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INDIAN SELF-DETERMINATION CONTRACTING

Effects of Individual Community Contracting for Health Services in Alaska

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The Honorable Ted Stevens, Chairman
The Honorable Robert C. Byrd
Ranking Minority Member
Committee on Appropriations
United States Senate

The Honorable Bob Livingston, Chairman
The Honorable David R. Obey
Ranking Minority Member
Committee on Appropriations
House of Representatives

In Alaska, the Indian Health Service (IHS) funds health services for more than 100,000 Alaska Natives—Eskimos, Aleuts, Athabascans, and American Indians—most of whom live in small, isolated communities. Under provisions of the Indian Self-Determination Act, nearly all of the health care programs traditionally administered by IHS have been transferred to 13 Alaska Native regional health organizations (RHO) with which IHS contracts to manage the programs for the Native communities.[1] In recent years, however, some Native communities have chosen to contract directly with IHS rather than go through an RHO to manage their health care programs.

Some of these individual community contracts have generated controversy. Critics contend that such contracts carry extra administrative costs that can shift dollars out of health care and into overhead. But supporters view the contracts as essential to maintaining the sovereignty of Native communities and achieving the Indian Self-Determination Act's goal of maximizing Native participation in federal health care services. The fiscal year 1998 appropriations act for the Department of the Interior placed a moratorium on IHS' further contracting with Native communities in Alaska in order to review these issues more closely.

The appropriations act requires us to study the impact of these individual contracts. As agreed with the staffs of your offices, we set the following objectives for our review:

[1]The RHOs are nonprofit organizations designated by the Native communities to contract with IHS in managing and delivering health services for Native residents.

- Determine the extent to which Alaska Native communities contract directly with IHS to manage their own health care services.
- Identify the effects these contracts are having on costs.
- Identify the effects these contracts are having on the availability of services.

Our review encompassed all IHS contracts currently in effect in Alaska under the provisions of the Indian Self-Determination Act, whether these contracts are with RHOs or with communities. We analyzed programs and services covered by each contract and compared costs and service availability. We conducted work on site at the IHS Alaska area office and the Alaska Native Health Board office in Anchorage and at IHS headquarters in Rockville, Maryland. To gain a better understanding of circumstances surrounding a recent IHS award of a large individual community contract in Ketchikan, we also conducted work there. We supplemented this information through interviews with officials from RHOs and Native communities. Our work was conducted from December 1997 through April 1998 in accordance with generally accepted government auditing standards.

Results in Brief

Relatively few Alaska Native communities have contracted directly with IHS, and those that have done so generally contracted for a limited range of health services and thus continue to receive many services through an RHO. Fifteen percent of the 227 Alaska Native communities—which represents about 10 percent of the Alaska Native population—have some form of direct contract with IHS.[2] Most communities participating in such contracts are small, and the scope of the contracts are limited. The services they have most often decided to manage on their own have included alcohol abuse and mental health services; primary care services delivered by community health aides and other nonphysician providers; and health education, transportation, and other services provided by community health representatives. A notable exception to the limited scope of these contracts is in Ketchikan, where a Native community recently assumed management and operation of a comprehensive primary care health center staffed with physicians and dentists. The dollar amount of these direct contracts represents about 6.5 percent of all IHS contracts in Alaska under the Indian Self-Determination Act; the contract with the Native community in Ketchikan accounts for about one quarter of the 6.5 percent.

[2]Of the 227 Alaska Native communities, 224 are federally recognized entities as determined by the Bureau of Indian Affairs. The three exceptions are Native communities recognized in Alaska for self-determination contracting purposes: Cook Inlet Region Natives, Valdez Native Tribe, and Qutekcak (Seward area) Native Tribe.

We found that communities with their own contracts have higher administrative costs than RHOs. IHS works with each contractor to determine the amount of administrative costs needed to manage the contracts. Indirect costs—the major component of the administrative costs—include such expenses as financial and personnel management, utilities and housekeeping, and insurance and legal services. Community contracts need about twice the amount of indirect costs that an RHO would need to manage the same programs. When a community chooses to contract directly with IHS for services previously provided by an RHO, it also has a need for one-time start-up costs that increase the administrative cost differences between community contracts and RHOs.

Determining the effects of individual community contracts on service availability proved difficult because contracts involving a switch from RHOs to local communities are relatively few in number, cover few services, and some have been in effect for a short time. The limited comparisons that can be made show that service levels have not been greatly affected by the switches thus far. However, under current IHS funding limitations, new contractors are receiving only part of their funding needs for administrative costs and may have to wait several years to receive full funding. If communities decide to contract for service programs but do not receive full funding for administrative costs and do not have other resources from which to pay for these costs, they face the risk of having to divert funds from services to cover their unfunded administrative costs. While funding shortfalls have not yet resulted in widespread adverse effects on health services availability in Alaska, the long-term picture raises cause for concern. In choosing to operate their health services without waiting for sufficient administrative funding, Alaska Native communities may have little option but to accept a potential for reduced services as a trade-off for managing elements of their health care systems.

Background

IHS, an agency within the Department of Health and Human Services, is responsible for providing federal health services to an estimated 1.5 million American Indians and Alaska Natives. In fiscal year 1998, IHS received appropriations of about $1.8 billion to provide these services, with about $291 million of this amount for Alaska. To provide care to Alaska's estimated 104,305 Natives, most of whom live in small and isolated villages, a three-tiered health care delivery system of local clinics, regional hospitals, and a comprehensive medical center was developed. (See table 1.)

Table 1: Overview of Health Care Delivery System for Alaska Natives

Service	Source of care
Routine health maintenance and emergency first aid	Care is usually provided by community health aides in 178 village clinics throughout the state. The community health aide is usually a village resident selected and trained to deliver routine health services under the long-distance telephone supervision of a physician. In some larger cities and towns, 17 health centers and clinics provide care (8 staffed with a physician and 9 with a midlevel provider, such as a physician assistant or nurse practitioner).
Routine hospital admissions	Care is usually provided in one of six regional hospitals or, when authorized, in a local private hospital.
Treatment of serious illnesses and injuries	Care is generally provided by referral to the Alaska Native Medical Center in Anchorage, which is available to all of Alaska's Natives. In some cases, care is authorized to be provided by private hospitals in Alaska or elsewhere in the United States.

