CHECK ONE.) (15)

1. [ ] Increase greatly
2. [ ] Increase somewhat
3. [ ] Remain about the same
4. [ ] Decrease somewhat
5. [ ] Decrease greatly

39. What does your tribe/organization feel will happen to the amount of direct federal health services provided by IHS over the next several years? (CHECK ONE.) (16)

1. [ ] Increase greatly
2. [ ] Increase somewhat
3. [ ] Remain about the same
4. [ ] Decrease somewhat
5. [ ] Decrease greatly

40. To what extent does your tribe/organization feel that federal support for health services could eventually terminate because of the self determination brought about by P.L. 93-638? (CHECK ONE.) (17)

1. [ ] Very great extent
2. [ ] Great extent
3. [ ] Moderate extent
4. [ ] Some extent
5. [ ] Little or no extent

41. Do you want to receive a copy of our final report on this study? (CHECK ONE.) (18)

1. [ ] Yes
2. [ ] No

15

42. If you have comments about any of the questions in this questionnaire or about P.L. 93-638 in general please make them here. (19)

16

Analysis Plan for Questions 33 and 34 of Questionnaire

We identified 14 different health services and asked the respondents to provide information on how they were getting a particular service Additionally, we identified seven different sources for providing the health services. For the analysis of how tribes and organizations would like to see health services delivered, we grouped the seven sources as follows:

Table II.1: Grouping of Sources of Health Services

Category of source	Source
IHS delivery	IHS directly IHS through non-Public Law 93-638 contracts
Participate in self-determination	Public Law 93-638 contracts Grants from the U S government Intergovernmental agreement (U S government and tribe/organization)
Other sources	Tribe/organization's own funds Non-Indian sources of funds or services

Additionally, for a responding tribe or organization to be considered to be receiving a service through "IHS delivery," it could not have checked any of the "participate in self-determination" categories. However, if a tribe or organization stated that it received a particular service both through "IHS delivery" and "participate in self-determination," it was considered as receiving the service through "participating in self-determination." For example, if a responding tribe stated it was receiving inpatient care through an IHS non-Public Law 93-638 contract and its own funds, for our analysis we considered the tribe's source of inpatient care to be "IHS delivery." Additionally, if the tribe said it received outpatient care from IHS directly and through a Public Law 93-638 contract, we considered that the source for outpatient care was from the tribe "participating in self-determination" since it was responsible for at least a portion of outpatient services.

Advance Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington D C 20201

AUG 1 1986

Mr. Richard L. Fogel
Director, Human Resources
Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report, "Indian Health Service: Contracting for Health Services Under Indian Self-Determination Act." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "INDIAN HEALTH SERVICE: CONTRACTING FOR HEALTH SERVICES UNDER INDIAN SELF-DETERMINATION ACT"

General Comments

We appreciate the opportunity to comment on the draft report. The report provides a comprehensive view of contracting under P.L. 93-638. We have initiated most of the changes enumerated in the report as the result of a study completed several months ago by the PHS Office of Management regarding contracting problems under the Act.

Following is a discussion of the actions we are taking to improve contracting under P.L. 93-638:

1. Discontinue the incorporation of budgets as a part of the contract document. Contractors will be required to submit a detailed line item budget with their contract proposal only for the purpose of negotiating the contract. The budget proposal will be kept in the contract file but the contract document will contain only the estimated total contract cost. Deleting budgets from the contract document will eliminate the need for contract modifications which were formerly necessary for budget adjustments and will increase the flexibility of the tribe to manage their contract.

2. Contract modifications will no longer be issued for "common accounting number" changes, rebudgeting, and domestic travel. Additionally, project officer and project director assignments and key personnel changes will be authorized by a contract officer letter.

3. Contractors will be encouraged to submit requests for Contractor Acquired or Government Furnished Property with the submission of their cost proposals. Required approvals for most items can then be made concurrent with contract award leaving the contractors free to obtain identified items without further review. Additional property requirements, identified after award, will be approved in accordance with contract provisions.

4. Encourage P.L. 93-638 contractors to accept the substitution of Federal Acquisition Regulation Clause 52.244, "Subcontracting Under Cost Reimbursement and Letter Contracts" for P.L. 93-638, General Provision 10, titled "Subcontracts." Such agreements would substantially reduce the need for seeking contracting officer prior approval to only those subcontracts in excess of $25,000 or 5 percent of the total estimated cost of the contract(s).

5. Actively encourage the continued use and expansion of 3-year contracts as indicative of the Government's partnership with Indian tribes in providing continuing health care services.

Page 2

6. Standard program reporting requirements will be established and consistently applied to ensure that the impact on contractors is minimized while simultaneously assuring that national programmatic data needs are met. Area/Program Office officials will be permitted to supplement these reporting requirements only to the extent that project peculiarities dictate.

7. Ensure that proposal requirements to renew contracts for substantially the same program of services (scope of work) will only require an update submission rather than a complete resubmission and restatement of comprehensive medical, technical, and administrative data.

8. Require full annual funding of contracts within the constraints of continuing resolutions. P.L. 93-638 contracts will be funded for the full estimated amounts negotiated when the Appropriation Act becomes effective.

In addition, funding allocation problems are being addressed by a new methodology of funding (Resource Allocation Methodology) in which IHS appropriations to directly operated and tribally operated programs will be based on an allocation methodology reflecting need and providing for a rational and equitable distribution of funds.

Finally, in response to an identified need, HRSA is in the process of developing a sample P.L. 93-638 contract for facilities construction.