

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**TRIBAL CONTRACTING
FOR INDIAN HEALTH SERVICES**



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EXECUTIVE SUMMARY

PURPOSE

This inspection provides feedback from Indian tribes on how the Indian Health Service can best support and enhance 638 contracting.

BACKGROUND

The Indian Health Service's (IHS) Office of the Director asked that the Office of Inspector General (OIG) evaluate efforts by IHS and Indian tribes to implement the Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638.¹

Within the Department of Health and Human Services, IHS is the primary provider of health care to tribes. Through a contract, tribes can receive the money that IHS would have used to provide direct health services for tribal members. Tribes can use these funds to provide directly, or through another entity, a broad range of health services. This option was part of P.L. 93-638 and is commonly known as "638 contracting."

The extent of 638 contracting varies widely among tribes and IHS areas, ranging from as much as 91 percent to as little as 1 percent of an Area Office's budget. According to 1994 IHS data, tribes and tribal organizations operate 9 hospitals and 342 health centers, stations, and clinics. The IHS operates 119 health centers, stations, and clinics and oversees 40 hospitals. Tribes contract for nearly 32 percent of the total IHS budget, which is approximately \$1.7 billion.²

We conducted telephone and in-person interviews regarding a wide range of 638 contracting issues with 70 tribes, 12 tribal organizations (representing an additional 154 tribes), 44 IHS headquarters and Area Office staff, and 10 Indian health boards. The majority of these interviews were conducted from January through April 1995. Our sample included the universe of noncontracting tribes and a stratified sample of contracting tribes.

FINDINGS

- ***Because tribes view 638 contracting as an opportunity to customize and improve health care for their communities, almost 75 percent of them want to increase the number and scope of their contracts.***

¹ Indian tribe means any Indian tribe, band, nation, or other organized group (including any Alaska Native village or corporation) that is eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

² This figure includes all appropriations except facilities, which totals \$279 million.

In addition to contracting for health services, one-half of the tribes want to contract for their shares of Area Office and headquarters functions.

- *Although the 1994 amendments enable tribes to increase their level of contracting, many of the smaller noncontracting tribes face barriers that the amendments do not address.*

The barriers include tribes' relatively small size, geographic isolation, program funding concerns, termination fears, and, what they perceive to be, reluctance on the part of some IHS staff to support or promote contracting.

- *Many tribes remain poorly informed about the 638 contracting process.*

Noncontracting tribes and tribes that contract through tribal organizations lack basic knowledge about 638 contracting and related IHS initiatives. They are less knowledgeable than contracting tribes on subjects such as the 1994 amendments, the Indian Health Design Team, the tribal management grant program, and IHS contracting staff.

- *Well-informed tribes rely on Indian health boards, consulting firms, other tribes, and attorneys for 638 contracting information, technical assistance, training, and contract monitoring.*

RECOMMENDATION

The IHS should continue and expand its efforts to increase tribal awareness and foster self-determination.

The goal of the P.L. 93-638 legislation and subsequent amendments is to enable tribes to exercise their self-determination rights. In order to accomplish this, tribes need to be fully informed and administrative barriers must be eliminated. The IHS can best serve tribal self-determination efforts by:

- continuously informing tribes about their 638 contracting options,
- helping tribes increase their use of non-IHS sources of information, technical assistance, training, and contract monitoring, and
- facilitating the transfer of health services and administrative functions.

The IHS could take a number of actions to improve tribal awareness, including: (1) providing 638 contracting orientations to tribes that need them, (2) simplifying communications and increasing personal contact, (3) distributing individual tribal budget information annually, and (4) informing tribes of their option to use existing community health services.

AGENCY COMMENTS

The IHS provided comments on the draft report and agreed with our recommendation to continue and expand its efforts to increase tribal awareness and foster self-determination. We have made minor revisions to the report based on IHS' technical comments. As IHS mentioned in its comments, it has initiated multiple communication activities including use of the Internet to better convey contracting and other information to Indian tribes. In our review of the Internet home page, we were impressed with the design of the page and the quantity of information. The home page includes a section entitled "IHS Communications Page" that gives detailed and up-to-date information on legislative activities, agency operations such as the Indian Health Design Team, and comments by leading IHS officials. The full text of IHS' comments appears in Appendix B.

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INTRODUCTION

PURPOSE

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BACKGROUND

The Indian Health Service's (IHS) Office of the Director asked that the Office of Inspector General (OIG) evaluate efforts by IHS and Indian tribes to implement the Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638.³

Indian Self-Determination and Education Assistance Act

In 1975, Congress gave tribes the option to contract for programs provided by the Secretaries of the Department of Health and Human Services and the Department of Interior for the benefit of Indians because of their status as Indians.⁴ This option was part of P.L. 93-638 and is commonly known as "638 contracting." In developing P.L. 93-638, Congress recognized its responsibility to:

...respond to the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities.⁵

Within the Department of Health and Human Services, IHS is the primary provider of health care to tribes.⁶ Through contracts, tribes can receive the money that IHS would have used to provide direct health services for tribal members. Tribes can use these funds to provide directly, or through another entity, a broad range of health services. The health services could include community health representatives, treatment for alcohol and substance abuse, outpatient clinics, hospitals, and contract health services dollars, which are used to pay for care rendered by non-IHS providers (i.e., referrals to specialists and

³ Indian tribe means any Indian tribe, band, nation, or other organized group (including any Alaska Native village or corporation) that is eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

⁴ Indian means a person who is a member of an Indian tribe.

⁵ P.L. 93-638, Section 3(a), as amended.

⁶ The Bureau of Indian Affairs within the Department of the Interior is responsible for education, law enforcement, and tribal government activities.

private hospitals). Tribes decide whether they want to contract under P.L. 93-638, and a tribe's informed decision not to contract is an equal expression of self-determination.