IHS' mission is to provide a comprehensive health services system, while at the same time providing opportunity for maximum tribal involvement in developing and managing programs to meet their needs. The Indian Self-Determination Act gives Alaska Native communities, as well as Indian tribes throughout the United States, the option of replacing IHS as the manager and provider of health care services. To cover the costs of operating such systems on their own, the act authorizes IHS to contract with any of the recognized Alaska Native communities or other tribal organizations, such as regional or village corporations.[3]

In Alaska, IHS has established an order of precedence for recognizing various Native entities for purposes of self-determination contracting.[4] In this order of precedence, an individual Native community has priority over an RHO in obtaining contract awards from IHS. If a contract is awarded to an organization that performs services benefiting more than one community, the approval of each community's governing body (a resolution of support) is a prerequisite.

[3]The Indian Self-Determination Act as amended in 1992 also authorizes IHS to negotiate self-governance compacts with Indian tribes that allow them greater flexibility in the operation of health programs. For purposes of this report, both self-determination contracts and self-governance compacts are referred to as "contracts."

[4]In establishing the order of precedence, IHS' Alaska Area Circular No. 82-10 states that Alaska Native villages, as the smallest tribal units under the Alaska Native Claims Settlement Act (ANCSA), must approve contracts that will benefit their members. IHS will recognize as the village governing body the following entities in order of precedence: (1) Indian Reorganization Act Councils, which provide governmental functions for the village; (2) traditional village councils; (3) village for-profit Native corporations; and (4) regional for-profit Native corporations. This order of precedence has withstood several court challenges.

Relatively Few Alaska Native Communities Contract Directly With IHS to Manage Health Services

Alaska Native communities that contract directly with IHS manage a relatively small share of health care services in Alaska. Thirty-four of Alaska's 227 Native communities (15 percent)—which represents about 10 percent of the total Alaska Native population—have obtained funding in direct contracts from IHS to provide some of the health services they receive. (See table 2.) These 34 communities comprise two main groups—25 communities that decided at some point to separate from their RHO to obtain certain services, and 9 communities, mostly in the Cook Inlet area near Anchorage, that generally have not participated in an RHO. Because some communities have banded together for contracting purposes, the 34 communities are involved in a total of 21 contracts, which account for 6.5 percent of IHS' total contract funding in Alaska under the Indian Self-Determination Act.

Table 2: Indian Self-Determination Act Contracting in Alaska, Fiscal Year 1998

		Communities served		People served		Contract funding	
Type of entity contracting with IHS	**Number of contracts**	**Number**	**Percent of total**	**Number**	**Percent of total**	**Amount (in millions)**	**Percent of total**
RHO	13	193[a]	85%	94,326[a]	90.4%	$185.0	93.5%
Native communities							
Community contractors that separated from an RHO	12	25	11	6,974	6.7	8.7	4.4
Community contractors that did not participate in an RHO	9	9	4	3,005	2.9	4.1	2.1
Total	**34**	**227**	**100%**	**104,305**	**100%**	**$197.8**	**100%**

Note: Number and percent of people served are estimates for fiscal year 1998 prepared by IHS on the basis of 1990 U.S. Census Bureau data.

[a]This figure does not include the communities or people served by community contractors, although in many cases, RHOs continue to provide some services to residents in these communities and are funded by IHS to do so.

RHOs Deliver Most Health Services to Alaska Natives

Of those entities contracting with IHS, the 13 RHOs have the greatest capacity to deliver comprehensive inpatient and outpatient services. The RHOs vary considerably in size. The largest serves more than 20,000 Natives and has a budget of nearly $40 million; the four smallest serve fewer than 2,000 Natives each and have budgets of $2 million to $4 million. (See app. I for details on the 13 RHOs.) Six of the RHOs operate regional hospitals, and all 13 provide community health services to some outlying communities in

their areas. Community health services usually include training and placement of community health aides, long-distance physician supervision for the village-based community health aides, itinerant physician and dental coverage, mental health and alcohol abuse programs, and a wide range of other health and social services.

Some Communities Contract Directly to Manage Services Formerly Obtained Through RHOs

Historically, IHS has contracted with RHOs in Alaska because the RHOs were well established when the Indian Self-Determination Act became law in 1975[5] and because they were able to obtain resolutions of support from the Native communities they represented. However, a Native community has the option of withdrawing its resolution from an RHO and contracting directly with IHS to manage all or part of the health services that previously were provided by the RHO. Communities have pursued this option for a variety of reasons, including the belief that local control will improve the delivery of health services and help them attain self-determination goals. Under the Self-Determination Act, IHS' authority to decline such community contract proposals is very limited.[6]

Twenty-five communities have decided to stop obtaining some services through RHOs and to contract directly with IHS. In total, there are 12 contractors that separated from RHOs because some contracts cover more than one community. These contracts are generally for a limited number of services—most often alcohol and mental health services, community health aides, community health representatives, and other community-based services. Ten of the contracts, for example, involve management of village community health aide clinics, often in conjunction with alcohol education, prevention, and counseling activities. The Native populations served by the 12 contracts range in size from fewer than 30 people to nearly 2,000, and contract awards range from about $100,000 to more than $3 million. (See app. II.)

[5]Between 1930 and 1960, Alaska Natives established local organizations in many parts of the state to assist Native communities and advocate on their behalf. When ANCSA was passed in 1971, these organizations were in place and became the designated nonprofit service corporations to work with the for-profit ANCSA corporations in managing programs for Native residents. Thus, the majority of today's RHOs were in existence before 1975.

