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United States Government Accountability Office
Washington, DC 20548

October 22, 2009

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate

Subject: *Indian Health Service*: *Updated Policies and Procedures and Increased Oversight Needed for Billings and Collections from Private Insurers*

Dear Mr. Chairman:

The Indian Health Service (IHS), an agency in the Department of Health and Human Services (HHS), provides health care services to American Indians and Alaskan Natives. For fiscal year 2009, Congress appropriated approximately $3.6 billion for health care services to be made available through IHS. The agency provides direct medical care, including primary care services, ancillary services, and some specialty services, through its network of facilities, including hospitals, health centers, and clinics.[1] IHS also provides funding to direct care facilities that are operated by tribes. IHS headquarters oversees 12 area offices that cover 161 service units in 35 states.

The Indian Health Care Improvement Act of 1976, as amended, authorizes IHS to collect reimbursement for services provided at IHS facilities from third-party insurers, including Medicare, the federal health insurance program for elderly and disabled individuals; Medicaid, a joint federal and state health financing program for certain low-income families and individuals; and private health insurers.[2] IHS is allowed to retain funds collected from these insurers without a corresponding offset against its appropriations, so that all revenue collected by a facility remains with that facility, supplementing its appropriations.[3] For fiscal year 2008, IHS reported that it collected about $795 million from all third-party insurers, of which about $94 million, or 12 percent, was collected from private insurers. The remaining 88 percent was

[1]Primary care services include medical, dental, and vision; ancillary services include laboratory, diagnostic imaging, and pharmacy services; and specialty care includes services provided by cardiologists, surgeons, and other physician specialists.

[2]25 U.S.C. § 1621e(a). The act authorizes IHS to collect reimbursement for reasonable expenses incurred to the same extent that an individual or nongovernmental provider would be eligible to receive reimbursement.

[3]25 U.S.C. § 1621(b).

collected from the Medicare and Medicaid programs. According to IHS, these funds were used to purchase new medical equipment and medical supplies, and to provide compensation and benefits for IHS employees.

Given the importance of these collections to IHS's mission, you asked us to examine several areas related to IHS's billings and collections activities. Specifically, you asked us to review IHS's policies and procedures for writing off amounts owed to the agency by private insurers, internal control procedures related to billing and collection, and the amounts and reasons for denied claims and claims written off as uncollectible by IHS.[4] Because IHS was unable to provide much of the information we requested on the amounts of denied and adjusted claims and amounts written off for more than 6 months after our requests for these data, we agreed with your staff to provide you a report that examines (1) the design of IHS's policies and procedures for billing and collecting revenue from private insurers including write-offs of uncollectible claims, and (2) the adequacy of IHS headquarters' monitoring of area office and service unit compliance with policies and procedures for the billing and collection of revenue from private insurers.

To examine the design of IHS's policies and procedures for third-party collections, we identified key billing and collection policies and procedures related to private insurers contained in IHS's Indian Health Manual and its Revenue Operations Manual. We compared these policies and procedures to the Financial Systems Integration Office's (FSIO) standard business processes for administering and managing federal accounts receivables.[5] We also obtained written responses to questions we developed and submitted to IHS officials in the nine area offices and nine nonstatistically selected service units to gain an understanding of the types of activities they were undertaking to comply with IHS policies and procedures for billing and collection.[6] As agreed with your office, the scope of our review was limited to IHS-administered facilities because under federal law, tribally operated facilities are not generally subject to the policies, procedures, and reporting requirements established for IHS-administered facilities. Because IHS could not provide us with detailed transaction-level billing and collection data until more than 6 months after our initial data requests due to system limitations that are discussed later in this report, we were unable to conduct testing to determine whether IHS is

[4]A write-off is an accounting action that results in reporting a debt as having no value on IHS's financial statements and internal management reports. However, a write-off does not waive IHS's right to the amount in question and does not preclude IHS from pursuing debt collection. IHS also makes accounting adjustments to claims to reduce the outstanding balance for amounts that are not collectible from the private insurance companies such as for copayments, deductibles, and other amounts.

[5]FSIO, *Financial Management Systems Standard Business Processes for U.S. Government Agencies* (Washington D.C.: November 2008). FSIO assumed the standards-setting function of the Joint Financial Management Improvement Program, and has been tasked with developing standard business processes, data specifications, and business rules for core financial management functions to be adopted by all federal agencies to help federal agencies meet the objectives of the Federal Financial Management Improvement Act of 1996 and Office of Management and Budget Circular A-127.

