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INDIAN HEALTH SERVICE

Health Care Services Are Not Always Available to Native Americans





Highlights of [GAO-05-789](#), a report to the Committee on Indian Affairs, U.S. Senate

Why GAO Did This Study

The Indian Health Service (IHS), located within the Department of Health and Human Services, is responsible for arranging health care services for Native Americans (American Indians and Alaska Natives). IHS services include primary care (medical, dental, and vision); ancillary services, such as laboratory and pharmacy; and specialty care, including services provided by physician specialists. IHS provides some services through direct care at hospitals, health centers, and health stations, which may be federally or tribally operated. When services are not available—that is, both offered and accessible—on site, IHS offers them, as funds permit, through contract care furnished by outside providers. Concerns persist that some Native Americans are experiencing gaps in necessary health care.

GAO was asked to examine the availability of (1) primary care services and (2) ancillary and specialty services for Native Americans. Additionally, GAO examined the underlying factors associated with variations in the availability of services and strategies used by facilities to increase service availability. GAO conducted site visits to 13 facilities and interviewed IHS officials from all 12 IHS areas, which cover all or part of 35 states.

GAO received written comments from IHS. IHS substantially agreed with the findings and conclusions of this report.

www.gao.gov/cgi-bin/getrpt?GAO-05-789.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie Aronovitz at (312) 220-7600 or aronovitzl@gao.gov.

INDIAN HEALTH SERVICE

Health Care Services Are Not Always Available to Native Americans

What GAO Found

The availability of primary care—medical, dental, and vision—services was largely dependent on the extent to which Native Americans living in IHS areas were able to gain access to the services offered at IHS-funded facilities. All of the 13 facilities GAO visited offered medical services, such as physical examinations, while 12 facilities offered dental and 12 facilities offered vision services. However, access to these services was not always assured because of factors such as the amount of waiting time between the call to make an appointment and the delivery of a service, travel distances to facilities, or a lack of transportation.

Certain ancillary and specialty services were not always available to the Native Americans served by the 13 facilities, primarily because of gaps in the services offered by the facilities. While some ancillary and specialty services were offered to all patients, GAO also identified gaps in other services, including services to diagnose and treat nonurgent conditions—such as arthritis and knee injuries—specialty dental care, and behavioral health care. Most facilities lacked the staff or equipment to offer these services on site and thus had to purchase them with contract care funds, which were rationed on the basis of relative medical need at 12 of the 13 facilities. Five of the 12 facilities were unable to pay for any contract care services that were not deemed emergent or acutely urgent.

GAO identified three distinct factors that were associated with variations in the availability of services, namely a facility's structure, location, and funding from sources other than IHS. A facility's structure was associated with the overall amount and range of services available. For example, hospitals offered a broader array of services on site for more hours per week compared with other facilities. Location was a factor in recruiting and retaining staff for geographically remote facilities and in the cost of certain types of services, most notably transportation. Finally, a facility's funding from two types of sources—reimbursements from private and federal health insurance programs for care offered on site and any tribal contributions made—affected the extent to which the facility was able to offer services. The amount of these funds varied across facilities.

Facilities reported using at least one of six strategies to increase the availability of services. These strategies included bringing specialists on site and negotiating discounts for contract care. According to officials, the strategies were not available to, or effective for, every facility. For example, four facilities reported that while hospitals generally offered discounted rates for contract care, physicians were not always willing to do so.

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Abbreviations

CT	computerized tomography
IHS	Indian Health Service
MRI	magnetic resonance imaging
Ob/gyn	obstetrics/gynecology

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United States Government Accountability Office
Washington, DC 20548

August 31, 2005

The Honorable John S. McCain
Chairman
The Honorable Byron L. Dorgan
Vice-Chairman
Committee on Indian Affairs
United States Senate

Native Americans—American Indians and Alaska Natives—have historically had poorer health than the U.S. general population, as evidenced by their higher incidence of certain medical conditions and their shorter average life spans.¹ In 1976, the Indian Health Care Improvement Act sought to raise the health status of Native Americans through increased funding and personnel for the Indian Health Service (IHS).² This agency, located within the Department of Health and Human Services, arranges the provision of health care services for Native Americans across 12 federally designated areas that cover all or part of 35 states. For fiscal year 2005, the Congress appropriated approximately \$2.6 billion for health care services to be made available through IHS, which included primary care services (medical, dental, and vision); ancillary services, including laboratory, diagnostic imaging, and pharmacy services; and specialty care, including services provided by cardiologists, surgeons, and other physician specialists. Primary care, ancillary, and specialty services are offered through a combination of direct care, which is provided on site at IHS-funded facilities, and care purchased from other public and private providers—referred to here as “contract care.”³

IHS-funded facilities have varied in the health care services they have provided for Native Americans, and in some cases this has adversely affected the ability of Native Americans to obtain needed services. Our prior work identified issues regarding the availability of services for Native Americans, particularly services to meet the need for substance abuse

¹In this report, we use the term Native Americans to refer to American Indians and Alaska Natives. IHS typically refers to this population as AI/AN or Indians.