Subsequent amendments to P.L. 93-638

Congress significantly amended P.L. 93-638 in 1988. These amendments (1) added timeframes for IHS and the Bureau of Indian Affairs (BIA) to approve or decline contract proposals and (2) clarified that most contracts would be exempted from the cumbersome Federal acquisition regulations which govern procurement contracts. The amendments also required IHS and BIA to promulgate new regulations with the active participation of tribes within 10 months. These draft regulations were not published until January 1994.

The 1988 amendments further allowed tribes to use another funding option commonly known as self-governance. A self-governance tribe is relatively free from IHS oversight in both the design of its programs and the way it utilizes and distributes program funds. These tribes receive an annual lump-sum amount for their health programs. Self-governance is a demonstration program for IHS but is permanent for BIA.

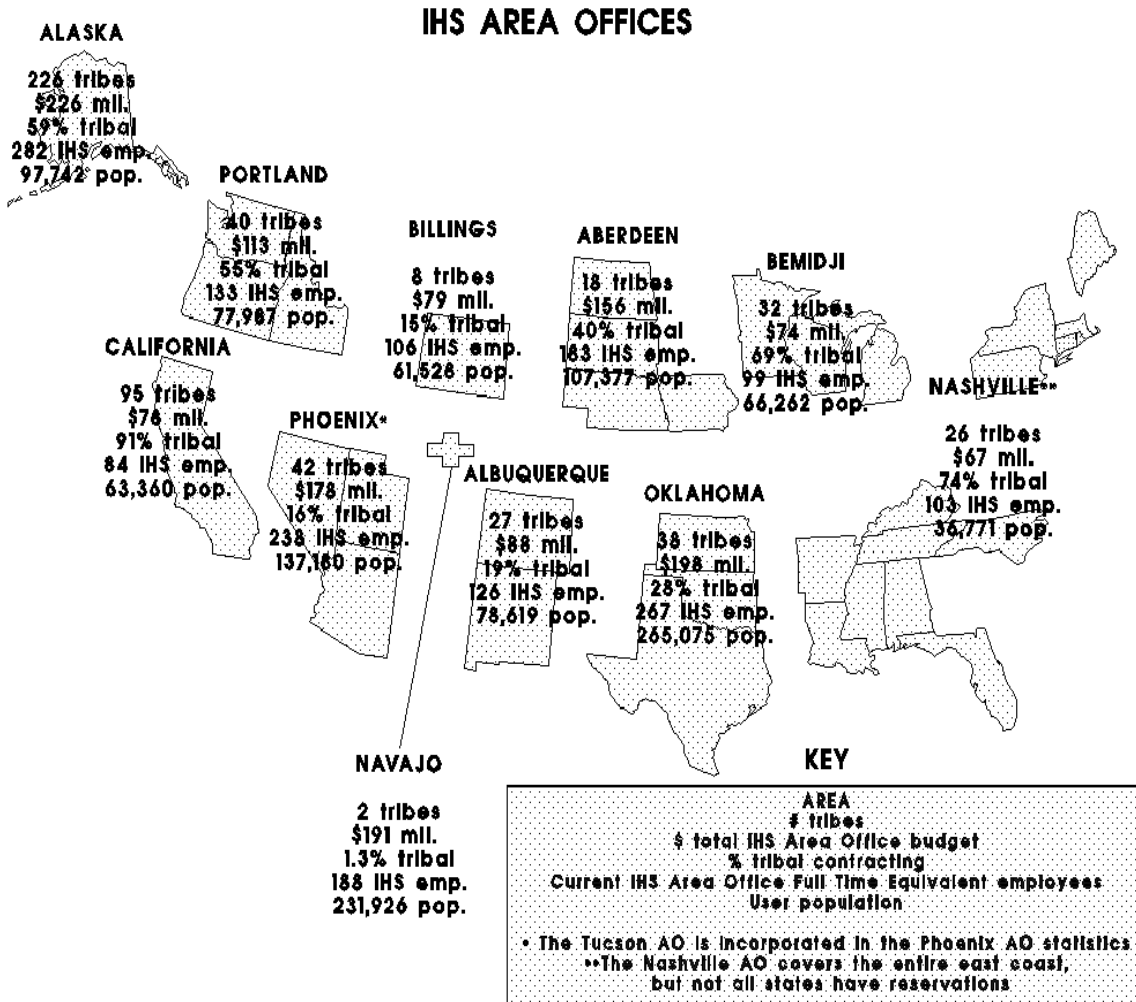
At the request of tribes, Congress further amended the 638 contracting law in 1994. The 1994 amendments supersede the January 1994 draft regulations. These new amendments give tribes almost the same latitude under contracting as they have under self-governance. Among other things, tribes can (1) contract for their shares of IHS Area Office and headquarters functions, (2) shift funding from one health program to another, (3) redesign health programs, (4) utilize a simple model format for every contract, and (5) receive annual lump-sum payments. The amendments limit the Department of Health and Human Services and the Department of Interior to promulgating regulations for a few specified areas and require that they produce these regulations within 18 months. The Indian Self-Determination Negotiated Rulemaking Committee, comprised of tribal and Federal representatives, oversaw the development of the draft regulations which were published in the Federal Register on January 24th, 1996.

Tribal contracting efforts

The extent of 638 contracting varies widely among tribes and IHS areas. Some tribes contract for millions of dollars for the construction, renovation, and operation of entire hospitals and outpatient clinics. Tribes also contract for contract health services dollars to pay for referrals to outside specialists and often have small contracts for emergency medical services and community health representative programs. According to 1994 IHS data, tribes and tribal organizations operate 9 hospitals and 342 health centers, stations, and clinics. The IHS operates 119 health centers, stations, and clinics and oversees 40 hospitals. Tribes contract for nearly 32 percent of the total IHS budget, which is approximately \$1.7 billion.⁷ As the map on the next page shows, the level of

⁷ This figure includes all appropriations except facilities, which totals \$279 million.