[6]IHS is organized into 12 area offices, 9 of which support a total of 61 IHS-administered service units. Of the 3 remaining area offices, California and Alaska support only tribally administered service units. The Nashville area office supports tribally administered service units and one recently converted IHS-administered service unit for which IHS did not have data at the time of our request.

actually complying with its policies and procedures. As a result and as agreed with your staff, this report covers the design of IHS's policies and procedures for billing and collecting revenue from private insurers, but does not assess implementation. To examine IHS headquarters' monitoring of area offices' and service units' compliance with billing and collection policies and procedures, we compared IHS headquarters' monitoring activities to those described in its policies and procedures and to GAO's *Standards for Internal Control in the Federal Government.*[7] We interviewed senior IHS officials about the policies and procedures and their activities related to monitoring billings and collections. We also reviewed IHS's documentation of one of the five completed IHS on-site service unit compliance reviews as well as components of IHS's new Web-based "Third-Party, Internal-Controls Policy, Self-Assessment Audit Program." We did not assess the adequacy of monitoring activities performed by IHS's area offices and service units. Enclosure I provides additional details on our scope and methodology.

We conducted this performance audit from June 2008 through September 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

IHS has established policies and procedures for billing and collecting revenue from private insurers that are generally consistent with federal standard business processes for billings and collections. However, IHS had not updated them to reflect its recent implementation of HHS's new financial management system, Unified Financial Management System (UFMS). The new system entirely automated some previous employee-administered activities. Outdated policy and procedure manuals increase the risk that management directives will not be met as well as the risk of noncompliance with federal regulations. Also, ORAP officials acknowledged that although IHS's debt management policies and procedures included some specific requirements for service units and area offices to develop debt management plans or programs, they provided no guidance on implementation of these requirements. Additionally, through interviews with service unit and area office officials that addressed debt management activities, we found that none of the area offices or service units we spoke with had developed and implemented these location-specific debt management plans. Some area office and service unit officials told us that they were developing a program or plan, while others said that they were using the Indian Health Manual, Part 9 "Debt Management" as their debt management policies and procedures, rather than developing separate programs or plans. Without well-defined debt management plans, area offices and service units may not be conducting debt collection activities in compliance with IHS's policies and procedures or federal regulations, and may not be maximizing collection of the amounts due from private insurers.

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[7]GAO, *Standards for Internal Control in the Federal Government* GAO/AIMD-00-21.3.1 (Washington D.C.: November 1999).

IHS headquarters' monitoring activities are inadequate to ensure area office and service unit compliance with billing, collection, and debt management policies and procedures. Although ORAP has been responsible for performing policy compliance reviews since 2005, ORAP officials reported that due to limited staff and the significant amount of time required for each on-site review, they have only completed reviews at 5 of the 61 IHS-administered service units. They also reported that if deficiencies were found, ORAP would communicate their review findings to the service units and request corrective actions plans, but did not have the authority to ensure that corrective actions were developed and implemented. IHS has begun taking additional steps to increase its oversight of IHS-wide billing and collection by expanding ORAP's compliance review activities by implementing a new Web-based tool to monitor service unit policy compliance, ensuring access to billing and collection performance data contained in UFMS, and establishing direct line authority over area offices through the creation of a Deputy Director of Field Operations position. However, as currently designed, these initiatives have shortfalls. For example, the Web-based tool does not include questions on debt management activities, and IHS has not completed development of management reporting capability either through the Web-based tool or UFMS database. Full implementation of the current initiatives, along with additional data and reporting, would enable reporting to IHS management, including the Deputy Director of Field Operations, and enhance IHS's monitoring of its billing and collection activities. Until then, IHS management's ability to monitor area offices and service units will continue to be limited.

We are making four recommendations to the Director of IHS to help strengthen its management and oversight of billing and collection activities, including updating policies and procedures; developing additional debt management guidance, as needed; analyzing available data and further developing tools to monitor and manage billings and collections; and developing a risk-based approach using the information obtained from the new data sources to prioritize which service units receive future on-site compliance reviews.

We received written comments from HHS on a draft of this report (reprinted in their entirety in enclosure II). HHS agreed with the draft report and discussed actions IHS was taking to improve its monitoring of billings and collections at IHS headquarters. HHS also recognized the need for IHS to update its policies and procedures and outlined how IHS would complete this action. IHS also provided separate technical comments which we have considered and incorporated into this report as appropriate.