²Pub. L. No. 94-437, 90 Stat. 1400 (1976).

³IHS refers to contract care as contract health services or CHS.

treatment.⁴ There remain concerns about the extent to which health care services are available—that is, both offered and accessible—to Native Americans served by IHS.⁵

You asked us to examine the health care services—both direct and contract care—that are available to Native Americans through IHS. We examined (1) the extent to which primary care services were available to Native Americans, (2) the extent to which ancillary and specialty services were available to Native Americans, (3) the underlying factors associated with variations in service availability among IHS-funded facilities, and (4) strategies used by IHS-funded facilities to increase the availability of services.

To perform our work, we conducted site visits in three IHS areas in October and November 2004.⁶ Our site visits included interviews with officials at 13 IHS-funded facilities (4 hospitals, 8 health centers, and 1 health station⁷), 8 of which were federally operated and 5 of which were tribally operated. We also interviewed representatives of health systems, hospitals, and physician groups that deliver contract care services and representatives of the tribes served by the facilities. The areas and facilities were selected to represent a mix in terms of size of patient population, geographic location, type of facility, size of contract care budget, whether the facilities were federally or tribally operated, and health status of Native Americans in that area. (See app. I for a more detailed description of our selection criteria.) To supplement the information collected on the site visits, we conducted follow-up interviews with officials at the 13 facilities about the availability of specific services

⁴See GAO, *Indian Health Service: Basic Services Mostly Available; Substance Abuse Problems Need Attention*, [GAO/HRD-93-48](#) (Washington, D.C.: Apr. 9, 1993).

⁵See U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* (Washington, D.C.: September 2004), and U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *National Healthcare Disparities Report* (Rockville, Md.: July 2003).

⁶The three areas we visited were (1) Aberdeen, which includes locations in South Dakota, North Dakota, Nebraska, Iowa, and Minnesota; (2) Oklahoma City, which includes locations in Oklahoma, Kansas, Nebraska, and Texas; and (3) Portland, which includes locations in Idaho, Oregon, Utah, and Washington.

⁷Health centers are facilities with a full range of ambulatory services, including at least primary care, nursing, pharmacy, laboratory, and X-ray, which are available at least 40 hours a week for outpatient care. Health stations offer primary care services on a regularly scheduled basis for less than 40 hours a week.

for health conditions prevalent among the populations served by the facilities. Of these services, we analyzed the availability of 9 primary care services, 32 ancillary services, and 30 specialty services. (See app. II for a list of the services.) Findings pertaining to the 13 facilities we visited cannot be generalized to all IHS facilities.

To assess the availability of services, we considered both whether the service was offered and whether it was accessible to individuals in the facility's coverage area. We considered a health care service to be offered if a facility (1) delivered the service on site, (2) referred patients to another IHS-funded facility in the vicinity for the service, or (3) provided the service through contract care regardless of the acuity of the patient's condition. Services that did not meet one or more of these three criteria—including services that were offered to some, but not all, patients—we considered to be gaps in services. To assess the accessibility of services, we considered (1) the length of time between the call to make an appointment and the delivery of a service, (2) the travel distances to facilities, and (3) the amount of time spent waiting at a facility for services. We corroborated information obtained in interviews by drawing on our observations of facilities and on documentation, such as policy and budget documents, collected during the site visits. We also interviewed IHS area officials about how service availability varied within each of the 12 IHS areas, what factors were associated with those variations, and what strategies were being used to improve service availability. We drew on data from IHS area offices and headquarters related to funding, patient volume, and health status of Native Americans living in these areas.⁸ To assess the reliability of these data, we interviewed knowledgeable agency officials and reviewed supporting documentation about procedures for collecting, analyzing, and compiling the information. We also consulted experts at the Centers for Disease Control and Prevention about the health status data, which IHS publishes regularly. In all cases, we determined that the data were sufficiently reliable for purposes of this report. We conducted our work from August 2004 through June 2005 in accordance with generally accepted government auditing standards.

⁸We reviewed funding data from fiscal years 2003 and 2004, patient volume data from fiscal years 2003 and 2004, and health status data from 1996 to 2001.

