111784

GAO

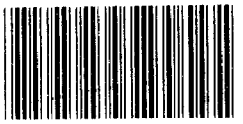
United States General Accounting Office
Washington, DC 20548

Human Resources
Division

B-197671

RELEASED

MARCH 11, 1980



111784

The Honorable Mike Gravel
United States Senate

RSN000001

Dear Senator Gravel:

Subject: Indian Health Service Contracts with Alaska Native Health Organizations (HRD-80-60)

DLG04068
DLG04070
AGC00022
DLG01219
DLG04071

On November 15, 1978, you asked us to compare the costs the Indian Health Service (IHS) has incurred in contracting with Alaska Native health organizations for administering health service programs with the costs IHS had previously incurred in administering such programs directly.

On March 14, 1979, we discussed with your staff the various factors which prevented us from making a meaningful comparative study. Essentially, we said that (1) some programs under contract with the Native health organizations were never administered totally by IHS and (2) the IHS accounting system lacked sufficient data to make a meaningful study. We also discussed various problems impairing the working relationships among IHS and several Native health organizations and agreed to obtain additional information to better identify the problems and their effects on health services to the Alaska Natives. This report summarizes the results of this additional undertaking.

During our study, we met with IHS headquarters officials, Alaska Area Native Health Service officials, and representatives of several Native health organizations and reviewed accounting records maintained by the area office and the Native health organizations and reviewed applicable IHS policy and procedures manuals. We conducted our work at IHS headquarters, Rockville, Maryland; the Alaska Area Native Health Service, Anchorage, Alaska; the Mauneluk Association, Kotzebue, Alaska; the Norton Sound Health Corporation, Nome, Alaska; and the villages of Buckland, Little Diomede, Norvik, Selawik, and Wales, Alaska.

(102040)

508919

BACKGROUND

IHS, a component of the Health Services Administration, Department of Health, Education, and Welfare (HEW), is responsible for providing comprehensive health care to Indians and Alaska Natives. This is accomplished in the field through eight area offices and four program offices. The Alaska Area Native Health Service (AANHS) is the IHS area organization responsible for providing health care services to Alaska Natives.

AANHS operates an administrative headquarters and a medical center in Anchorage and service units (including medical facilities) in Barrow, Bethel, Kanakanak, Kotzebue, Mount Edgecumbe, and Tanana. AANHS contracts with the Norton Sound Health Corporation to provide health services in the Nome area.

The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450), enacted January 4, 1975, permits Indian tribes and Alaska Natives to assume control over Federal Indian programs. Through title I, designated the "Indian Self-Determination Act," the Congress established contracting as the way of achieving self-determination by designing the act so that tribes must request contracts. Upon receipt of such a request, the Secretaries of the Interior and HEW are directed to contract with the tribe to plan and conduct programs which the Bureau of Indian Affairs and/or IHS administers for Indians and Alaska Natives.

In response to the opportunities offered by the act, the Alaska Natives formed a nonprofit Native health organization in each of the 12 regions of Alaska which had been established by the Alaska Native Claims Settlement Act (43 U.S.C. 1606). The types of health service programs which a Native health organization chooses to administer depend upon its willingness and ability to contract with AANHS.

In fiscal year 1977, AANHS contracted directly with 11 of the 12 Native health organizations to provide a variety of health services to Natives--since then AANHS has contracted with all 12 regional Native health organizations. Contract expenditures with these Native health organizations totaled about $12 million in fiscal years 1977 and 1978, $13.5 million in fiscal year 1979, and are estimated to be about $20 million in fiscal year 1980.

The types of services to be delivered under the fiscal year 1979 contracts included:

--Providing management and staffing for 178 village health clinics; providing service in mental health care, dental care, and eye care; providing pharmaceutic services, patient boarding house services, traffic management for patient emergency travel, and other health care services.

--Providing preventive service programs, including alcohol and drug abuse, venereal disease, accident and injury prevention, and providing planned parenthood programs, environmental health programs, prenatal and postnatal care and education, consumer input to AANHS, and other health-related programs.

FACTORS THAT PREVENTED A MEANINGFUL COMPARISON OF IHS PROGRAM COSTS BEFORE AND AFTER CONTRACTING WITH NATIVE HEALTH ORGANIZATIONS

We could not make a meaningful comparison of the costs IHS has incurred in contracting with Native health organizations for administering health service programs with the costs IHS had incurred in administering such programs directly because of several factors. Specifically, we found that

--accounting records for periods before fiscal year 1978 were not readily available;

--many of the health service programs administered by Native health organizations under title I contracts had previously been administered by Natives through contracts under the Buy Indian Act of 1910 (25 U.S.C. 47);

--several health service programs administered under title I contracts were new programs which had not been previously administered by IHS; and

--the total cost of any specific program is difficult to accurately determine because IHS (1) frequently shifts funds among programs, particularly those which provide for similar health activities, and the accounting records do not show some of the changes and (2) lacks a system for assigning its indirect costs,

such as administrative expenses, to individual programs.