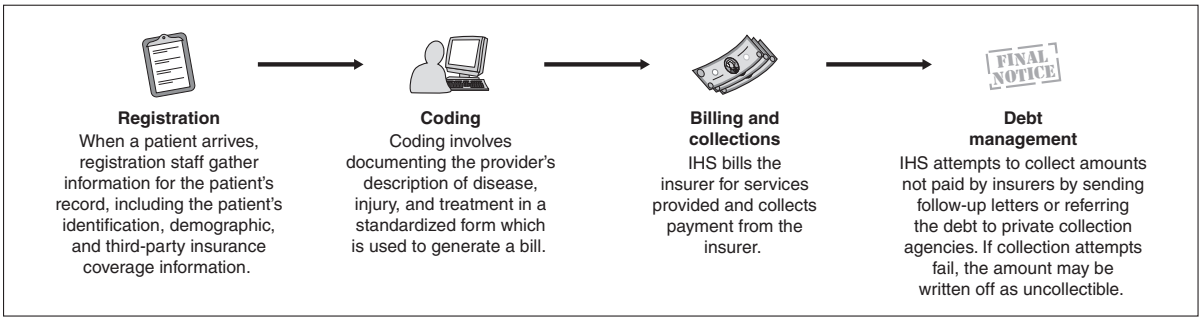
Background

IHS operates a large decentralized health delivery system comprised of 12 area offices, which include all or part of 35 states where many American Indian and Alaskan Native communities are located. The area offices provide guidance and technical support to the facilities in their area, which are organized into 161 service units. Each service unit may include federally or tribally operated hospitals, health centers, clinics, and other smaller health facilities.

IHS Business Revenue Cycle

The IHS business revenue cycle consists of four major phases: patient registration, coding, billing and collection, and debt management (see fig. 1).[8] Complete and accurate reporting of data at each phase of the cycle is necessary for generating accurate billings, as well as collecting payments from insurers in a timely manner. Debt management occurs at the end of the business cycle, and refers to IHS's activities to collect amounts owed from insurance companies that have been outstanding more than 30 days including procedures for when the collection attempts are not successful. Typically, facilities perform all four phases of the business revenue cycle, while area offices and service units have primary responsibility for monitoring these processes.

Figure 1: IHS Business Revenue Cycle



Source: GAO analysis of IHS policies and procedures.

To assist area offices and service units in managing the business revenue cycle, IHS developed and implemented the Resource and Patient Management System (RPMS) to provide comprehensive admissions, clinical, billing, and collection information on all health services provided at IHS facilities. RPMS is a computerized system that captures detailed patient-level transaction information, such as amounts owed from private insurers, as well as amounts collected. The detailed transaction information is then summarized and recorded automatically into UFMS, the primary financial management system for HHS. IHS fully implemented UFMS in October 2008.

Monitoring

IHS headquarters shares monitoring responsibilities with its area offices and service units. Part 5 of the Indian Health Manual delegates the primary responsibility for monitoring the day-to-day performance of billing and collection activities to the area offices and service units. In general, service unit business office staff use RPMS reporting to monitor billing and collection activities. They also monitor patient registration and coding activities in order to detect errors and backlogs that can delay billings and hinder collections.

[8]IHS's business revenue cycle policies and procedures cover revenue from both private insurers and government programs such as Medicare and Medicaid.

The service unit Chief Executive Officer, or designee, performs evaluations and reviews these reports on a periodic basis. Some reports, such as those on patient registration, coding, billing, and the status of claims,[9] are reviewed weekly while others, such as those on outstanding balances and deleted claims, are reviewed monthly. The reports are also forwarded to the area office, where officials review and summarize them, and provide feedback on performance to service unit and facility management, as well as recommend periodic follow-up and corrective action when needed. Within headquarters, ORAP was established in 2004 to provide leadership and direction to the area offices and service units to increase third-party revenue collections, and to monitor compliance with IHS policies governing business revenue cycle processes. In addition, ORAP is involved in providing leadership on payment policy in coordination with HHS, Centers for Medicare & Medicaid Services, and area offices. Further, ORAP is responsible for technical assistance to the area offices, IHS-wide training and consultation, hospital cost report and rate development, review of legislation and regulations that may impact revenue, and program technical support. As of July 2009, ORAP had five staff members.

Design of Policies and Procedures for Billing and Collection Is Generally Consistent with Federal Standard Business Processes, but Some Are Outdated, and Others Lack Necessary Guidance

The design of IHS's policies and procedures for billing and collection activities—as reflected in Part 5 and Part 9 of the Indian Health Manual, and IHS's Revenue Operations Manual—is generally consistent with FSIO's standard business processes for managing federal accounts receivable, which include key processes related to the four phases of IHS's business revenue cycle.[10] For example, FSIO specifies that there typically are triggering events that require establishing a receivable as well as processes for capturing, verifying, and reviewing customer information. Consistent with these expectations, IHS's policies and procedures include specific guidance on obtaining and verifying patient data at registration and for recording these data in RPMS.