Results in Brief

The availability of primary care—medical, dental, and vision—services largely depended on the extent to which Native Americans were able to gain access to the services offered at the 13 IHS-funded facilities we visited. Overall, we found that the facilities generally offered primary care services, with all 13 facilities offering medical services, such as physical examinations, and 12 facilities offering dental services, such as oral examinations. Additionally, 12 of the 13 facilities offered vision care. However, access to these services was not always assured because of factors such as the amount of waiting time between the call to make an appointment and the delivery of a service, travel distances to facilities, or a lack of transportation. For example, waiting times at 4 IHS-funded facilities ranged from 2 to 6 months for certain types of appointments, and 3 IHS-funded facilities reported that some Native Americans were required to travel over 90 miles one way to obtain care. Facility officials noted that difficulties accessing primary care services could result in an outcome such as inadequate prenatal care.

Certain ancillary and specialty services were not always available to Native Americans, primarily due to gaps in services offered. Certain ancillary services, such as laboratory and X-ray services, and specialty services, such as obstetrics/gynecology (Ob/gyn) and outpatient mental health, were generally offered to Native Americans. However, we identified gaps in services to diagnose and treat nonurgent conditions, such as arthritis, knee injuries, and chronic pain. We also found gaps in specialty dental care and behavioral health care. Most facilities did not have the staff or equipment to offer certain services on site and thus had to purchase these services through contract care. However, contract care was not available in all cases because care was rationed on the basis of relative medical need at 12 of the 13 facilities. Facility officials reported that in some cases gaps in services resulted in diagnosis or treatment delays that exacerbated the severity of a patient's condition and created a need for more intensive treatment. They also noted that gaps in such specialty services as orthopedics and behavioral health care meant that some Native Americans were living with debilitating conditions.

We identified three distinct factors that were associated with variations in the availability of services, namely a facility's structure, location, and funding from sources other than IHS.

- A facility's structure was associated with the amount and range of services available. For example, the broader array of on-site services at hospitals compared with health centers increased the overall availability of services. Additionally, the five new facilities—those with buildings constructed

after 1990—had more space to offer additional types of services to more patients than did the eight older facilities.

- A facility’s location was associated with its ability to recruit and retain staff and control the costs of providing health care services, which influenced the range of services offered as well as their accessibility. The more geographically remote facilities we visited faced the most significant challenges recruiting and retaining health care workers, as well as increased transportation costs for care needed but unavailable at the facility.
- A facility’s funding from two types of sources, specifically (1) reimbursements from private health insurance and federal health insurance programs for on-site services and (2) tribal contributions, affected the extent to which the facility was able to offer services. The amount of funding from these two sources varied among facilities. For example, reimbursements ranged from less than 10 percent of direct medical care budgets to more than 50 percent among the 12 facilities providing budget information.

Officials at the 13 facilities we visited reported having implemented at least one of six strategies to increase the availability of services. The strategies most commonly implemented—cited by 9 or more of the 13 facilities—were (1) bringing specialists on site, (2) improving efforts to obtain reimbursements on behalf of patients who qualify for private health insurance or federal health insurance programs, and (3) implementing prevention and wellness programs aimed at improving the overall health care outcomes of Native Americans. Facilities implemented these strategies through a variety of efforts. For example, facilities used contract care funds to bring specialists to the facilities and shared medical staff with other IHS-funded facilities.