PROBLEMS STRAINING IHS-ALASKA NATIVE HEALTH ORGANIZATION WORKING RELATIONSHIPS

A number of problems have strained the working relationships among AANHS and several Native health organizations. In some cases, the problems have either delayed the start of new health service programs or disrupted ongoing programs. Several Native health organizations have interpreted these problems as being indicative of IHS's lack of commitment to self-determination. We did not find any evidence that AANHS or IHS was intentionally depriving the organizations of the benefits available to them under the Indian Self-Determination Act.

The problems as viewed by the Alaska Native health organizations are

--inability to obtain information on the direct and indirect costs incurred by IHS in providing health services by specific program,

--inability to finalize contract negotiations before the contract period began and the resultant need for contract modifications and fund reprograming during the contract period, and

--the inclusion of provisions in the contracts which require the organizations to obtain AANHS or IHS approval before obligating contract funds for selected activities.

IHS cannot readily determine total cost of its programs

Because IHS does not have a system for assigning its indirect costs, such as administrative expenses, to individual programs, it is difficult to readily determine a program's total cost. Native health organizations assert that they

--cannot determine if IHS is meeting the program funding level requirements of the act and

--lack important financial data needed to reach informed decisions as to whether to (1) seek a contract to assume responsibility for providing services under a program which IHS operates directly or (2) let IHS continue operating the program.

A special analysis of IHS and AANHS costs is required to identify IHS indirect costs and assign the indirect costs to individual programs to determine their total cost. Total cost data are important because the Indian Self-Determination Act requires that the amount of funds provided by IHS for a particular program under contract not be less than the amount of funds IHS incurred, or would incur, in operating the program.

Native health organizations believe that AANHS is not funding contracts to the level of direct and indirect costs that IHS incurred or would incur if IHS were providing the program services directly. One Native health organization prepared an analysis of AANHS expenditures in Alaska and concluded that it was not receiving its fair share of AANHS funding; in 1978 it requested AANHS to confirm its conclusions. According to the organization's executive director, AANHS rejected the conclusions but never provided the organization an adequate explanation.

Both AANHS and IHS officials told us that, until IHS revises its financial management information system, the total costs incurred in providing a program's services cannot be identified. They stated, however, that they attempt to respond to specific requests concerning the cost of each program and will otherwise assist a tribal or Native health organization plan in assuming responsibility for delivering IHS program services.

IHS officials told us that implementation of a revised financial management information system is planned for fiscal year 1981. They said the revised system is expected to increase IHS's ability to identify indirect costs associated with a program.

Difficulties in finalizing contract negotiations

Several Native health organizations have had difficulty in finalizing their contract negotiations with AANHS before the beginning of the contract period. Prompt completion of the negotiations is critical to the organizations' effectiveness because (1) final program plans must be predicated on funding levels and (2) some contract services must be provided early in the contract period before the Natives leave their villages for their annual migration to the fishing grounds.

AANHS enters into a cost-reimbursement-type contract with each Native health organization. The contracts are for a 1-year period which coincides with the fiscal year. Contract proposals are drafted by the Native health organizations about 6 months before the contract year begins and are to recognize to the extent possible activities and funding levels of the current year's contracts.

Anxieties among AANHS and the Native health organizations arise because they have had difficulty in reaching prompt resolution of contract proposal disputes. AANHS contends that the proposals did not always contain sufficient, accurate, and current data for IHS to meet its program management and fiscal accountability responsibilities. The organizations counter that AANHS does not notify them of all deficiencies in their proposals at the same time, but provides this information in a piecemeal manner and that their requests to AANHS for specific data needed to revise their proposals are not provided promptly.

Both parties' allegations have merit. Some deficiencies in the organizations' contract proposals occur because firm contracts for the prior year's activities and program plans for the upcoming year are not complete when the proposals are drafted. The heavy workload of the AANHS Native contract unit responsible for contract administration made it difficult for the staff to provide prompt responses to organizations' inquiries. The AANHS-Native health organizations' experience for the fiscal year 1979 contracts demonstrates these problems.

The Native health organizations began preparing their fiscal year 1979 contract proposals in early fiscal year 1978 and submitted them to AANHS in February 1978. Contract

negotiations between AANHS and Native health organizations began in March 1978. Five of the 12 organizations did not finalize their fiscal year 1979 contract negotiations until March 1979--6 months into the fiscal year. A sixth organization finalized only a portion of its normally contracted activity in June 1979 and never finalized the other activities. At our request, AANHS prepared the following information to show the Native contract unit's activity between May and December 1978 on 1978 and 1979 contracts with the 12 Native health organizations.

--122 contract modifications processed.

--62 contract reprograming requests.

--61 equipment approvals.

--70 subcontract approvals.

--144 scheduled meetings attended.