Another FSIO expectation is that procedures exist for ensuring critical data elements are captured in the supporting documentation which are necessary to establish a receivable such as dates of performance, description of services, and amounts to be billed. Along these lines, IHS's polices and procedures include activities for the proper and complete coding of medical services and the billing of these services to private insurance companies. Another FSIO expectation is that agencies, on a periodic basis, determine the age of outstanding receivable balances and review the status of these outstanding accounts receivable balances. We confirmed that IHS's

[9]Claims for medical services provided by IHS facilities are submitted to private insurance companies for payment. The private insurance companies make a determination on which services they cover and how much the reimbursement will be. In addition, in some cases they may decide not to reimburse the IHS facility for some or all of the billed items for various reasons such as the claim was not submitted within the allowed period of time as defined by the insurance company.

[10]FSIO, *Financial Management Systems Standard Business Processes for U.S. Government Agencies* (November 2008).

policies and procedures included requirements that periodic review, research, and follow-up action must be performed and properly documented. An additional FSIO expectation is that procedures exist for determining debts that are uncollectible and therefore should be written off. We identified that IHS's policies and procedures include a requirement that debts are written off when an authorized IHS official has determined, after using all appropriate collection tools, that the debt is uncollectible.

While generally consistent with FSIO, we determined that some of IHS's policies and procedures did not reflect current operations because they were not updated to reflect IHS's recent implementation of its new financial management system, UFMS, in October 2008. As a result, IHS policies and procedures include requirements that still refer to the previous financial management system, CORE, such as:

- area business office coordinators ensure that service unit data to be entered into CORE are submitted timely by service units;
- area office financial management officers ensure that all third-party accounting transactions are recorded timely in CORE's accounts receivable application; and
- financial management officers should reconcile balances from the RPMS accounts receivable system with the CORE general ledger.

However, with the switch to UFMS, these routines have been mostly automated. For example, previously, data recorded in RPMS had to be summarized by the service units and then forwarded to the area offices where the data were manually recorded in CORE. With the implementation of UFMS, transaction data recorded in RPMS are automatically uploaded to a central UFMS database, then summary data are uploaded from this database into the UFMS general ledger and the manual recording is no longer necessary.

According to federal internal control standards,[11] formally documented policies and procedures that are clear and readily available are an essential part of an agency's internal control system. They provide guidance to staff in the performance of their day-to-day activities; help to ensure that activities are performed consistently across an agency; communicate management's directives; and help ensure that the agency is in compliance with federal laws and regulations. These control standards require that policies and procedures be reviewed regularly and updated, when necessary. In discussions, the Director of ORAP told us that ORAP's goal is to perform in-depth reviews of relevant policies and procedures every 3 to 5 years. The officials said they plan to update Part 5 of the Indian Health Manual by the end of calendar year 2009 to reflect any changes in their operations and systems since the manual was implemented in calendar year 2005. Similarly, in 2010, they may update Part 9 of the Indian Health Manual and the Revenue Operations Manual, which were implemented in calendar years 2007 and 2006, respectively.

Because Parts 5 and 9 of the Indian Health Manual had not been updated, ORAP officials told us they conducted regional accounts receivable training during fiscal year 2009 to help address the differences between the guidance in the unrevised policies and procedures and actual practice due to switching to UFMS. We reviewed

[11]GAO/AIMD-00-21.3.1.

the training slides used in the sessions and noted that they covered the activities involved in IHS's business revenue cycle (registration, coding, billings and collections, and debt management), RPMS management reports, compliance with policies related to accounts receivable, debt management, and third-party internal controls. Nonetheless, policies and procedures that are not updated increase the risk that management directives will not be followed, as well as the risk that the agency may not be in compliance with federal regulations. For example, billing and collection data, if submitted to an area office, could potentially be recorded twice, which could affect the agency's financial records and financial statements.

We also found that while Part 9 of the Indian Health Manual included policies and procedures for managing and collecting debts owed to IHS, it also included requirements for area offices to develop area debt management programs and for each service unit to develop location-specific debt management plans. However, the policies and procedures did not include guidance on what should be included in either the debt management programs or plans, or how the area offices and service units would implement them. Additionally, the training provided by ORAP included guidance on debt management policies and procedures, but did not include guidance on what is expected or required in the location-specific debt management programs or plans. Location-specific debt management programs and plans help ensure that agencywide policies and procedures are implemented at specific locations with special considerations for the various operating environments of the area offices and service units.

When we discussed these particular requirements with ORAP officials, they agreed that the policies and procedures lacked the necessary guidance to allow the area offices and services units to implement location-specific programs or plans required by the policies and procedures. When we discussed debt management activities with officials from the nine IHS-administered area offices and nine of IHS's service units, none of them indicated that they had location-specific programs or plans in place. Some area office and service unit officials told us that they were developing a program or plan, while others said that they were using the Indian Health Manual, Part 9 "Debt Management" as their debt management policies and procedures, rather than developing separate programs or plans. Without well-defined debt management plans, area offices and service units may not be conducting debt collection activities in compliance with IHS's policies and procedures or federal regulations, and may not be maximizing collection of the amounts due from private insurers.