[6]IHS can only decline a contract proposal on the basis of one or more of the five specific reasons listed in the Indian Self-Determination Act: (1) the service to be rendered or function to be contracted will not be provided in a satisfactory manner; (2) adequate protection of trust resources is not ensured; (3) the proposed project or function cannot be properly completed or maintained by the proposed contract; (4) the amount of funds proposed is in excess of the applicable funding level for the contract; and (5) the program, function, service, or activity proposed is beyond the scope covered under the act. In cases where IHS cannot approve a contract proposal fully, it is required to approve any severable portion of it and to provide technical assistance to help tribes overcome other obstacles to successful contracting. In addition, the burden of proof for declination rests with IHS.

Although these communities, through direct contracting, manage some of their own health services, they most often remain part of the RHO network for other services, such as community health aide supervision and training, physician and dentist services, inpatient care, and management of referrals for specialty services obtained from private providers (known as contract health care).

One contractor that separated from an RHO—Ketchikan Indian Corporation (KIC)—has assumed the management of a much broader scope of services. KIC is the largest Native community contractor, serving a Native population of nearly 2,000 and with nearly $3.4 million in fiscal year 1998 funding—one quarter of the 6.5 percent share of Alaska self-determination contract funding received by community contractors. KIC manages a comprehensive primary care health center with a permanent staff of physicians, dentists, nurses, and a wide range of ancillary services, such as laboratory, X-ray, and pharmacy. KIC officials told us that the community decided to manage the health center itself because it was dissatisfied that the RHO did not provide information that it had agreed to provide, such as quarterly financial statements; did not attend KIC tribal council meetings; and had planned to replace the existing health center with a new one in the neighboring village of Saxman rather than on KIC property in Ketchikan. Nonetheless, Ketchikan continues to participate in the RHO and use the RHO's hospital in Sitka for some inpatient care.

Some Communities Have Not Been Part of a Regional Network

Nine of the communities that contract directly with IHS present a somewhat different picture than the 25 communities that separated from an RHO in that they did not previously obtain the contracted services from an RHO. Most of these communities are located in the Cook Inlet (Anchorage) area, where they have access to the extensive resources of the Alaska Native Medical Center.[7]

Eight of these nine contractors serve one small Native community each, with populations ranging from 11 to 392. (See app. III.) The ninth contractor, Kenaitze, is exceptionally large, serving a resident population of more than 1,400 Alaska Natives on the Kenai Peninsula south of Anchorage. Kenaitze has administered a health services contract since 1983; its current contract—which is over $1.1 million—provides for a

[7]For self-determination contracting purposes, the Southcentral Foundation is viewed as a "one-tribe" RHO representing the Cook Inlet area. According to an IHS official, however, under IHS policy, Southcentral Foundation represents only those Natives who reside in geographic locations in the Cook Inlet area that are not represented by a tribal government. A number of tribal governments in the area have chosen not to give resolutions of support to Southcentral Foundation to act as their RHO.

midlevel practitioner clinic with a dentist, a community health representative, and alcohol and mental health services. In addition to the Kenaitze clinic, two other contractors manage clinics with midlevel practitioners, and two manage community health aide clinics with some additional services.

Two of the contracts, which were initiated in 1997, are especially limited: Chickaloon Village, which serves 11 Natives with $46,327 in fiscal year 1998 contract funding, and Knik Tribal Council, which serves 39 Natives with $53,079 in fiscal year 1998 contract funding. The Chickaloon and Knik contracts illustrate the extent to which IHS is bound to support village self-determination decisions. When IHS identified funding to open a new midlevel clinic in the Matanuska-Susitna Valley northeast of Anchorage, three Native organizations in that area submitted proposals to manage the clinic: Southcentral Foundation (an RHO), Chickaloon, and Knik. IHS approved Southcentral's proposal to manage the clinic; in addition, IHS—under rules requiring IHS to approve any severable portion of a self-determination proposal—negotiated with Chickaloon and Knik regarding what services they could provide with their limited per-capita-based shares of the clinic funding. IHS and the villages agreed on transportation for village residents who need services in Anchorage, plus management of contract health care for Knik.

Individual Community Contracts Have Higher Administrative Costs

Administrative costs are higher under individual community contracts than under contracts with RHOs. Under either contracting arrangement, the Native organization receives the same amount of funding for direct program costs, but IHS has determined that individual communities need more funding for administrative expenses—both to start up the contract and to administer it on an ongoing basis. The higher administrative costs generally reflect lost economies of scale that result from the smaller scope of most individual contracts.

IHS Determines Funding Needs With Native Organizations

Under the Indian Self-Determination Act, an Indian tribe or Alaska Native community that chooses to contract with IHS is entitled to funding for both direct program costs and contract support costs (CSC) to cover administrative functions. In Alaska, these provisions apply both to contracts between IHS and RHOs and to contracts between IHS and individual Native communities. Direct program funding is the amount that IHS would have spent to operate the programs that were transferred to the contractors. CSC funding generally is an additional amount, not normally

spent by IHS, that is needed to cover reasonable costs incurred by Native organizations to ensure compliance with the terms of the contracts and prudent management of the programs. Direct program costs are the same regardless of who manages the contracts—communities or RHOs. In contrast, CSC amounts may differ considerably.

Determination of CSC needs is based on three cost categories: start-up costs, indirect costs, and direct costs. (See table 3.) The largest cost category is indirect costs, which include most ongoing overhead expenses. For most contracts, indirect costs account for over 80 percent of the recurring CSC funding needs.

Table 3: Categories and Types of Contract Support Costs

CSC category	Description
Start-up costs	One-time costs incurred in planning and assuming management of the programs. Examples include buying computers and training staff.
Indirect costs	Ongoing overhead expenses, which are often divided into three groups—management and administration, facilities and equipment, and general services and expenses. Management and administration includes financial and personnel management, procurement, property and records management, data processing, and office services. Facility and equipment includes building, utilities, housekeeping, repair and maintenance, and equipment. General services includes insurance and legal services, audit, general expenses, interest, and depreciation.
Direct costs	This category covers such costs as unemployment taxes and workers' compensation insurance for direct program salaries.