638 contracting among Area Offices ranges from as much as 91 percent to as little as 1 percent of their annual budgets.⁸



IHS contracting roles and responsibilities

Within IHS, 12 Area Offices have the primary responsibility for working directly with tribes on 638 contracting.⁹ Staff in these Area Offices are responsible for (1) informing

⁸ All figures are based on 1994-1995 data except for the number of IHS Area Office employees which is based on data from January 1996. Further, the number of IHS Area Office employees does not include current reduction in force activities in three Area Offices.

⁹ The 12 Area Offices are: Aberdeen, Albuquerque, Alaska, Bemidji, Billings, California, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson. We have included Tucson as an Area Office since it has contracting responsibilities for the two tribes in its area.

tribes about the contracting process, (2) providing technical assistance, and (3) overseeing both programmatic and financial aspects of specific contracts.

The IHS uses a number of methods to share 638 contracting information with tribes. The IHS headquarters sends "Dear Tribal Leader" letters and holds annual IHS/tribal consultation conferences. In addition, the IHS contracts with the National Indian Health Board to provide consultation and information dissemination services, including a quarterly newsletter. The board is composed of tribal representatives from each area. The board disseminates information both directly to tribes and through its local chapters, which are called area Indian health boards and inter-tribal councils. These local boards vary in size, organization, and funding levels. The IHS Area Office staff communicate directly with tribes through letters, faxes, telephone calls, and area meetings, and also route information through the Indian health boards and inter-tribal councils. Within an area office, the *contract proposal liaison officer* is the primary contact person for all 638 contract proposals and is responsible for the dissemination of information to tribes. *Project officers* communicate with their respective contracting tribes regarding more detailed contract and programmatic issues. *Contracting officers* award the contracts and oversee and monitor the financial aspects of each contract.

METHODOLOGY

We conducted telephone and in-person interviews regarding a wide range of 638 contracting issues with tribal leaders, tribal organization officials, IHS headquarters and Area Office staff, and Indian health board directors. We completed 70 tribal, 12 tribal organization, 44 IHS, and 10 Indian health board interviews. The tribal organizations we interviewed provide services to an additional 154 tribes. We interviewed the universe of noncontracting tribes and a stratified sample of contracting tribes. The majority of these interviews were conducted from January through April 1995. For each interview, the tribal leader or tribal organization director designated specific respondents to represent the 638 contracting views of the tribe or organization. The respondents included tribal leaders, business officers, and health directors who were interviewed individually or as a group. The statistics in this report are based on our sample of tribes, not on a projection to the total population. Appendix A contains a detailed description of the methodology.

For most of this report, our findings are based on the distinctions between contracting and noncontracting tribes. For some issues, however, the data revealed important differences among groups of tribes. Therefore, we conducted additional analysis to refine the findings and provide information necessary for IHS to be responsive to all tribes. As a result, in a few instances, we made a distinction between contracting tribes that contract with IHS directly and those that contract through tribal organizations to receive health services.

FINDINGS

TRIBES VIEW 638 CONTRACTING AS AN OPPORTUNITY TO CUSTOMIZE AND IMPROVE HEALTH CARE FOR THEIR COMMUNITIES

According to tribes, 638 contracting for health services can result in (1) improved quality, (2) expanded coverage, and (3) easier access. Contracting enables tribes to accomplish these changes by allowing them to:

- improve the management of their health programs,
- redesign programs to address local needs,
- develop and use alternative funding sources, and
- access non-IHS health care systems.

Once tribes take control of their health programs, they can manage them in ways that dramatically improve services. They can also more easily supplement IHS funding. Tribes can (1) increase their third party billing, (2) redesign parts of direct health care programs, (3) improve their contract health services management, and (4) utilize other sources such as State funding, grants, and tribal gaming funds. For example, one IHS official described a tribe that used 638 contracting to turn a run-down clinic into a "plush" and fully-functioning outpatient clinic without additional IHS funds. The tribe increased its third party funding by serving private paying members of the community. When another tribe took over its contract health services dollars, it was able to negotiate better rates with local providers and increase the number of providers willing to take its patients. Many IHS Area Office staff also believe that some tribes manage their health care better and are able to respond to local needs more quickly and effectively than IHS ever could.

To address access and/or quality concerns, some tribes use 638 contracting funds to purchase non-IHS health care in their local communities. During our interviews, 35 percent of contracting tribes and 22 percent of noncontracting tribes volunteered that they would prefer to use local providers instead of IHS health care systems but were not aware of their options to do so. The following are examples of tribes that have used 638 contracting to purchase non-IHS health care:

- One tribe purchases primary care services from local physicians for a fixed monthly fee. Tribal members benefit from this arrangement, because the closest IHS outpatient clinic is 70 miles away.
- Another tribe sponsors a weekly night clinic, so tribal members do not have to drive 20 miles to the nearest IHS clinic.
- Several tribes purchase health maintenance organization or preferred provider organization insurance plans that provide a comprehensive range of services for all of their members.

INCREASED CONTRACTING, THE GOAL OF MORE THAN HALF OF THE TRIBES, WILL BE EASIER FOR SOME THAN OTHERS

The majority of tribes want to increase their level of contracting for both health services and IHS administrative functions. Tribes want to contract, among other reasons, because they are dissatisfied with IHS health care and administrative services. Following the 1994 amendments, contracting tribes face few barriers to additional contracting, but noncontracting tribes still face substantial barriers.

Most tribes want to increase their level of contracting for direct health programs and IHS administrative functions

Almost three-quarters of both contracting and noncontracting tribes want to contract for more health services, but few have specific plans.¹⁰ Some of these tribes want to contract for outpatient, mental health, alcohol and substance abuse, and dental services. They also want to assume responsibility for their contract health services dollars. At present, few tribes are considering 638 contracting for the remaining IHS hospitals.