IHS Headquarters' Monitoring of Area Office and Service Unit Compliance with Billing and Collection Policies and Procedures Is Inadequate, but Initiatives are Under Way to Increase Oversight

IHS headquarters' monitoring activities of area office and service unit compliance with billing and collection policies and procedures are inadequate, but agency officials told us they are taking steps to increase oversight. Federal internal control standards require agency management to conduct monitoring of program quality and performance.[12] Part 5 of the Indian Health Manual requires the Director of ORAP to

[12]GAO/AIMD-00-21.3.1.

monitor area office and service unit compliance with IHS policies and procedures for billing and collecting revenue through IHS-wide policy compliance reviews and internal audits. Before implementing the Web-based tool, ORAP's monitoring of policy compliance had consisted of a small number of on-site compliance reviews at IHS service units and through regular meetings with field staff.[13]

Since the policy was implemented in 2005, ORAP has not conducted any area office reviews, and has conducted on-site compliance reviews of only 5 of the 61 IHS–administered service units—all of which were completed in 2007 and 2008. During the on-site reviews, ORAP assessed service unit compliance with key policies and procedures included in Part 5 of the Indian Health Manual. For example, ORAP determined whether the service unit was billing for outpatient services within 6 business days from the date of service as required by obtaining and reviewing the data from specific RPMS reports to identify items of noncompliance. If there were any deficiencies noted during the review, ORAP communicated its findings and requested the service unit to develop and submit a corrective action plan to address them. However, ORAP officials told us they lacked direct authority over the service units to ensure that the corrective action plans were prepared or implemented. Additionally, ORAP officials told us that they were only able to accomplish the 5 on-site reviews because these reviews are time consuming and require significant staff resources to perform. These on-site reviews also did not assess compliance with IHS's debt management policies and procedures contained in Part 9 of the Indian Health manual. Therefore, ORAP lacked assurance that the service units were taking all required actions to collect outstanding debts from private insurers.

Federal internal control standards require that agency management conduct effective monitoring to assess program quality and performance over time and work to address any identified deficiencies.[14] While ORAP had some limited processes for reviewing compliance with policies and procedures, we found that ORAP does not monitor actual performance of billing and collection activities. ORAP officials told us that IHS headquarters does not have access to RPMS to routinely monitor IHS-wide billing and collection data. This is a major limitation because they also have not been able to readily obtain detailed reports on area offices' and service units' performance on key business revenue cycle activities, such as amounts billed, amounts collected, amounts outstanding, and amounts adjusted or written off. However, Part 5 of the Indian Health Manual does not include requirements for ORAP, or any other office in headquarters, to collect billing and collection data from area offices and service units, and ORAP officials have not developed a process for routinely collecting and analyzing data on amounts billed, amounts outstanding, as well as debts that have been written off. On occasion, when prompted by internal or external requests, ORAP has called upon area offices and service units to submit detailed billing and collection data; however it does not request these data on a routine basis. In addition,

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[13]The Director of ORAP told us the office routinely facilitated monthly teleconferences and quarterly meetings with business office staff from the area offices and service units to discuss issues related to business revenue cycle activities. These meetings allow ORAP to disseminate information, discuss RPMS issues, and obtain service units' collection reports. However, the reports from these meetings have not been used to produce annual performance reports or used for programwide decision making.

[14]GAO/AIMD-00-21.3.1.

ORAP cannot ensure that data are submitted in a timely manner because of system limitations and lack of authority. For example, when we asked ORAP officials for data on billing, adjustment, write-off, and collections related to private insurers covering all IHS facilities for fiscal years 2006 through 2008, officials told us they would need to contact each area office and service unit, who would then need to access the data from RPMS and forward them to IHS headquarters. For most of the requested data, ORAP required several months to provide the information to us.[15]

To increase its oversight, IHS headquarters officials told us they have begun taking steps to expand ORAP's compliance review activities, ensure access to billing and collection performance data, and establish direct line authority over area offices. In April 2008, ORAP developed the "Third-Party, Internal-Controls Policy, Self-Assessment Audit Program," a Web-based tool to assess service unit compliance with the IHS's internal control policy and procedures on a more frequent basis than the on-site reviews allowed. The tool, modeled after the on-site review, contains questions on policies and procedures related to billing and collection. Each service unit is required to complete the tool on a quarterly basis and upload supporting documentation with its responses. Supporting documentation includes detailed billing and collection information, such as the aging account summary report used by the service unit to monitor outstanding accounts. ORAP officials told us that they plan to produce management reports from the Web-based tool to enhance operations and assess compliance with policies and procedures for billings and collections. As of August 2009, ORAP officials had not developed or produced these reports. Additionally, the Web-based tool does not include questions on key policies and procedures from IHS's debt management policy, Part 9, which includes procedures for following up on delinquent debt and writing off balances deemed uncollectible. As a result, ORAP's ability to monitor service unit compliance with IHS's debt management policy is limited.