Many of the contract modifications and fund reprograming efforts related to fiscal year 1978 contracts were necessitated because the 1978 contracts contained provisions later deemed inconsistent with revised program plans. Even though one-half of the fiscal year 1979 contracts were negotiated in that fiscal year, the Native contract unit processed 1979 contract modifications and reprogramings applicable to all 12 organizations. Some provisions of the contracts which were initially resolved by negotiation were later reopened for negotiation because of other changes in the contracts or changes in program plans.

AANHS officials acknowledge that each of the contract activities, such as a reprograming request, can be completed within a few days. They point out, however, that the volume of activities and the fact that the staff is working on several activities simultaneously has the effect of extending the total time required to process requests from the organizations or otherwise resolve contract issues.

Several studies have shown that increasing the number of AANHS staff working with the organizations would reduce the time required to (1) formulate acceptable proposals, (2) negotiate the contracts, and (3) reduce the frequency of contract modification. In December 1978, AANHS increased

the authorized staffing level by three positions, but only two positions were filled because of the Office of Management and Budget staff limitations. Later, the two positions that were filled became vacant.

IHS and AANHS have stated that the AANHS Native contract unit staff might have to be increased, particularly if the organizations increase the number of their contract activities under the Self-Determination Act. They expressed the belief, however, that adherence to the Office of Management and Budget staffing limitation would preclude increasing the number of positions.

AANHS has initiated other efforts which should eventually reduce the time required to process and execute contracts with the Native health organizations. It has created a Program Formulation Branch to coordinate ongoing Self-Determination Act support activities and made it responsible for developing programs to train Native health organizations and AANHS project officers in contract administration.

We noted that all fiscal year 1980 contracts were negotiated before October 1, 1979. We do not know whether the number of requests for modifications and reprogramings will increase or decrease from prior years.

Restrictive contract provisions

Restrictive contract provisions on subcontracting, equipment purchases, out-of-State travel, and contract advances have also been a source of friction between AANHS and the Native health organizations. The provisions, some of which are required by IHS regulations or HEW policies, have been implemented to provide program accountability and improve management, and are generally applicable to all contracting by IHS area offices. In essence, the contracts state that, before funds can be expended for these purposes, the approval of IHS or AANHS is required. Native health organizations believe that the need for AANHS or IHS approval for such expenditures while contracts are in force creates unnecessary program delays.

AANHS and IHS can waive some of the required approvals and/or modify the circumstances under which approval must be obtained. During 1979 approval for subcontracting was waived for several Native health organizations. Under all

fiscal year 1980 contracts, contracting officer approval is not required for travel within the United States for other than scientific meetings, as long as travel costs are reasonable and can be identified with a specific program. IHS officials told us that waivers are granted when it believes an organization has achieved stability in staffing and business expertise.

CONCLUSIONS AND RECOMMENDATIONS TO THE SECRETARY OF HEW

Native health organizations believe that IHS and AANHS are not supporting the intent of the Indian Self-Determination Act because (1) IHS has not developed a system for identifying all costs it incurs and for assigning total costs to individual programs and program segments, (2) IHS and AANHS have not provided information promptly to facilitate contract negotiations and agreement before the beginning of the contract period and reduce the frequent contract modifications, and (3) unnecessary restrictive provisions have been included in the contracts.

IHS and AANHS assert that they favor compliance with the provisions of the Indian Self-Determination Act and cite increases in contracted activities as evidence of such support. They also state that procurement regulations and the need to satisfy their fiscal and program accountability responsibilities require that (1) contract provisions be explicit in stating the tasks and costs that will be incurred under the contracts and (2) contracts include certain controls. IHS points out that the restrictions are generally applicable in all contracts awarded by its area offices, but it waives the restrictions when an Indian tribal or Native health organization achieves staffing stability and business expertise. In 1979 waivers were granted for several organizations for some contract activities. Implementation of a financial management system to identify all indirect costs of providing services is not imminent, but IHS officials said they will try to respond to specific requests.

We believe that IHS and AANHS should continue to demonstrate to the Native health organizations their support of the provisions of the Indian Self-Determination Act. The establishment of the Program Formulation Branch within AANHS is a positive action. In addition, we recommend that the Secretary of HEW require that the Director of IHS:

--Expedite efforts to develop a financial management information system that provides for allocating indirect costs to programs and activities subject to tribal and Native health organization contracting. Such a system should allow more informed decisions by the tribal and Native health organizations on the costs of administering a program.

--Expedite training development activities assigned to the recently established AANHS Program Formulation Branch.

--Expedite efforts to fill vacancies in the AANHS Native contract unit and monitor the workload of the AANHS contracting unit to determine if additional positions are needed.

We discussed this report with IHS officials and, where appropriate, have incorporated their comments.

As arranged with your office we are sending a copy of this report to the Secretary of HEW and will make copies available to others upon request.

Sincerely yours,

Gregory J. Ahart
Director