Most tribes are dissatisfied with the health care they receive directly from IHS. More than half of contracting tribes and one-third of noncontracting tribes rate their IHS health care as below average (lower than "3" on a scale of 1 to 5).¹¹ In contrast, only 18 percent of contracting tribes rate their 638 contracted health care as below average. Tribes are dissatisfied with IHS health care for several reasons including the waiting time, the travel distance, and, in their opinion, the poor attitudes of some IHS health care providers. One tribe complained that, even with an appointment, tribal members have to wait up to 8 hours at the IHS hospital for a primary care visit. Another tribe that uses the same IHS hospital claimed that supplies are outdated and there are too many interns and not enough experienced physicians. Some tribes also noted that the IHS fiscal intermediary that processes contract health services claims is so slow that providers have referred tribal members to collection agencies and refused to see additional patients.

One-half of tribes want to contract for their shares of Area Office and headquarters functions.¹² These functions include, among other things, technical assistance, training, monitoring, and information dissemination. Some tribes mentioned that they plan to contract selectively for these shares depending on the cost of hiring outside sources to perform the functions.

¹⁰ This statistic does not include tribes that are fully contracting or are now part of the self-governance program.

¹¹ Ibid.

¹² This statistic does not include tribes that already contract for their tribal shares or tribes that did not know of their right to do so at the time of our interviews.

The 1994 amendments will allow many tribes to increase their level of contracting with few barriers

The 1994 amendments will greatly benefit tribes that want to increase contracting. Of the contracting tribes in our sample, 80 percent think that the amendments will make it easier for them to contract. The amendments have given tribes much more control over the 638 contracting process, both for health services and for tribal shares of Area Office and headquarters functions. While some tribes and IHS staff see the need for some technical revisions to clarify the differences between contracting and self-governance, the response to the amendments was overwhelmingly positive. Some contracting tribes believe now that nothing stands in the way of increased contracting.

Noncontracting tribes face several barriers that have not been addressed by the 1994 amendments

Noncontracting tribes face many barriers including tribal size and geographic location, program funding issues, tribal termination fears, and IHS staff attitudes.

Size of Tribe

Small tribes have a more difficult time contracting for their health services. Almost three-quarters of noncontracting tribes have fewer than 500 members each. These small tribes are less likely to contract, because they lack administrative staff and management capabilities. Also, they are concerned that available 638 funding may be insufficient to provide complete health services to their tribal members.

Small tribes are not able to take advantage of economies of scale, and political differences can prevent them from forming consortiums. Small tribes also tend to have less-developed governmental systems, and tribal council turnover may impede the contracting process.

Geographic Isolation

Geographically isolated tribes often do not attempt to contract, because it is very difficult for them to recruit providers and they face almost insurmountable transportation problems. Remote locations also make it difficult for tribes to form consortiums with other tribes and to participate in 638 contracting meetings and training. Some tribes are located in such remote areas as the bottom of the Grand Canyon and the northern slope of Alaska.

Funding Issues

Many noncontracting tribes perceive various funding issues as barriers. Some tribes will not contract for what they believe to be underfunded IHS programs and are not convinced that efficiencies can be gained through contracting. Other tribes complained about inequitable funding distribution. These tribes believe that Area Offices allocate funds differently and that some tribes and areas are favored. Still other tribes and Area Office

staff noted what they called "double-dipping" problems which create inefficiencies and affect tribal perceptions of contracting. This double-dipping occurs when tribes take their share of funds from a clinic or hospital that serves multiple tribes while their members continue to use the facility's services.

Fear of Termination

More than half of the tribes are concerned that increased contracting will lead to termination of Federal funding for health services. Some tribes in the Aberdeen and Billings areas flatly refuse to contract for more health services until the termination issue is resolved. Some Area Office staff, including a few contract proposal liaison officers, also believe that contracting may lead to the termination of Federal support. Tribal suggestions to alleviate these fears ranged from fully funding Indian health care to creating a separate 51st Indian State, making one separate Federal Indian Department, or making health care an entitlement rather than a discretionary program.

IHS Staff Attitudes

Almost all of the tribal and IHS respondents believe that IHS should be proactive in informing tribes of their 638 contracting options. Many tribes and some IHS employees even suggested that IHS encourage tribes to contract. However, most Area Offices supply detailed information on contracting only when tribes request it. Both tribal and Area Office staff believe that some IHS staff may be reluctant to promote or authorize maximum contracting as they fear losing their Federal jobs.

MANY TRIBES REMAIN POORLY INFORMED ABOUT THE 638 CONTRACTING PROCESS

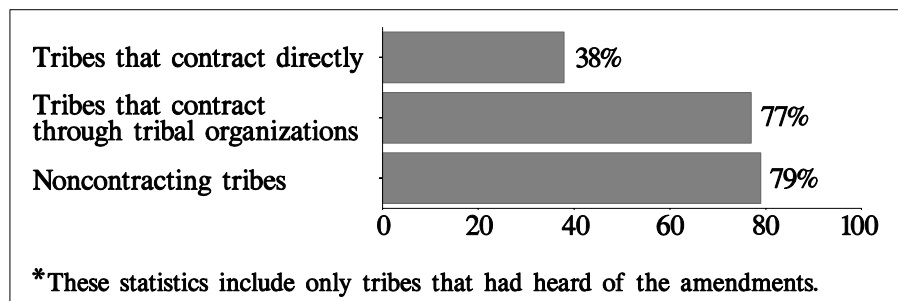
The data revealed important distinctions among tribes' levels of knowledge and needs for assistance. Therefore, we conducted additional analysis to refine the findings and provide information necessary for IHS to be responsive to all tribes. Based on our additional analysis and for purposes of clarifying this finding, we have subdivided the contracting tribes into (1) tribes that contract directly with IHS and (2) those that contract through tribal organizations.