To further increase its oversight, ORAP plans to monitor billing and collection data that are now captured in UFMS since its implementation in October 2008. According to IHS officials, the integration of RPMS with UFMS permits the consolidation of financial data across all IHS facilities to support timely and reliable financial reporting to IHS headquarters. ORAP officials told us that by the end of calendar year 2009, they expect to begin producing management reports from the UFMS database to help them monitor performance of billing and collection activities. As of July 2009, ORAP had engaged a contractor to help it develop a plan for producing management reports from UFMS.

Additionally, IHS has established a Deputy Director of Field Operations position, which reports directly to the Director of IHS, to oversee area offices' compliance with policies and procedures for billing and collection by monitoring the performance of the area directors. Recognizing the need for increased oversight of the area offices, IHS gave the new Deputy Director of Field Operations position a direct line of authority over area office directors. As part of this responsibility, the new Deputy

[15]In order to provide the requested data, ORAP officials designed a software program to extract the data from RPMS and instructed each of the 61 service units to install the software as it could not be done centrally. After installation, each service unit generated the required reports and submitted data to ORAP where they were summarized for our use.

Director of Field Operations is expected to evaluate area office directors' performance. We verified that the area office directors' performance contracts contain performance measures related to compliance with policies and procedures for billing and collection and some contained performance measures for area offices' collection performance. While ORAP does not report directly to the new Deputy Director of Field Operations, IHS officials expect that the new Deputy Director of Field Operations will work closely with ORAP to communicate and enforce service unit corrective action plans for deficiencies, if any, identified by ORAP through its utilization of the Web-based tool. Per the Deputy Director of Field Operations position description, a major responsibility of the position will be to provide direction to area offices to ensure IHS policies are consistently applied in the field and that field operations and programs do not conflict with laws and regulations and HHS/IHS policy. As of August 2009, IHS had not permanently filled this position, although there is currently an acting Deputy Director in place performing these functions.

Full implementation of the current initiatives, along with additional data and reporting, would enable reporting to IHS management, including the Deputy Director of Field Operations, and enhance IHS's monitoring of its billing and collection activities. Until then, IHS management's ability to monitor area offices and service units will continue to be limited.

Conclusions

While the design of IHS's policies and procedures relating to its billings and collections from private insurers is consistent with federal standards, to remain useful these policies and procedures must be periodically evaluated to ensure that they are still relevant and up to date. Policies and procedures that include outdated processes that do not reflect IHS's current operating environment could lead to operational inefficiencies and errors in recording transactions that negatively impact IHS's program management and financial reporting. Further, the lack of complete guidance related to the location-specific debt management plans increases the risk that IHS offices and facilities will not consistently implement the debt collection actions necessary to comply with federal law or maximize the amounts collected and used to provide needed services.

Until recently, IHS headquarters had largely delegated its monitoring responsibilities for billing and collection activities to the area offices and service units and did not have direct or timely access to performance data to effectively manage the program. IHS headquarters has now focused increased attention on monitoring the billing and collection activities of its area offices and service units and has recently developed tools for collecting compliance and performance data. While these tools provide more data to IHS headquarters on billing and collection activities, the data captured by these new tools have not yet been analyzed and communicated back to management in a manner that would assist in monitoring compliance with IHS policies and procedures and improving agency operations and collection activity. Moreover, IHS has an opportunity to enhance the tools by considering other data sources and performance metrics to provide a more comprehensive assessment of service unit and area office debt management activities. Such enhancements could also be used to prioritize the on-site compliance reviews to focus on the units with

the most risk using the data captured in these tools. These efforts can help IHS make decisions regarding the resources expended in its monitoring efforts based on the potential benefits of those activities based on risk.

Recommendations

We recommend that the Director of IHS strengthen IHS's management and oversight of billing and collection activities by updating and providing additional guidance in the agency's policies and procedures for billing and collection from private insurers. As part of this effort, the Director of IHS should direct IHS officials to take the following actions:

- Review and update the outdated parts of the Indian Health Manual to reflect IHS's implementation of UFMS.
- Develop and establish location-specific guidance for implementing the requirements in Part 9 of the Indian Health Manual for area offices and service units to individually develop and implement debt management programs and operational plans, and direct the Area Office Directors and Service Unit CEOs to provide training at the local level to ensure the programs and plans are effectively implemented.
- Develop specific tools and reporting mechanisms to monitor and manage the business revenue cycle, including billing and collection, and debt management activities.
- Develop a risk-based approach using the information obtained from the new data sources (i.e., the UFMS database and Web-based tool) to prioritize which service units receive future on-site compliance reviews.