Our analysis of cost differences between RHO contracts and individual community contracts focused on the first two types of contract support costs—start-up and indirect costs.[8] To provide a consistent comparison, we examined the fiscal year 1998 funding needs of each contractor for these costs as determined by IHS.

Start-Up Costs

New and expanded contracts are eligible for start-up CSC funding. If an individual Native community decides to contract separately for services formerly obtained through an RHO, its funding needs for start-up costs represent an increased, one-time cost for the program. IHS records show that the 12 community contracts involving services formerly provided by RHOs received IHS approval for at least $452,000 in start-up CSC

[8]We excluded direct costs from the analysis because it is a small component of contract support costs and because, unlike the two other cost categories, it consists mainly of costs that tend not to be affected by who is doing the contracting.

needs—ranging from about $22,500 to $140,000 per contract—which were generally based on program size.[9]

Indirect Costs

On average, individual community contractors have considerably higher indirect costs than RHOs would have to manage the same programs. For fiscal year 1998, IHS determined indirect cost needs of slightly more than $3 million for the 12 individual community contracts that separated from RHOs.[10] The IHS official responsible for negotiating these contracts told us that to estimate what the indirect costs would have been if the services provided under the 12 contracts had instead been provided through RHOs, he would use the indirect cost rates in place for the RHOs during fiscal year 1998. Using these rates that he provided, we determined the indirect costs for the RHOs to be about $1.3 million—or less than half of the indirect costs for the community contractors. (See app. IV for a contract-by-contract comparison of indirect cost needs of the Native communities and RHOs.)

IHS officials said the main reason individual community contracts had higher indirect costs was that the small size of these contracts resulted in the loss of administrative economies of scale. Because RHOs have an administrative structure in place to support other contracts and services, they can spread the overhead expenses among their programs. Small communities, however, generally have to build the administrative structure for these services alone.

We did not compare the indirect costs of the other nine community contracts with those of RHOs because the programs managed by these contracts were not formerly a part of an RHO. However, we found that indirect costs as a proportion of total funding needs that IHS determined for these contracts were similar to those of the 12 community contracts that cover services formerly obtained through an RHO. This would indicate that these contracts also are likely to have higher indirect costs than RHOs.

[9]IHS has data on start-up costs for only 9 of the 12 community contracts that cover services formerly obtained through an RHO.

[10]IHS determines CSC funding needs with each contractor on an annual basis. For large Native organizations that have negotiated their indirect cost rates with another federal agency—such as the Bureau of Indian Affairs (BIA)—for other contracts, IHS will apply those rates to the program costs to determine the amount of indirect costs. For organizations without an existing rate, IHS negotiates the amount of indirect costs by identifying and calculating overhead cost items.

Availability of Services Not Greatly Affected, but Risk for Adverse Effects Exists

To date, IHS contracting with Native communities rather than RHOs does not appear to have had a significant impact on the level of services available to Alaska Natives, although we did identify a few temporary service disruptions. The small number of these contracts; their generally restricted scope; and in some cases, their recent implementation have likely been key factors in limiting the effects on Native communities or RHOs. However, a shortfall in available CSC funding may jeopardize the continuation of this level of service. Native communities that are not in a financial position to absorb unfunded contract support costs may face the risk of having to divert funds from health services to cover their unfunded contract support needs. We found one instance, in Fort Yukon, where this may already have occurred.

To Date, Service Availability Has Not Been Greatly Affected

When individual Alaska Native communities have contracted directly with IHS to provide some of their own health services, they generally have assumed management responsibility for existing, defined service programs being operated by IHS or an RHO. Because these contracts essentially enable program transfers, the types of services provided do not change initially. In addition, the community contractors generally continue to employ the same staff and use the same facilities.

Generally, we did not find that a community's takeover of services from an RHO in itself had a substantial effect on the types of services provided or service utilization. The service disruptions that we did find in some communities, such as in Ketchikan, and in some clinics staffed by community health aides tended to be transitory in nature.

- In Ketchikan, when KIC took over the contract from the RHO in October 1997, the health center's resources, staff, and patient population were split and two separate facilities were established. KIC's health center initially had a gap in dental services because the RHO retained both dentists when staffing was split. This gap has been partly remedied, and we observed no other gaps in services at the time of our review. However, due to uncertainty surrounding the future of this contract, the staffing situation at both the KIC and RHO clinics was not stable.[11]
- A review of clinics staffed by community health aides that now are managed by community contractors revealed sharp variations in some communities over past years in the numbers of patient encounters

[11]Because of concerns about cost inefficiencies in this case, the Congress enacted P.L. 105-143 in December 1997, which requires IHS to make only one contract award in the Ketchikan area beginning in fiscal year 1999. As of April 1998, IHS had not decided whether KIC or the RHO would receive the renewal contract award.

provided. However, these variations did not appear to be related to community contracting because they occurred whether a community or an RHO was managing the services. The variations most likely reflect temporary losses of staff because in small, remote Alaska communities, it takes time and training to replace community health aides.

Shortfall in CSC Funding Poses Risks to Service Availability

The 1988 and 1994 amendments to the Indian Self-Determination Act clarified that CSC funding should be made available to provide Indian tribes and Alaska Native communities with additional resources to develop the capability and expertise to manage services on their own. The Senate report accompanying the 1994 amendments expressed concern that without this additional support, Indian tribes would be compelled to divert funds from health services to contract support costs.