Many noncontracting tribes and tribes that contract through tribal organizations lack basic knowledge about 638 contracting and IHS initiatives. In contrast, contracting tribes tend to be very knowledgeable about these subjects. Further, 82 percent of noncontracting tribes believe they do not have enough information to make informed decisions regarding contracting. To assess tribes' knowledge, we asked a series of questions on the 1994 amendments, the Indian Health Design Team, the tribal management grant program, and the Area Office contracting staff.

1994 Amendments

Although most tribes had heard of the 1994 amendments at the time of our interviews, few noncontracting tribes and tribes that contract through tribal organizations understood them, as illustrated in the following chart.¹³ While these amendments passed in October 1994, 18 percent of noncontracting tribes and 24 percent of tribes that contract through tribal organizations had not heard of the amendments. Furthermore, 37 percent of the tribes in our sample who knew of the amendments had not heard of them until January 1995 or later, 3 months after passage. Interestingly, 2 IHS Area Office project officers had not heard of the amendments 1 month after they passed.

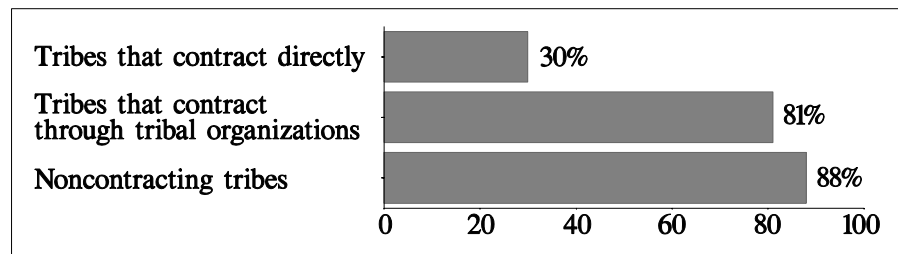
PERCENT OF TRIBES* THAT DID NOT UNDERSTAND THE 1994 AMENDMENTS



Indian Health Design Team

In late 1994, the Indian Health Design Team began to explore IHS organizational changes that will be needed in the future. The team is comprised of two-thirds tribal representatives and one-third senior IHS staff. The team surveyed IHS employees and tribes about their opinions on IHS reorganization using a one-page questionnaire. Few tribes responded.

PERCENT OF TRIBES THAT HAD NOT HEARD OF THE INDIAN HEALTH DESIGN TEAM

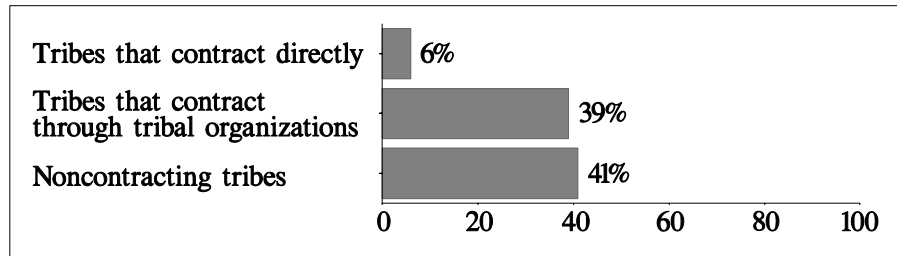


¹³ These interviews were conducted from January through April 1995.

Tribal Management Grant Program

The tribal management grant program is a \$5 million competitive grant program designed to help tribes build the capacity to contract or decide whether to contract. Tribes typically use these funds to hire consultants, conduct feasibility studies, train staff, purchase computers, and improve financial and program systems.

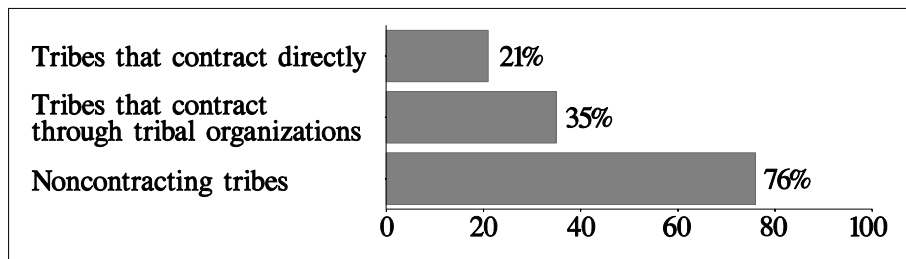
**PERCENT OF TRIBES THAT HAD NOT HEARD
OF THE TRIBAL MANAGEMENT GRANT PROGRAM**



Area Office Contracting Staff

Without knowledge of the roles and responsibilities of key Area Office staff such as the contract proposal liaison officer and project officer, tribes may not know whom to approach when considering contracting.

**PERCENT OF TRIBES THAT DID NOT UNDERSTAND THE ROLES
OF THE AREA OFFICE 638 CONTRACTING STAFF**



TRIBES RELY ON ORGANIZATIONS OTHER THAN IHS FOR 638 CONTRACTING INFORMATION, TECHNICAL ASSISTANCE, TRAINING, AND CONTRACT MONITORING

While IHS information sharing methods are effective for some tribes, many tribes are dissatisfied with these methods and complain of the lack of a formal feedback mechanism. As a result, many contracting tribes utilize non-IHS sources for various administrative services. Tribes sometimes use non-IHS funds to purchase services from the private sector. With the passage of the 1994 amendments, tribes are able to contract for tribal shares, giving them additional funds to access these outside sources.

Many tribes are dissatisfied with the 638 contracting information that IHS now provides

More than half of both noncontracting and contracting tribes rate the information they receive from IHS as below average. Tribes are unhappy with the quality, quantity, and timeliness of the information. Furthermore, tribes are not satisfied with the methods IHS uses to share information, noting the absence of 638 contracting orientations, varying Indian health board systems, incomplete budget information, few local meetings, poor written communication, and a lack of formal feedback mechanisms.