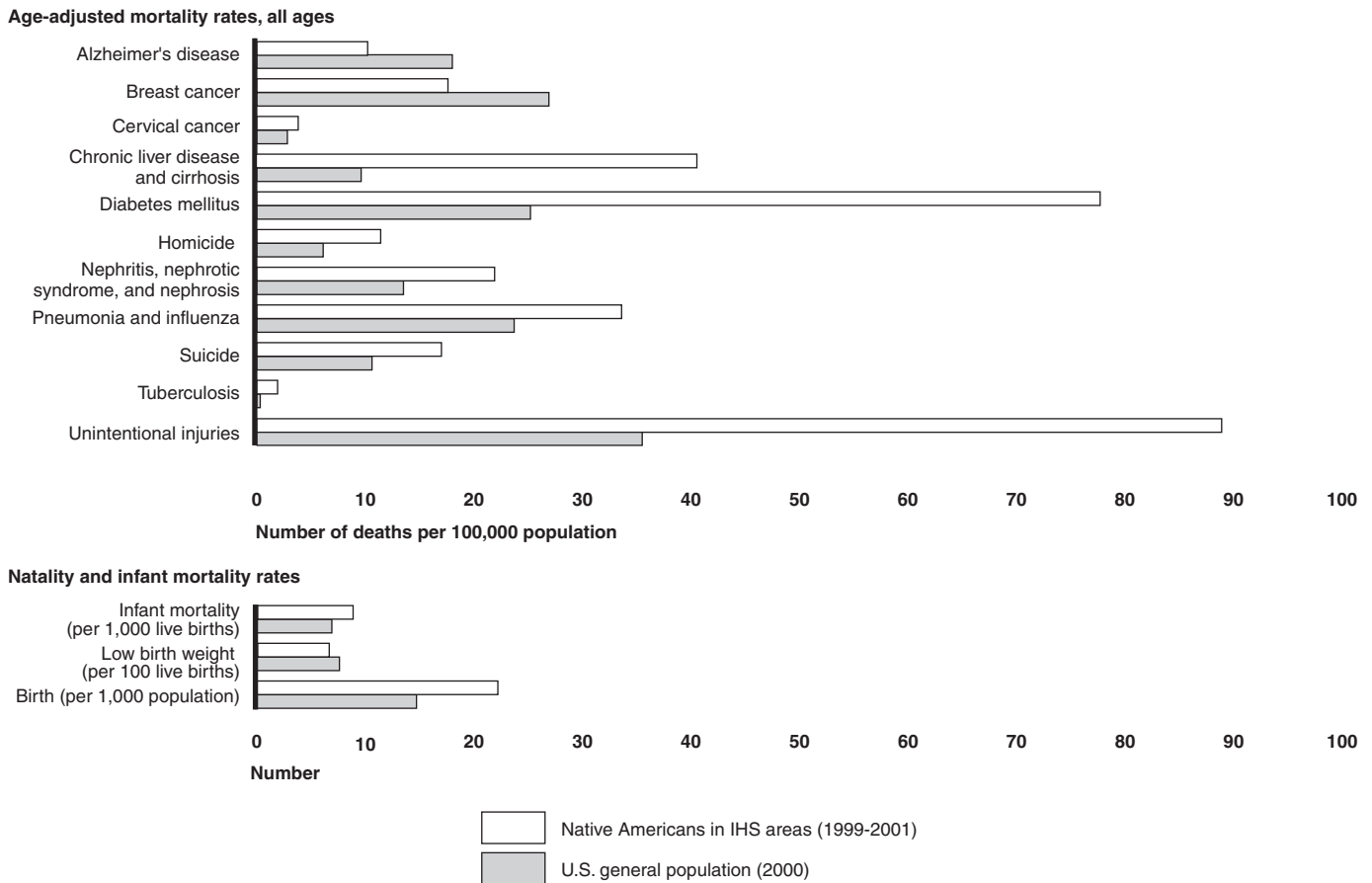
We received written comments from IHS. IHS substantially agreed with the findings and conclusions of our report, but did offer comments regarding examples used in our report, as well as comments about terminology and other technical issues. We incorporated information provided by IHS as appropriate. IHS’s comments are reprinted in appendix III.

Background

Native Americans living in IHS areas have lower life expectancies than the U.S. population as a whole and face considerably higher mortality rates for some conditions.⁹ For Native Americans ages 15 to 44 living in those areas, mortality rates are more than twice those of the general population. Native Americans living in IHS areas have substantially higher rates for diseases such as diabetes. Fatal accidents, suicide, and homicide are also more common among them. Mortality rates for some leading causes of death—such as heart disease, cancer, and chronic lower respiratory diseases—are nearly the same for these Native Americans as for the general population. However, these Native Americans also have substantially lower rates of mortality for other conditions, such as Alzheimer’s disease (see fig. 1 for a summary of key differences in health status indicators between the two groups).

⁹From 1996 through 1998, the life expectancy for Native Americans living in IHS areas was 70.6 years, compared with 76.5 years for the U.S. population as a whole.

Figure 1: Key Differences in Health Status Indicators for Native Americans in IHS Areas and the U.S. General Population