IHS has established two separate pools of CSC funding—one for the recurring CSC needs of ongoing contracts and the other for additional CSC needs of new or expanded contracts. IHS-wide, CSC funding for ongoing contracts has increased from about $100.6 million in fiscal year 1993 to $168.7 million in fiscal year 1998; and since 1994, the Congress has appropriated $7.5 million per year specifically for the CSC needs of new or expanded contracts. However, the demand for CSC funding has greatly exceeded these appropriations. As a result, while IHS has agreed with each contractor on the amount of their CSC funding needs, it has not been able to fully fund those needs. The contractors have the option of delaying or going ahead without full CSC funding, and most of them have chosen to begin implementing their contracts without full funding. Since 1995, IHS has reported a shortfall in CSC funding each year, largely because of the rapid increase in tribal assumption of IHS programs nationwide. For fiscal year 1997, the shortfall totaled $82 million nationwide, over $12 million of it in Alaska.[12]

As a mechanism for allocating available CSC funds among contractors, IHS maintains a waiting list for new contractors that have chosen to operate without full CSC funding. Available funding is allocated on a first-come, first-served basis, and a new contractor's waiting time for full CSC funding may be at least several years. For example, contractors that entered into

[12]Based on IHS' fiscal year 1997 report to the Congress, about $33 million of this shortfall was for ongoing contracts and $49 million was for new or expanded awards. IHS maintains a waiting list for the CSC funding needed for new or expanded contracts. When a contract on the waiting list receives CSC funding, that amount is treated as recurring costs and is funded from ongoing CSC funding in subsequent years.

contracts in 1994 are now at the top of the waiting list and expect to be funded in fiscal year 1998, a 3- to 4-year wait.[13]

IHS reports that a continued lack of sufficient CSC funds could, by necessity, result in tribes funding administrative functions with moneys that otherwise would have been used to provide direct health care services.[14] This condition could occur if tribes are unable to realize efficiency gains or do not have other resources to help offset their CSC funding shortfalls.

This risk is present in Alaska. Fourteen of the 21 direct community contractors were operating with CSC shortfalls in fiscal year 1998, and 7 of these shortfalls represented between 30 to 74 percent of the contract's total recurring CSC funding needs. (See app. V for details on the CSC shortfalls by contractor.) Shortfalls of this magnitude could make it difficult for tribes to continue to maintain the same level of health services. The risk is less for RHOs, which also may have CSC shortfalls but generally are in a better financial position than community contractors to manage these shortfalls because they manage large multimillion-dollar operations that can benefit from economies of scale and have multiple sources of revenue that can generate positive cash flow. The varying effects of substantial CSC shortfalls on communities that contract directly with IHS can be seen in Ketchikan and Fort Yukon—which are served by the two largest direct community contractors.

In Ketchikan, Other Resources Were Initially Available to Manage the CSC Shortfall

In Ketchikan, the large CSC shortfall of over $500,000 a year has not had a negative impact on overall services to the communities involved because both the community contractor, KIC, and the RHO, Southeast Alaska Regional Health Consortium (SEARHC), were able—at least temporarily—to provide additional resources to make up for the funding gap.

Prior to October 1997, SEARHC was managing the Ketchikan Indian health center to serve six Native communities—Ketchikan, Saxman, and four outlying communities on Prince of Wales Island. When the health center contract was split, KIC received 58 percent of the funding to serve Ketchikan Natives and SEARHC retained the remainder to serve Saxman and the other communities. Loss of economies of scale occurred in two ways.

[13]The wait could be significantly longer or shorter for contractors at the bottom of the waiting list, depending on the amount of CSC funding appropriated in future years.

[14]The Indian Self-Determination Act allows tribes the flexibility to rebudget funds between program and administrative functions as needed to perform the contract.

First, additional clinic space was leased to operate two separate clinics. Second, additional staff were needed to deliver the same level of services in two facilities. For example, the total number of clinical and administrative staff for the clinic before the split was 59.5 full time equivalents (FTE). After the split, the two clinics had a combined total of 68 FTEs. Most of the increase was for duplicated administrative functions, such as the need to have two clinic directors, two business office directors, and two computer programmers. Both SEARHC and KIC had the additional resources to initially absorb the additional costs.

- SEARHC is a large RHO that manages many federal and state health programs and services for the benefit of Alaska Natives in Southeast Alaska. At the end of fiscal year 1996, its annual budget was over $50 million and it had over $23 million in net assets. Although the Ketchikan clinic had 2 years remaining on its lease, SEARHC decided to lease a new facility nearby for its own clinic to serve Saxman and the outlying communities, asserting that it was not practical to share the original building with KIC. SEARHC spent almost an additional $1 million of its own resources on this new clinic. With the new clinic and additional staff, clinic waiting times for the Saxman Native community were reduced.
- KIC assumed management of the original clinic with a contract award of nearly $3.4 million and a CSC shortfall of over $500,000. Although it is too soon to determine the long-term impact of this shortfall, KIC has been able to use its tribal government resources—especially management staff from other programs—to reduce the additional administrative need. A large tribe by Alaska standards, Ketchikan has a well-established tribal government with a staff of more than 70 that administers BIA and other federal and state-funded programs totaling at least $2.5 million in addition to the IHS contract.

In Fort Yukon, Other Resources Were Not Available to Manage the CSC Shortfall

CSC shortfalls have created significant difficulties for the Council of Athabascan Tribal Governments (CATG) in managing the small Fort Yukon clinic and community health aide services in the Yukon Flats area northeast of Fairbanks. CATG, which is a consortium of eight small Native communities, has been operating its $1.8 million contract with an annual CSC shortfall of about $500,000. This shortfall represents almost 53 percent of CATG's total recurring CSC funding needs. According to its most recent audit report, CATG did not have any additional resources to compensate for a shortfall of this size. The official responsible for CATG operations told us that because CATG did not have resources to cover the CSC funding gap, it

had no option but to use some program funds to support administrative functions.

There were some indications that CATG's financial strain may have contributed to other operational problems. In 1997, for example, there was considerable turnover in the Fort Yukon clinic's physician assistant staff, resulting in vacancies that were not immediately filled. Although the number of outpatient visits at the clinic did not decline substantially, the Native Village of Fort Yukon was so dissatisfied with CATG's failure to fill the clinic vacancies and with other matters that the village considered asking IHS or the RHO to resume management of the clinic or contracting directly with IHS. In the end, however, no action was taken; and as of April 1998, the Native Village of Fort Yukon remained a member of CATG and was receiving health services through its contract.