638 Contracting Orientations

Although 638 contracting has existed for 20 years, many tribes still need a basic orientation on the law, process, and options. More than half of noncontracting tribes need this kind of orientation. In contrast, contracting tribes want specialized training on programmatic and financial issues and on the 1994 amendments. Area Office staff concurred, noting that many tribes, new tribal councils, and new health directors do not get the necessary training on 638 contracting and IHS responsibilities.

Tribes, as well as IHS staff, believe that a training videotape could provide tribes with basic 638 contracting information. While more than 80 percent of noncontracting and the majority of contracting tribes agree that a videotape should be distributed to tribes, only 9 percent of all tribes have seen or heard of the IHS 1990 videotape on 638 contracting. Area Office staff who have seen the video agree that, although dated, it could be useful for many tribes. This video was produced in response to a recommendation from the 1990 Quality Management P.L. 93-638 Implementation Work Group.

Indian Health Boards

Area Indian health boards and inter-tribal councils vary in how effectively they distribute 638 contracting information to tribes. The IHS formally contracts with the National Indian Health Board to disseminate information to tribes, area Indian health boards, and inter-tribal councils. Area Office staff send information directly to these organizations as well. The area Indian health boards vary in strength, size, organization, and effectiveness. In some locations, they are well funded and even contract for additional administrative and direct health programs, while in other locations they have little staff and few responsibilities. The efforts of the Indian health boards are not always coordinated with IHS headquarters and Area Offices. Therefore, some tribes receive duplicate copies of information, while others receive no information at all.

Budget Information

Tribes and Area Office staff often have difficulty obtaining complete funding information for 638 contracting. Some tribes complained that they were not given timely and accurate data. Area Office staff added that they often encountered internal problems in compiling complete budget data. Some contract proposal liaison officers receive incomplete information from area program and service unit staff and have to piece together complete

budgets for tribes. Typically, the original budget information is missing costs for peripheral items such as transportation and phone service. Although the law requires that IHS annually provide tribes with complete funding information, few Area Offices do so unless requested.

Written Communication

Tribes are dissatisfied with the information IHS mails to them for several reasons:

- The information is not written in lay terms. For example, a respondent noted that "one usually needs to be an attorney to understand the documents from IHS."
- The quantity of information is overwhelming, not identified by priorities, and lacks personal follow-up. Many tribes complained that IHS sends significant amounts of written information without any personal follow-up to ensure that they understand the information and its importance.
- Although one-quarter of contracting tribes have access to electronic mail, IHS does not use it to communicate with them. Further, IHS does not foster development of state-of-the-art computer and telecommunication systems.

National and Area Meetings

Because of travel costs and logistics, tribes sometimes are unable to attend national and area meetings. The IHS routinely convenes (1) an annual national IHS/tribal consultation conference and (2) quarterly areawide meetings. Recently, IHS has begun to host smaller meetings within and across areas to reduce tribes' transportation costs and to increase personal contact. According to some tribes, these meetings foster better attendance, and tribal representatives are more likely to speak up in front of smaller groups of people they know.