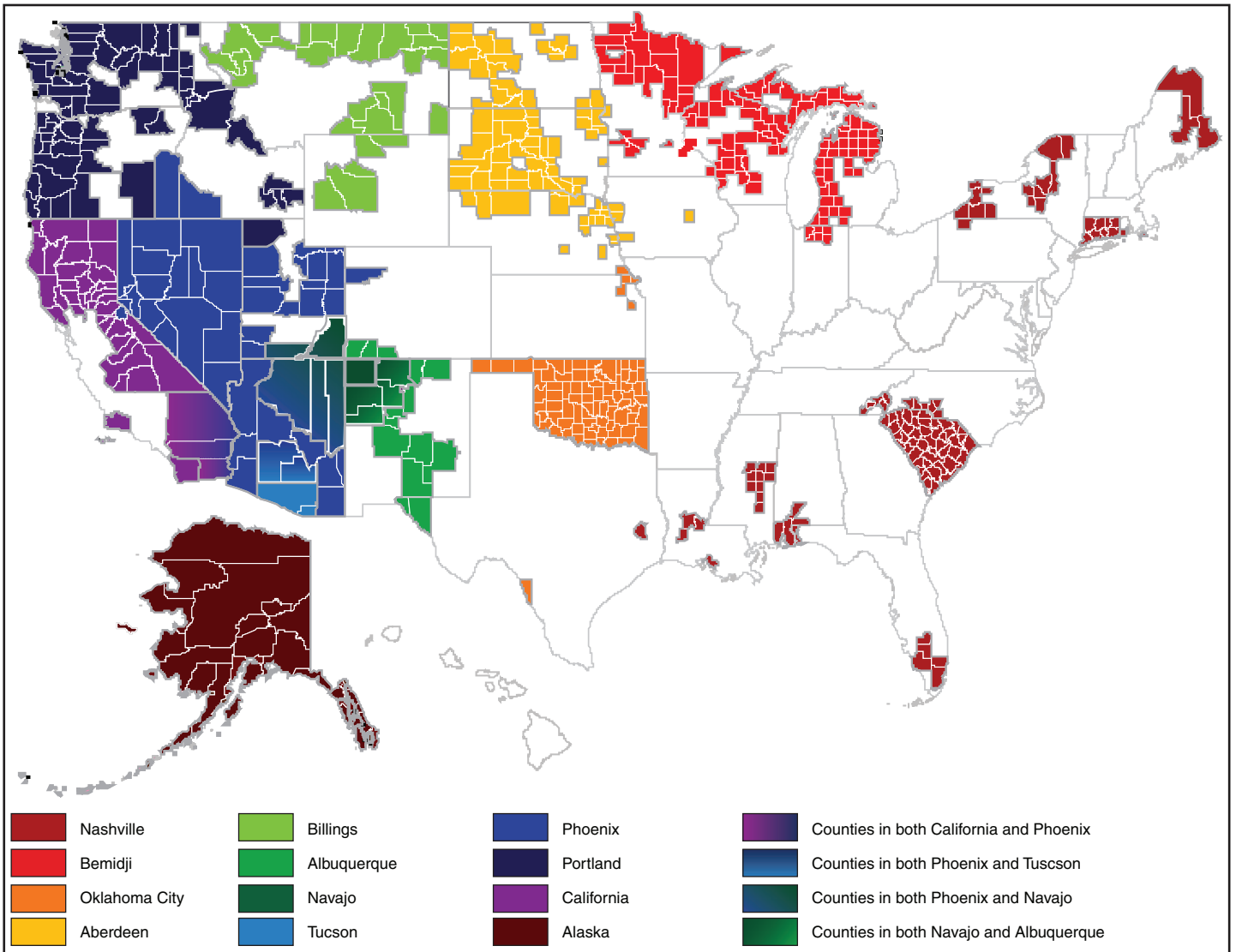
Source: GAO analysis of IHS data, June 2005.

Notes: Mortality rates for Native Americans (American Indians and Alaska Natives) in IHS areas are adjusted to compensate for misreporting of race on state death certificates. Mortality rates for Native Americans in IHS areas and the U.S. general population are based on the 2000 U.S. Census Populations with Bridged Race Categories. Age-adjusted rates have been standardized to the 2000 population. The age-adjusted mortality rate for all causes for Native Americans in IHS areas was 1059.8, compared with 872 for the U.S. general population. We investigated the possibility of comparing mortality rates for Native Americans in IHS areas with mortality rates for Native Americans nationwide but concluded that the nationwide data were not reliable.

IHS Administration

In 2004, IHS estimated that its patient population was approximately 1.4 million Native Americans. Area offices oversee the delivery of services and provide guidance and technical support to the area's facilities. The 12 IHS areas include all or part of 35 states (see fig. 2 for a map of the counties included in the 12 areas).

Figure 2: Counties in the 12 IHS Areas



Source: GAO analysis of IHS information, as of June 2005.

Note: IHS refers to the counties highlighted in this map as contract health service delivery areas. Residence in these counties is generally one of the prerequisites for obtaining contract care services through IHS, while eligibility requirements for direct care services—services provided at an IHS-funded facility—are broader.

Within the 12 areas, direct care services are generally delivered through IHS-funded hospitals, health centers, and health stations. As of October 2001, which is the most recent year of available data, there were 413 such facilities. These included 49 hospitals that ranged in size from 4 to 156 beds. Nineteen of these hospitals had operating rooms. There were 231 health centers and 133 health stations. These two types of facilities vary in the scope of their services and in their hours of operation. Health centers offer a range of care, including primary care services and at least some ancillary services, such as pharmacy, laboratory, and X-ray, at least 40 hours a week. Health stations offer primary care services and are open fewer than 40 hours a week.

Services not available through direct care may be purchased through contracts with outside providers. In most cases, the facility that provides a patient's direct care services also authorizes payment for contract care services. The use of contract care services varies considerably. For example, in two areas (California and Portland) all hospital-based services are purchased through contract care. In the other 10 areas, some hospital-based services are provided at IHS-funded facilities, while others are purchased through contract care.