Conclusions

Through the Indian Self-Determination Act, the Congress has clearly expressed support for Alaska Native communities to exercise their preferences for managing health care resources, such as through an RHO or on their own. Many Native communities view the option to contract directly with IHS as fundamental to their ability to achieve self-determination and self-governance objectives, and about 15 percent of Native communities in Alaska have chosen to do so.

However, funds have been available to only partially support the additional administrative costs created by lost economies of scale when Native communities contract directly with IHS. These funding shortfalls appear not to have greatly affected the availability of health services in Alaska at this time, but maintaining the availability of services in the future could pose challenges to some Native community contractors. To the extent that Native communities assume management of a greater portion of their health services in a time of increasing CSC funding shortfalls, the risk for adverse impacts on health services delivery also increases.

Agency Comments

We provided a draft of this report to IHS officials, who concurred with the report's findings. In addition, they provided some technical comments, which we incorporated as appropriate. Appendix VI contains the full text of IHS' comments.

We are sending copies of this report to the Secretary of Health and Human Services, the Director of Indian Health Service, the Director of the Office of Management and Budget, and other interested parties. We will also make copies available to others upon request.

The information contained in this report was developed by Frank Pasquier, Assistant Director; Sophia Ku; and Ellen M. Smith. Please contact me at (202) 512-6543 or Frank Pasquier at (206) 287-4861 if you or your staff have any questions.

Bernice Steinhardt
Director, Health Services Quality
and Public Health Issues

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Tables

Abbreviations

ANCSA	Alaska Native Claims Settlement Act
BIA	Bureau of Indian Affairs
CATG	Council of Athabascan Tribal Governments
CSC	contract support cost
FTE	full-time equivalent
IHS	Indian Health Service
KIC	Ketchikan Indian Corporation
RHO	regional health organization
SEARHC	Southeast Alaska Regional Health Consortium

Alaska Native RHO Contractors

This appendix presents data to describe the 13 Alaska Native RHOs in terms of the amount of their fiscal year 1998 contract awards, numbers of Alaska Natives and Native communities served in 1998, and types of facilities operated. Six of the RHOs operate regional hospitals, and all 13 use the Alaska Native Medical Center in Anchorage for treatment of serious illnesses and injuries. Outpatient medical care is provided at three types of facilities: (1) health centers staffed with physicians and dentists; (2) midlevel clinics staffed with physician assistants or nurse practitioners; and (3) village-based clinics that rely on community health aides—who usually are village residents with special training—to provide first aid in emergencies, primary care, and preventive health services under telephone supervision by physicians.

Table I.1: Key Characteristics of Alaska Native RHO Contractors

RHO	FY 1998 award amount	1998 Census population[a]	Number of Alaska Native communities[b]	Facilities
Aleutian/Pribilof Islands Association, Inc.	$2,336,138	1,189	7	St. Paul midlevel clinic
Arctic Slope Native Association	4,764,444	4,216	7	Samuel Simmonds Hospital, Barrow
Bristol Bay Area Health Corporation	19,018,994	6,069	32	Kanakanak Hospital, Dillingham; midlevel clinics at Chignik and Togiak
Chugachmiut	3,722,339	1,769	7	Seward midlevel clinic
Copper River Native Association	2,013,338	669	8	Community health aide clinics only
Kodiak Area Native Association	5,633,895	2,465	9	Kodiak physician and dentist health center
Maniilaq Association	21,763,548	7,017	12	Maniilaq Hospital, Kotzebue
Metlakatla Indian Community	2,310,839	1,398	1	Metlakatla physician and dentist health center
Norton Sound Health Corporation	18,501,941	7,386	20	Norton Sound Hospital, Nome
Southcentral Foundation	9,264,759	21,374	1	Patient Care Center, Anchorage; physician and dentist health center
Southeast Alaska Regional Health Consortium	32,800,865	13,693	17	Mt. Edgecumbe Hospital, Sitka; physician and dentist health centers at Juneau, Ketchikan, and Klawock
Tanana Chiefs Conference, Inc.	23,299,626	11,993	34	Fairbanks physician and dentist health center; McGrath midlevel clinic
Yukon-Kuskokwim Health Corporation	39,521,229	21,364	58	Yukon-Kuskokwim Hospital, Bethel; Aniak midlevel clinic
Other[c]		3,703	14	
Total	**$184,951,955**	**104,305**	**227**	

Note: We included as RHOs those specified in section 325 of the Department of the Interior's appropriations act for fiscal year 1998.

[a]These are Census-based population estimates for 1998 developed by IHS. Populations include Alaska Natives served by community contractors within the RHOs' areas because the RHOs generally continue to provide some services, such as inpatient care, to contractor populations. Alaska Natives living in "unspecified" areas or in other communities in RHO or contractor areas are included in counts for those areas.

[b]Numbers of Alaska Native communities include federally recognized tribes and villages as determined by BIA, with the following exceptions that are recognized for self-determination contracting purposes: Cook Inlet Region Natives represented by Southcentral Foundation, Valdez Native Tribe, and Qutekcak (Seward area) Native Tribe.

[c]Includes communities in the Anchorage and Cook Inlet areas that do not participate in Southcentral Foundation.

Alaska Native Community Contractors That Separated From an RHO

This appendix describes the 12 community contractors that separated from an RHO, listing the facilities operated and some of the services provided under each contract. Some of the services are somewhat unique to Alaska, and they may vary from one contractor to another, but they generally can be considered as follows:

- Community health aides usually are village residents trained to give first aid in emergencies, examine the ill, report symptoms by telephone to a supervising physician, and carry out recommended treatments, including dispensing prescription drugs. They also provide preventive health services, such as fluoride treatments, and health education.
- Community health representatives differ from community health aides by focusing more on social and support services than on health care, although there may be overlap in some areas. Community health representatives may provide general health care, including home health care visits to the elderly and new mothers, along with health education and outreach.
- Midlevel clinics most often are staffed by nurse practitioners and physician assistants.
- Contract health care programs purchase services for Alaska Natives from private providers when the services are not available from IHS or tribally operated programs.
- Alcohol, substance abuse, and mental health programs at the village level often are provided by local residents trained as behavioral counselors, supported by regional professionals. Many program elements are intended to prevent alcoholism, especially in youth, including Alcoholics Anonymous meetings, activities to promote sobriety, and home visits.
- Emergency medical services at the community level generally focus on safety training and injury prevention, such as swimming and bicycle safety and first aid and CPR (cardiopulmonary resuscitation) training. Some programs provide and monitor fire extinguishers and smoke alarms in the homes.
- Patient transportation programs generally help coordinate patient travel for necessary health services with local and outside health providers.