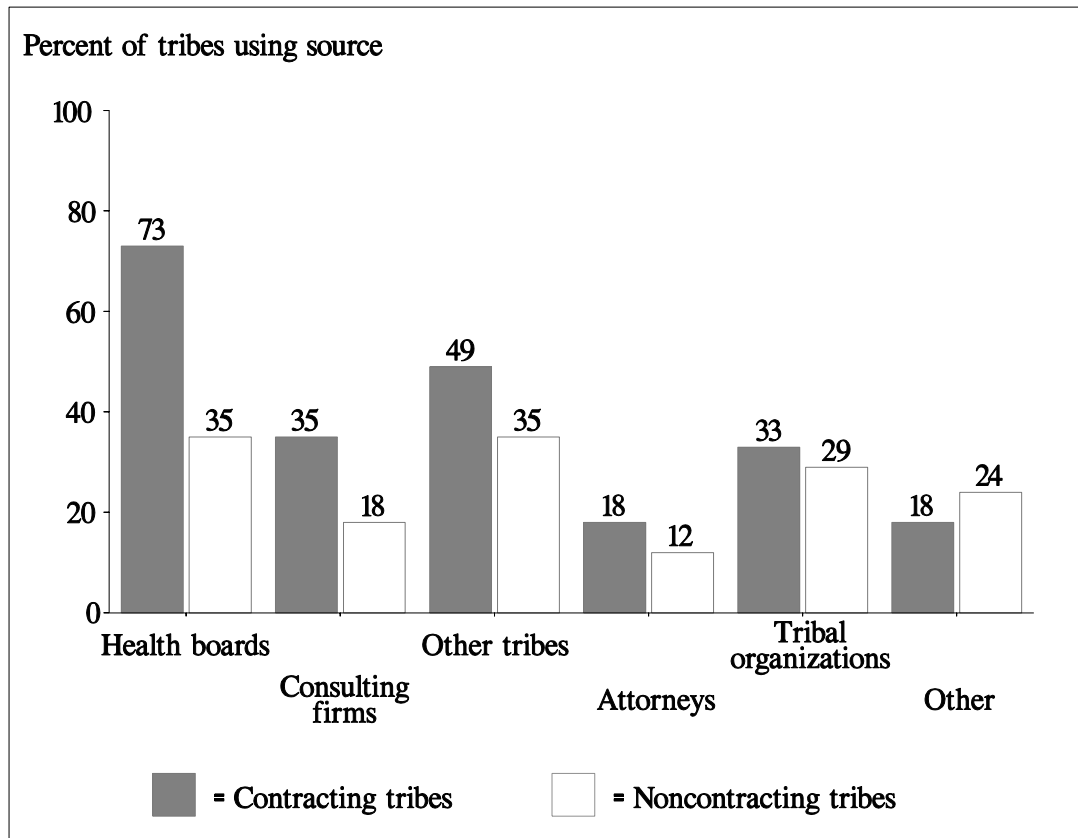
IHS Feedback Mechanisms

The IHS does not routinely ask tribes for customer feedback about the quality of IHS information, training, and technical assistance. Almost all tribes and most IHS employees believe IHS should conduct regular customer surveys. Two Area Offices use an evaluation survey form that allows tribes to rate the technical assistance and training they receive from IHS; however, like all other Area Offices, most feedback occurs at the time of the program evaluation. Asking for feedback during the program evaluation presents a possible conflict of interest, as tribes may be hesitant to critique the agency that is evaluating them. Tribal and IHS suggestions ranged from having regular survey forms and phone calls to including tribal reviews in individual IHS employee evaluations. The IHS is working on a 3-year customer survey initiative that may address this need.

Tribes rely on Indian health boards, consulting firms, other tribes, and attorneys for 638 contracting information

Ninety-six percent of contracting tribes and 71 percent of noncontracting tribes use non-IHS sources in addition to IHS. More than one-half of the tribes that are familiar with the 1994 amendments learned about them from a source other than IHS. Even Area Office staff rely on non-IHS sources for 638 information such as codified copies of the 1994 amendments. Many IHS Area Office staff admitted that tribes often know more than they do. The chart below illustrates which sources tribes most frequently use for contracting information.

TRIBES USE A NUMBER OF SOURCES FOR 638 CONTRACTING INFORMATION



Many tribes consider these sources superior to IHS for 638 contracting information. More than half of contracting tribes and 18 percent of noncontracting tribes rated another source of information better than IHS.

Most tribes want to purchase technical assistance and training from sources other than IHS

Almost three-quarters of contracting tribes and 69 percent of noncontracting tribes want IHS to provide funding so they can contract with sources other than IHS for technical assistance and training. Some of these same tribes also want IHS to continue providing some technical assistance and training.

Some tribes want IHS Area Offices to provide the initial orientation on the 638 contracting process. Then, following the initial orientation, they want to have funding they can use to hire non-IHS sources for more detailed training and technical assistance specific to their needs. These tribes prefer using outside sources to explore the feasibility of contracting for various health services.

Some tribes and IHS employees want IHS to change the way it monitors tribal health programs

Nine percent of contracting tribes volunteered that they want to use professionals such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to conduct their program evaluations instead of IHS. The JCAHO offers voluntary accreditation programs involving on-site surveys of health care organizations. As an example, one of the tribes routinely has its 638-contracted health services reviewed by a State agency as well as IHS. According to the tribe, the State agency uses higher standards than IHS--much more like JCAHO's standards--in its review. This provides the tribe with valuable information about how to improve its health services.

RECOMMENDATION

THE IHS SHOULD CONTINUE AND EXPAND ITS EFFORTS TO INCREASE TRIBAL AWARENESS AND FOSTER SELF-DETERMINATION

The goal of the P.L. 93-638 legislation and subsequent amendments is to enable tribes to exercise their self-determination rights. In order to accomplish this, tribes need to be fully informed and administrative barriers must be eliminated. The IHS can best serve tribal self-determination efforts by:

Continuously informing tribes about their 638 contracting options

Tribes are likely to increase 638 contracting when they are more aware of their options. The IHS could take a number of actions to improve tribal awareness, including:

- Providing 638 contracting orientations to tribes that need them

These orientations could include basic information about 638 contracting such as the law, the roles of IHS staff, health care options, other sources of technical assistance and training, and the steps needed to proceed with contracting. One component of the orientation could be distribution of the 1990 video on 638 contracting along with information about the impact of the 1994 amendments.

- Simplifying communications and increasing personal contact

Written communications to tribes should be directed to the appropriate tribal staff, and the language should be such that all can understand. Further, IHS should increase its personal contact with tribes by (1) having more area and local meetings, (2) following dissemination of significant written materials with telephone calls, and (3) encouraging use of electronic mail and other emerging communication technologies.

- Distributing individual tribal budget information annually

The annual budget information should include each tribe's share of health services and IHS Area Office and headquarters functions.

- Informing tribes of their option to use existing community health services

The IHS could give each tribe a description of all options available to them. This description would include an explanation of the tribe's option to use 638 contracting to pay for existing non-IHS health services. The IHS could help tribes that are interested in these existing community services to learn from other tribes that already have used this option.

Helping tribes increase their use of non-IHS sources of information, technical assistance, training, and contract monitoring

The IHS should inform tribes (particularly noncontracting tribes) about other sources of expertise and how tribes can get IHS funding to use these sources. For example, the tribal management grant program and tribal shares of IHS administrative functions can be used to fund feasibility studies, training sessions, technical assistance, and health program evaluations. The IHS could act as an information clearinghouse about these sources of expert assistance.

Facilitating the transfer of health services and administrative functions

Many tribes are ready to contract for more health services and Area Office and headquarters functions. The IHS should (1) provide complete budgetary information, (2) distribute the funds to interested tribes, and then (3) reduce staff and reorganize accordingly.

APPENDIX A

DETAILED DESCRIPTION OF METHODOLOGY

We randomly selected our sample of tribes through a four-step process:

1. We divided the total population of tribes into two groups: (1) tribes that contract under 638 for health services and (2) tribes that either do not contract or contract only for community health representative and/or emergency medical services programs (hereafter referred to as "noncontracting tribes").
2. We divided the Area Offices into 3 groups based on the percentage of each Area Office's budget that is contracted under 638. We assigned the "contracting" tribes (from step 1) to these three groups according to their Area Office.
3. We randomly selected 20 tribes from each of the 3 "contracting" strata. We selected all 34 of the "noncontracting" tribes.
4. If the tribe was contracting through a tribal organization, we interviewed the organization as well. This resulted in interviews with 12 tribal organizations.