Tribes have the option of operating their own direct care facilities and contract care programs. As of October 2001, tribes were operating 27 percent of the 49 hospitals and 70 percent of the 364 health centers and health stations. The remaining facilities were federally operated. For fiscal year 2005, approximately 50 percent of the IHS budget was allocated to tribes to deliver services.

Services Funded by IHS

IHS funds a range of health care services for Native Americans. These services can be organized into three broad categories: primary care, ancillary, and specialty services. Table 1 shows these three categories, as well as the subcategories of services (for example, laboratory and pathology services) within each. The table also provides examples of specific services, whose availability may vary among IHS-funded facilities.

Table 1: Examples of Primary Care, Ancillary, and Specialty Services

Primary care services	Ancillary services	Specialty services
Medical care <ul style="list-style-type: none"> Evaluation and management of patient conditions performed by midlevel practitioners (such as nurse practitioners or physician assistants) or physicians with primary care specialties 	Laboratory and pathology services <ul style="list-style-type: none"> Screenings for cancer, tuberculosis, and elevated blood glucose Initial assessments for diabetes and pregnancy 	Medical care <ul style="list-style-type: none"> Ob/gyn, podiatry, nephrology, and other services provided by physician specialists
Dental care <ul style="list-style-type: none"> Oral examinations, cleaning, sealants, and amalgam restorations 	Diagnostic imaging and testing <ul style="list-style-type: none"> X-ray, mammography, amniocentesis, computerized tomography (CT), and echocardiography 	Dental care <ul style="list-style-type: none"> Root canals, crowns, dentures, and periodontal surgery
Vision care <ul style="list-style-type: none"> Eye examinations and prescriptions for vision correction 	Pharmacy	Vision care <ul style="list-style-type: none"> Diabetic eye examinations and cataract surgery
	Durable medical equipment and adaptive devices <ul style="list-style-type: none"> Knee braces, canes, wheelchairs, and eyeglasses 	Behavioral health care <ul style="list-style-type: none"> Outpatient and inpatient mental health care and substance abuse treatment services
	Emergency medical transportation	Rehabilitative services <ul style="list-style-type: none"> Physical therapy

Source: GAO analysis of clinical standards published by IHS, medical associations, and other public entities, as of June 2005.

Primary care services constitute the first level of health care and are generally the entry point for all other services. Ancillary services can be ordered by either a primary care provider or a specialist. For example, a blood test can be ordered by a primary care provider for an initial health assessment or by an oncologist to test for recurrence of cancer. Specialty services constitute a second level of care and generally address conditions of higher acuity than those addressed by primary care.

Eligibility Requirements for Direct and Contract Care

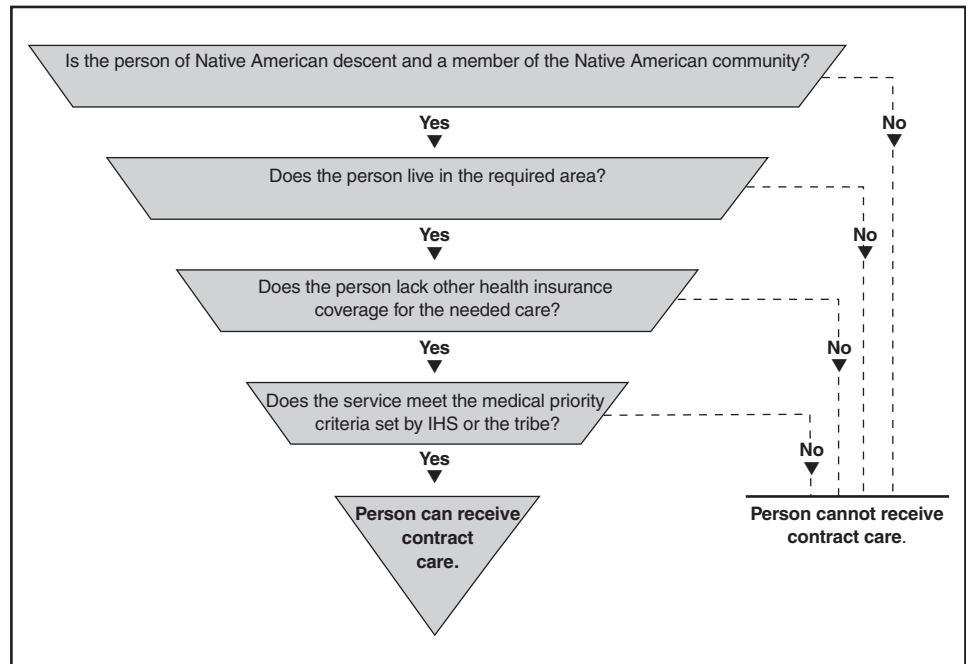
Eligibility requirements for direct care and contract care differ. In general, all persons of Native American descent who belong to the Native American community are eligible for direct care at IHS-funded facilities.¹⁰ To be eligible for contract care, a Native American generally must also reside within a federally established contract care area and either (1) reside on a reservation within the area or (2) belong to or maintain close economic and social ties with a tribe based on such a reservation.¹¹ In most cases, a contract care area consists of the county or counties in which a reservation is located, as well as any counties it borders.¹² Contract care pays for services only when patients are unable to obtain such services through other sources, including Medicare, Medicaid, or private insurance (fig. 3 provides an overview of the eligibility requirements for contract care).