Agency Comments and Our Evaluation

In written comments on a draft of this report (reprinted in their entirety in enclosure II), HHS stated that it agreed with the draft report and offered some comments that focused on steps being taken by IHS to improve its oversight over billings and collections. In particular, the letter discussed IHS's plans to use revenue reports from its new financial management system, UFMS, in conjunction with the new Web-based "Third-Party, Internal Controls Policy, Self-Assessment Audit Program" tool to improve monitoring of the third-party revenue program at IHS headquarters. HHS also recognized the need for IHS to update its policies and procedures and stated that IHS wanted to allow time to train staff on the new UFMS system, test new processes, evaluate those results, and make any additional changes that may be necessary before undertaking revisions to the policies and procedures in 2010. This is a reasonable approach and we encourage IHS to move forward expeditiously. Finally, HHS acknowledges that IHS had some initial implementation issues with UFMS and stated that the issues have now been resolved, which will allow IHS to focus on developing and producing the planned management reports. IHS provided separate technical comments which we considered and incorporated into this report as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the date of this report. We will then send copies to the Director of the Indian Health Services, appropriate congressional committees, and other interested parties. In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have questions about this report, please contact Kay L. Daly at (202) 512-9095 or at dalykl@gao.gov or Kathleen M. King at (202) 512-7114 or at kingk@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in enclosure III.

Sincerely yours,

Kay L. Daly
Director, Financial Management and Assurance

Kathleen M. King
Director, Health Care

Enclosure I: Scope and Methodology

To examine the design of Indian Health Service's (IHS) key policies and procedures for billing and collecting revenue from private insurers, we obtained and reviewed the following sections of the Indian Health Manual:

- Part 5, Chapter 1 "Third-party Revenue Accounts Management and Internal Controls" dated March 3, 2006, which provides policies and procedures for establishing, documenting, and monitoring IHS's accounts receivable; and

- Part 9, Chapter 4 "Debt Management" dated December 13, 2007, which establishes IHS policy, responsibilities, procedures to be followed for collecting debts owed to IHS, and writing off debts when they are determined to be uncollectible.

We also reviewed IHS's Revenue Operations Manual dated July 2006 which provides standardized policies, procedures, and guidelines for each task associated with the business revenue cycle activities of IHS facilities.

We compared IHS's documented policies and procedures with the Financial Systems Integration Office's (FSIO) standard business processes for administering and managing federal accounts receivables.[1] We selected the FSIO standard business processes because they were developed to standardize common financial business activities and processes to ensure that financial managers assess programs and make decisions with timely and accurate data.[2] We also considered GAO's *Standards for Internal Control in the Federal Government*.[3] Further, we interviewed relevant IHS officials about the agency's policies and procedures for billing and collection including the Director of Office of Resource Access and Partnerships (ORAP), and the Director of the Division of Business Office Enhancement. We limited the scope of our review to IHS-administered facilities because under federal law, tribally operated facilities are not generally subject to the policies, procedures, and reporting requirements established for IHS-administered facilities. Due to systems limitations, IHS could not provide us with detailed transaction-level billing and collection data in a timely manner. IHS required more than 6 months to provide the data we requested on the amounts of claims written off and adjusted and the reasons for those adjustments. As a result, we were unable to conduct testing to determine whether IHS is actually complying with its policies and procedures. Accordingly and as agreed with your staff, we limited our review to the design of IHS's policies and procedures over billing and collecting from private insurers, not their implementation. At the area

[1]FSIO, *Financial Management Systems Standard Business Processes for U.S. Government Agencies* (Washington D.C.: November 2008).

[2]We did not assess the extent to which the FSIO standard processes reflect the appropriate implementation of applicable laws, regulations, or standards.

[3]GAO/AIMD-00-21.3.1.

office and service unit levels, we obtained written responses to questions we developed and submitted, and conducted follow-up interviews with 9 of the 12 IHS area offices, as well as the Chief Executive Officers, or their designees, of 9 of the 61 service units.[4] At each level, we asked officials about the types of activities they typically undertake to comply with IHS's policies and procedures related to billing and collection.