Table II.1: Key Characteristics of Alaska Native Community Contractors That Separated From an RHO

Contractor	FY 1998 award amount	1998 Census population[a]	Number of Alaska Native communities[b]	Facilities and services
Akiachak Native Community	$287,560	562	1	1 community health aide clinic; community health representatives; alcohol and mental health services
Chitina Traditional Village Council	206,709	26	1	1 community health aide clinic; patient transportation services
Council of Athabascan Tribal Governments	1,777,668	1,271	8	Midlevel clinic; dentist; 6 community health aide clinics; community health representatives; alcohol and mental health services
Native Village of Diomede	109,691	201	1	1 community health aide clinic; alcohol and mental health services
Eastern Aleutian Tribes	1,240,785	1,160	6	5 community health aide clinics; community health representatives; alcohol and mental health and emergency medical services
Hoonah Indian Association	248,845	649	1	1 community health aide clinic (with a state-funded midlevel provider); community health representatives; alcohol and mental health services
Karluk Tribal Council	165,043	75	1	1 community health aide clinic; community health representatives; alcohol and mental health services
Ketchikan Indian Corporation	3,368,612	1,915	1	Health center with physicians; dentists; ancillary services; contract health care program; alcohol and mental health services
Native Village of Kwinhagak	327,933	578	1	1 community health aide clinic; alcohol and mental health services
Mt. Sanford Tribal Consortium	666,118	125	2	2 community health aide clinics; community health representatives; contract health care program; alcohol and mental health, emergency medical, and patient transportation services
St. George Traditional Council	153,188	145	1	1 community health aide clinic
Valdez Native Tribe	157,463	267	1	Community health representatives; contract health care program
Total	**$8,709,615**	**6,974**	**25**	

[a]These are Census-based population estimates for 1998 developed by IHS. Alaska Natives living in “unspecified” areas and other communities in contractor areas are included in these counts.

[b]Numbers of Alaska Native communities include federally recognized tribes and villages as determined by BIA, with the exception of Valdez Native Tribe, which is recognized for self-determination contracting purposes.

Other Community Contractors

This appendix describes the nine community contractors that did not separate services from an RHO. (See app. II for definitions of the types of services and facilities these contractors operate.)

Table III.1: Key Characteristics of Other Community Contractors

Contractor	FY 1998 award amount	1998 Census population[a]	Number of Alaska Native communities[b]	Facilities and services
Chickaloon Village	$46,327	11	1	Patient transportation services
Native Village of Eklutna	135,611	63	1	Community health representatives; alcohol and mental health and emergency medical services
Kenaitze Indian Tribe	1,142,154	1,428	1	Midlevel clinic; dentist; community health representatives; contract health care program; alcohol and mental health services
Knik Tribal Council	53,079	39	1	Contract health care program; patient transportation services
Ninilchik Traditional Council	558,411	266	1	1 community health aide clinic; contract health care program; alcohol and mental health and emergency medical services
Seldovia Village Tribe	807,305	392	1	Community health representatives; contract health care program; alcohol and mental health and emergency medical services
Tanana Tribal Council	861,622	297	1	Midlevel clinic; alcohol and mental health and emergency medical services
Native Village of Tyonek	214,648	185	1	1 community health aide clinic; community health representatives; contract health care program; alcohol and mental health and emergency medical services
Yakutat Tlingit Tribe	276,704	324	1	1 community health aide clinic (with a city-funded midlevel provider); community health representatives
Total	**$4,095,861**	**3,005**	**9**	

[a]These are Census-based population estimates for 1998 developed by IHS. Alaska Natives living in "unspecified" areas and other communities in the contractor areas are included in these counts.

[b]Numbers of Alaska Native communities include federally recognized tribes and villages as determined by BIA.

Comparison of IHS-Determined Funding Needs for Community and RHO Contractors

This appendix compares the recurring funding needs of the 12 community contractors that separated from RHOs with the funding needs of the RHOs for managing the same programs. The total funding needs include direct program costs and direct and indirect contract support costs. A comparison of indirect cost needs is also provided since this is the major cost category that can vary depending on who manages the contract. The indirect cost need for each affiliated RHO is estimated by applying the RHO's indirect cost rates to the community contractor's program costs; it represents what the indirect costs would have been if the services provided by the community contractor had instead been managed by the RHO.

Table IV.1: IHS-Determined Funding Needs for Community and RHO Contractors, Fiscal Year 1998