¹⁰Under IHS regulations, an individual is eligible for direct care if he or she is regarded as a Native American by the community in which he or she lives, as evidenced by factors such as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors. Non-Native Americans may in certain very limited circumstances also be eligible for direct care services. 42 C.F.R. § 136.12 (2004).

¹¹IHS refers to contract care areas as contract health service delivery areas or CHSDAs.

¹²In three states—Alaska, Nevada, and Oklahoma—the contract care area covers the entire state.

Figure 3: Overview of Eligibility Requirements for Contract Care



Source: GAO.

Note: This figure represents GAO's analysis of IHS regulations, which can be found at 42 C.F.R. §§ 136.23, 136.61 (2004).

The services for which IHS provides contract care must also meet medical priority criteria. Each IHS area office is required to establish medical priorities consistent with guidance published by IHS headquarters (see table 2 for an overview of the guidance). Federally operated facilities must abide by the priorities set by their respective area offices, assign a priority level to each service requested, and fund services in order of priority, as funds permit. Although federally operated facilities are required to pay for all priority I services (emergent/acutely urgent care), facilities may otherwise pay for all or only some of the services in the lowest priority level they fund.¹³ Tribally operated facilities have discretion in setting medical priorities. While these facilities must have a priority setting

¹³In commenting on our report, IHS explained that although federally operated facilities are required to pay for all priority I services, if available funds at a facility are expended before the end of the fiscal year, or if a facility has insufficient funds to pay for all priority I cases, payment is not made. IHS further explained that this is the case at many of its facilities.

system, they may develop a system that differs from the guidance established by IHS.

Table 2: IHS Headquarters' Guidance for Medical Priority Setting for Contract Care

Priority level	Examples of services
I. Emergent/acute/urgent care	Trauma care, acute/chronic renal dialysis, obstetrical delivery, neonatal care, emergency psychiatric care
II. Preventive care	Preventive ambulatory care, prenatal care, screening mammograms, public health intervention
III. Primary and secondary care	Scheduled ambulatory services for nonemergent conditions, elective surgeries, specialty consultation
IV. Chronic tertiary and extended care	Rehabilitation care, skilled nursing home care, highly specialized medical care, organ transplant
V. Excluded care	Cosmetic and experimental services, services with no proven medical benefit

Source: GAO analysis of IHS 2004 guidance.

In addition to meeting eligibility and medical priority requirements, Native Americans must meet certain procedural requirements for services to be paid for through contract care. In particular, individuals who obtain emergency services generally must notify IHS within 72 hours of obtaining the services.¹⁴ IHS headquarters data on denials of payment for contract care are incomplete.¹⁵ However, in fiscal year 2003, patients' or providers' failure to comply with two procedural requirements (72-hour notification of emergency services and prior approval of nonemergency services) accounted for at least 16 percent of all reported denials of payment for contract care nationwide.

¹⁴Notification may be made by someone acting on the patient's behalf. Some categories of individuals, such as elderly individuals, are exempt from the 72-hour notification requirement.

¹⁵Data are incomplete because not all tribally operated facilities report denial data to IHS headquarters, and not all requests for care are documented at the facilities that do report. Moreover, the number of denials of contract care ascribed to any particular reason for denial (e.g., failure to notify IHS within 72 hours of emergency services) is also likely to be an undercount because the data show only the primary reason for denial, and reasons are not necessarily ranked in the same way by different facilities.

IHS Funding

The \$2.6 billion that the Congress appropriated for fiscal year 2005 for IHS included funds for direct care, as well as \$505 million for contract care services.¹⁶ From the \$2.6 billion, IHS also funds public health nursing, scholarships to health professionals, and other functions. In addition to IHS's federal appropriation, facilities are reimbursed for the services they provide on site by private health insurance and federal health programs, such as Medicare and Medicaid.¹⁷ IHS-funded facilities are allowed to retain reimbursements from private and federal health programs, without an offsetting reduction in their IHS funding, in order to fund health services.¹⁸ In fiscal year 2004, IHS-funded facilities obtained approximately \$628 million in reimbursements, with 92 percent collected from Medicare and Medicaid and 8 percent from private insurance.¹⁹

The Availability of Primary Care Depended on Native Americans' Ability to Access Services at IHS-Funded Facilities

The availability of primary care—medical, dental, and vision—services largely depended on the extent to which Native Americans were able to gain access to the services offered at IHS-funded facilities. The 13 facilities we visited generally offered primary care—medical, dental, and vision—services; however, Native Americans' access to these services was not always assured. Although primary care services were offered, facility and tribal officials identified several factors that affected access to these services, such as wait times between scheduling an appointment and receiving services, travel distances to facilities, and a lack of transportation.