To examine the adequacy of IHS headquarters monitoring of area office and service unit compliance with IHS policies and procedures for the billing and collection of revenue, including debt management, we evaluated IHS headquarters' monitoring activities using the policies and procedures contained in Parts 5 and 9 of the Indian Health Manual and GAO's *Standards for Internal Control in the Federal Government*.[5] At IHS headquarters, we interviewed the Director and other officials within ORAP—whose responsibilities include developing policies and procedures for the agency—to ask them about the availability of billing and collection data and their monitoring activities. We also interviewed the acting Deputy Director of Field Operations. In addition, we reviewed IHS's documentation of one of the five completed IHS on-site service unit policy compliance reviews as well as components of IHS's new Web-based "Third-Party, Internal-Controls Policy, Self-Assessment Audit Program." We also reviewed the performance contracts of area office directors for fiscal year 2009 to identify performance measures related to billing and collection activities. We examined the adequacy of monitoring activities at IHS headquarters, but did not examine the adequacy of monitoring at the area office or service unit levels.

We requested comments on a draft of this report from IHS. We received written comments from HHS on October 19, 2009, and have summarized those comments and our responses in the Agency Comments and Our Evaluation section of this report. We conducted this performance audit from June 2008 through September 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[4]IHS is organized into 12 area offices, 9 of which support a total of 61 IHS-administered service units. Of the 3 remaining area offices, California and Alaska support only tribally administered service units. The Nashville area office supports tribally administered service units and 1 recently converted IHS-administered service unit for which IHS did not have data at the time of our request. We interviewed IHS officials at the 9 IHS-administered area offices, including Aberdeen, Albuquerque, Bemidji, Billings, Navaho, Oklahoma, Phoenix, Portland, and Tucson area offices. Within each of the 9 areas, we generally selected on a nonstatistical basis the service unit with the largest outstanding accounts receivable balance and interviewed cognizant officials in these service units.

[5]GAO, *Standards for Internal Control in the Federal Government* GAO/AIMD-00-21.3.1 (Washington D.C.: November 1999).

Enclosure II: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

OCT 19 2009

Kay L. Daly
Director, Financial Management and Assurance
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Ms. Daly:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: Indian Health Service: Updated Policies and Procedures and Increased Oversight by IHS Headquarters Needed for Billings and Collections from Private Insurers (GAO 10-42R).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Andrea Palm
Acting Assistant Secretary for Legislation

Enclosure

HHS Comments to the Draft GAO Report GAO-10-42R

The Department of Health and Human Services agrees with the subject Draft Report. We offer the following general comments:

1. In reference to the need for "Increased Oversight by IHS Headquarters," we are making improvements. The current initiative to access the Unified Financial Management System (UFMS) database will provide IHS wide revenue reports that Headquarters can use to monitor the revenue program in conjunction with the online Internal Controls Policy reporting tool. IHS will consider the development of a risk-based approach to using the information obtained from the new data sources (i.e., the UFMS database and the Web-based "Third-Party, Internal-Controls Policy, Self-Assessment Audit Program" tool) to prioritize which Service Units receive future onsite compliance reviews.

2. IHS recognizes that its policies and procedures must be updated. The accounts Receivable Module in UFMS and Subsidiary link to RPMS were not interfaced until October 1, 2008. With any transition of this magnitude, there is always a specified amount of time it takes to stabilize the new environment, train on new processes, test new processes, monitor and evaluate those results, and make any changes that may be necessary to ensure the validity of the data and outcome are stable.

We are working expeditiously to update policies and operations affected by the implementation of this new system. This will be accomplished once implementation and testing of new processes are fully designed, and training is provided to all sites. The new policies are scheduled to be completed in 2010. Development and implementation of centralized reporting capabilities using the UFMS database is also scheduled to be completed in 2010.

3. On page 14, paragraph 2, last sentence, "however, as of July 2009, ORAP had only taken an initial step of engaging a contractor to help them develop a plan for producing management reporting." IHS had on-going discussions between the Finance Office and the UFMS contractor back in FY 2007 and FY 2008 regarding UFMS implementation and reporting capabilities. Challenges with UFMS implementation have been ongoing because the UFMS system required numerous changes and adjustments throughout the implementation process. We were unable to interface the billing program with UFMS in October of 2007 as planned because the system did not have the capacity to handle the volume. This issue has now been resolved as of October 1, 2009.

Enclosure III: GAO Contacts and Staff Acknowledgments

GAO Contacts

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Staff Acknowledgments

In addition to the individuals named above, key contributions were made to this report by Phillip McIntyre, Assistant Director; Catina Bradley, Assistant Director; Carolyn Yocom, Acting Director; Jehan Abdel-Gawad; Devin Barnas; William Brown; Anthony Eason; Michael Grimes; Darryl Joyce; Drew Long; Kevin Milne; and Jasleen Modi.

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