Community contractor	Affiliated RHO	Total funding needs		Indirect cost needs		Indirect costs as percentage of total funding needs	
		Community	RHO	Community	RHO	Community	RHO
Akiachak Native Community	Yukon-Kuskokwim Health Corporation	$289,504	$284,274	$62,085	$56,855	21%	20%
Chitina Traditional Village Council	Copper River Native Association	218,891	159,310	92,471	32,890	42	21
Council of Athabascan Tribal Governments	Tanana Chiefs Conference, Inc.	2,290,874	1,436,404	974,280	119,810	43	8
Native Village of Diomede	Norton Sound Health Corporation	165,831	119,198	63,780	17,147	38	14
Eastern Aleutian Tribes	Aleutian/Pribilof Islands Association, Inc.	1,482,830	1,344,582	381,729	243,481	26	18
Hoonah Indian Association	Southeast Alaska Regional Health Consortium	334,630	279,956	97,000	42,326	29	15
Karluk Tribal Council	Kodiak Area Native Association	165,043	112,950	68,600	16,507	42	15
Ketchikan Indian Corporation	Southeast Alaska Regional Health Consortium	3,879,901	3,446,893	955,878	522,870	25	15
Native Village of Kwinhagak	Yukon-Kuskokwim Health Corporation	327,933	265,639	114,026	51,732	35	19
Mt. Sanford Tribal Consortium	Copper River Native Association	682,175	617,344	198,363	133,532	29	22
St. George Traditional Council	Aleutian/Pribilof Islands Association, Inc.	153,188	151,478	28,778	27,068	19	18
Valdez Native Tribe	Chugachmiut	148,521	122,236	50,810	24,525	34	20
Total		**$10,139,321**	**$8,340,264**	**$3,087,800**	**$1,288,743**	**30%**	**15%**

Community Contractors' Contract Support Cost Shortfalls

This appendix details the amount and the magnitude of CSC shortfalls for each of the 21 community contractors. The amount of CSC shortfall is computed by subtracting each contract's CSC funding from its recurring CSC needs. The magnitude of each contractor's CSC shortfall is shown by the percent of its recurring CSC needs that is represented by the shortfall.

Table V.1: CSC Shortfalls of Community Contractors, Fiscal Year 1998

Contractor	Total funding needs	Direct program funding	Recurring CSC needs[a]	CSC funding received	CSC shortfalls	Shortfall as percentage of recurring CSC needs
Akiachak Native Community	$289,504	$227,419	$62,085	$60,141	$1,944	3%
Chitina Traditional Village Council	218,891	119,167	99,724	87,542	12,182	12
Council of Athabascan Tribal Governments	2,290,874	1,316,594	974,280	461,074	513,206	53
Native Village of Diomede	165,831	90,248	75,583	19,443	56,140	74
Eastern Aleutian Tribes	1,482,830	1,031,701	451,129	209,084	242,045	54
Hoonah Indian Association	334,630	207,480	127,150	41,365	85,785	67
Karluk Tribal Council	165,043	88,748	76,295	76,295	0	0
Ketchikan Indian Corporation	3,879,901	2,563,087	1,316,814	805,525	511,289	39
Native Village of Kwinhagak	327,933	206,929	121,004	121,004	0	0
Mt. Sanford Tribal Consortium	682,175	483,812	198,363	182,306	16,057	8
St. George Traditional Council	153,188	114,694	38,494	38,494	0	0
Valdez Native Tribe	148,521	97,711	50,810	59,752	0[b]	0
Chickaloon Village	46,327	30,727	15,600	15,600	0	0
Native Village of Eklutna	162,008	111,517	50,491	24,094	26,397	52
Kenaitze Indian Tribe	1,142,243	929,636	212,607	212,518	89	0
Knik Tribal Council	53,079	36,122	16,957	16,957	0	0
Ninilchik Traditional Council	582,673	301,325	281,348	257,086	24,262	9
Seldovia Village Tribe	893,911	606,061	287,850	201,244	86,606	30
Tanana Tribal Council	898,816	679,648	219,168	181,974	37,194	17
Native Village of Tyonek	214,648	159,911	54,737	54,737	0	0
Yakutat Tlingit Tribe	282,562	186,817	95,745	89,887	5,858	6
Total	**$14,415,588**	**$9,589,354**	**$4,826,234**	**$3,216,122**	**$1,610,112[b]**	**33%**

[a]Recurring CSC funding needs do not include start-up costs.

[b]Valdez Native Tribe had a CSC surplus of $8,942, which reduced the total CSC shortfall from $1,619,054 to $1,610,112.

Comments From the Indian Health Service

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Indian Health Service
Rockville MD 20857

MAY 6 1998

Ms. Bernice Steinhardt
Director, Health Services Quality
and Public Health Issues
Health, Education, and
Human Services Division
United States General Accounting Office
Washington, D.C. 20548

Dear Ms. Steinhardt:

I am responding to your April 27 letter transmitting the General Accounting Office's draft report on "Indian Self-Determination Contracting -- Effects of Individual Community Contracting for Health Services in Alaska."

In general, I concur with the findings of this report and think it will be a valuable tool in informing the Congress of certain critical aspects of this issue. Most importantly, however, I believe the report fairly and accurately represents the status of contracting health services administered by regional health organizations (RHO), tribes, and native villages in Alaska.

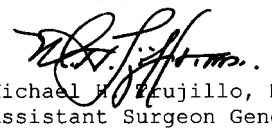
The issues discussed in the report involve a delicate balance between tribal efforts to exercise Self-Determination and the need to maintain cost efficiency in an era of tight resources. While I understand why the report could not address the intangible benefits of Self-Determination for individual tribes and native villages, I do not believe those issues should be overlooked. Indian Self-Determination should not be viewed as a budget tool to reduce Federal funding for Indian programs. It is much more important than that. It is the right of local people to govern themselves and to best determine how critical health services are to be provided to their communities. Tribes and native villages have first-hand knowledge of the needs of their people and have, by far, chosen to have their health services provided through RHOs. They will likely continue this arrangement because it is cost efficient and maximizes health services to their people. They do, however, understand very

well the concepts of tribal sovereignty and local control. They see these as basic rights afforded to all American Indians and Alaska Natives and further recognize that it is this essence of local control that affords them a strong voice in the services provided by the RHOs.

Over the past 25 years, the Indian Self-Determination program has produced many self-sufficient tribes that are managing their own affairs in admirable ways. They have replaced the Federal bureaucracies with local control and are now providing state-of-the art health care for their communities.

Thank you for taking the time to meet with Indian Health Service and Tribal people in the development of this report and for the opportunity to provide our reactions to the draft final report. It is a good report and should be well received by its intended audiences.

Sincerely yours,



Michael H. Trujillo, M.D., M.P.H., M.S.
Assistant Surgeon General
Acting Director

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