The four groups (or strata) of tribes are illustrated in the following table:

SAMPLE SELECTION



Stratum	Description	Number in sample	
1	Non-contracting tribes or tribes with very small contracts	34	
2	Contracting tribes grouped by Area Office	Alaska, California, and Nashville	20
3		Bemidji, Oklahoma, Aberdeen, and Portland	20
4		Albuquerque, Navajo, Billings, Phoenix, and Tucson	20

The response rate was 74 percent (70 interviews completed out of 94). The majority of non-responders were noncontracting tribes and tribes that contract through tribal organizations. Our fieldwork spanned 4 months, since many tribes were extremely difficult to contact and interview.

Out of the 12 IHS Area Offices, our sample contained tribes from 10 of them. For each of these 10 Area Offices we attempted to interview a representative from the area Indian health board. We also interviewed IHS officials from the respective Area Offices including project officers, contracting officers, contract proposal liaison officers, and area directors.

APPENDIX B

AGENCY COMMENTS

The IHS provided comments on the draft report and agreed with our recommendation to continue and expand its efforts to increase tribal awareness and foster self-determination. We have made minor revisions to the report based on IHS' technical comments. As IHS mentioned in its comments, it has initiated multiple communication activities including use of the Internet to better convey contracting and other information to Indian tribes. In our review of the Internet home page, we were impressed with the design of the page and the quantity of information. The home page includes a section entitled "IHS Communications Page" that gives detailed and up-to-date information on legislative activities, agency operations such as the Indian Health Design Team, and comments by leading IHS officials. The full text of IHS' comments begins on the next page.

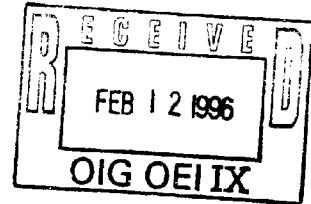


DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

JAN 26 1996



TO: Office of the Inspector General
FROM: Associate Director
Office of Administration and Management

SUBJECT: Indian Health Service Comments on the Office of Inspector General Draft Report, "Tribal Contracting for Indian Health Services" (OEI-09-93-00250)

I am attaching the Indian Health Service (IHS) comments on the Office of Inspector General draft report, "Tribal Contracting for Indian Health Services" (OEI-09-93-00250). The comments reflect the IHS' actions that are being taken or are planned in order to implement the single recommendation contained in the subject report.

Please direct your inquiries concerning this memorandum to Mr. Charles Miller, Chief, Management Control Branch, Division of Management Policy, on (301) 443-9597.

George Buzzard
George Buzzard

Attachment

IG	_____
SAIG	_____
FDIG	_____
DIG-AS	_____
DIG-EI	_____ /
DIG-OI	_____
DIG-MP	_____
AIG-CFAA	_____ /
OGC/IG	_____ /
EXSEC	_____ /
DATE SENT	2/2

INDIAN HEALTH SERVICE COMMENTS ON THE
OFFICE OF INSPECTOR GENERAL DRAFT REPORT, "TRIBAL CONTRACTING
FOR INDIAN HEALTH SERVICES." (OEI-09-93-00250)

General Comments

Since the enactment of Public Law (P.L.) 93-638, the "Indian Self-Determination and Education Assistance Act," the demand for information on tribal contracting or compacting with the Indian Health Service (IHS) for funds to provide health care to tribes has increased markedly. The IHS continues to meet the demand by providing up-to-date information to tribes by direct mail and the Internet.

OIG Recommendation

The IHS should continue and expand its efforts to increase tribal awareness and foster self determination.

IHS Comments

The Indian Health Service concurs with the recommendation.

Many tribes have become aware of the possible benefits of contracting or compacting with the IHS to provide health care from tribes negotiating for (or that have been awarded) a "Self-Governance Award" or a Title 1 contract. The IHS will continue its efforts to increase tribal awareness and foster self determination by providing tribes with comprehensive information concerning the benefits and opportunities available to tribes under P.L. 93-638.

Currently, the IHS mails announcements, concerning any program announcement, including the "Self-Governance Planning and Negotiation Cooperative Agreement Awards," directly to all tribal chairpersons, tribal health department heads, tribal attorneys, and other interested parties within tribal governments. Additionally, announcements are also mailed to all IHS Area Directors, Contract Proposal Liaison Officers, and Senior Area Contracting Officers.

Presently the following actions are underway:

1. Program announcements are currently being issued for Self-Governance Planning and Negotiation Cooperative Agreement Awards to prepare Tribes for the selection of the next group of approximately 30 P.L. 93-638 compacts.
2. "Dear Tribal Leader," letters are mailed to all tribes to disseminate information concerning P.L. 93-638 contracting or compacting issues.
3. The Director, IHS, issues a monthly report on IHS activities for distribution to all tribes in Indian Country and other interested groups or persons via the Internet or direct mail.

Technical Comments

The following revisions should be included in the text of the report:

The Executive Summary should be revised to include information that the IHS will continue to provide comprehensive health services to American Indians and Alaska Native people in the event tribe(s) decides not to contract.

In addition, the following sections should be corrected to read as follows:

- Page ii. "Recommendation" last paragraph, after the completion of the sentence numbered (4) add, "...or continuing use of IHS services."
- Page 3. In the "IHS Contracting Roles and Responsibilities" first sentence. Change the number 12 to 11. The number of Area Offices with contracting responsibilities is 11, (not 12).
- Page 15. "Simplifying communications and increasing personal contact," second sentence: The action step to followup "...dissemination of significant written material with telephone calls..." should be withdrawn, because funding cuts, reduced manpower, etc. render compliance unrealistic.
- Page A-2. Second paragraph: Change the number 12 to 11. The number of Area Offices with contracting responsibilities is 11, (not 12).