¹⁶We included in contract care funding the \$18 million appropriated by the Congress for the Catastrophic Health Emergency Fund, which distributes funds to facilities on a first-come, first-served basis for high-cost contract care cases.

¹⁷Medicare is a federal health insurance program for individuals aged 65 and older and for some disabled adults. Medicaid is a jointly funded federal-state health care program that covers certain low-income families and low-income individuals who are aged or disabled.

¹⁸See 25 U.S.C. §§ 1621f, 1645 (2000).

¹⁹These numbers include estimates of reimbursements from the Centers for Medicare & Medicaid Services and from tribes.

Facilities Generally Offered Primary Care Services

All 13 facilities we visited offered medical services, such as initial physical examinations for pregnant women and well-baby checkups, while 12 facilities offered dental services, such as oral examinations, cleanings, and sealants.²⁰ Twelve of 13 facilities offered vision care.

Four facilities offered certain primary care services by making arrangements for patients to obtain these services at other locations, including other IHS-funded facilities. The arrangements facilities made for care differed, depending on their relationships with other IHS-funded facilities, the nature of the service, and proximity to other facilities. For example, one clinic routinely referred patients needing eye examinations to an IHS-funded hospital located about 50 miles away with which it had an ongoing relationship. Another facility provided dental services on site to children, pregnant women, and adults with diabetes, while referring all others seeking dental care to other IHS-funded facilities. For vision services, this facility directed patients to a different facility that offered eye examinations for children and adults. Another facility purchased primary care services from private providers for Native Americans who lived 75 miles from that facility.

At Some Facilities, Access to Primary Care Was Not Assured due to Lengthy Waits for Certain Services and Limited Transportation

At over half of the facilities we visited, facility officials indicated that patients were able to obtain certain primary care services—such as physical examinations and well-baby checkups—often within 3 weeks of calling for an appointment. However, the waiting times between calling for an appointment and receiving services were considerably longer for other primary care services. For example, four facilities reported that patients routinely had to wait more than a month for some types of primary care, which was in excess of standards or goals identified in other federally operated health care service delivery systems.²¹ The wait times at the four facilities ranged from 2 to 6 months, with the services cited as requiring lengthy waits being women’s health care, general physicals, and dental care.

²⁰The remaining facility offered certain dental services, such as sealants and oral examinations to children only, and cleanings to children, pregnant women, and adults with diabetes.

²¹Under the Department of Veterans Affairs policy, veterans who have high priority for receipt of health care through the department are to be given nonurgent outpatient appointments within 30 days of the desired date. The Department of Defense requires health plans in its managed care program, TRICARE Prime, to schedule routine appointments within 7 days and routine specialty care within 30 days.

In some cases, facility officials reported that the demand for services exceeded available appointment slots. For example, facility or tribal officials at 7 of the 13 facilities cited a need to increase dental services in order to keep up with their populations' demand. Additionally, three facilities indicated that medical care slots made available for same-day appointments were usually filled within 45 minutes of the phone lines being opened.²² At one of these facilities, 20 to 30 slots were usually filled within 15 to 30 minutes. An official at this facility estimated that it was turning away 25 to 30 patients a day. Officials at 6 of the 13 facilities we visited cited a need to increase the amount of primary care services to meet demand in the service population. Some tribal officials remarked on the demoralizing effect on patients who had difficulty getting appointments. For example, one tribal official noted that rather than remain at the facility all day to see a provider, patients would wait to seek care until their condition became an emergency that required a higher level of treatment. Officials at another facility reported that 21 percent of their maternity patients had three or fewer prenatal care visits, well below the recommended number.²³

Transportation challenges also affected the extent to which access to care was assured for some Native Americans. Of the 10 facilities that provided information on their patient coverage areas—the greatest distance patients traveled to the facility to obtain services—8 reported that some of their patients traveled 60 miles or more one way for care (see table 3). Of these 8 facilities, 3 reported over 90 miles of travel one way to obtain care—a distance in excess of what IHS considers reasonable for primary care services.²⁴

²²Some facility officials said that they established same-day appointment systems in an effort to make more daily appointments available or to respond to the number of missed appointments for services scheduled in advance.

²³The American College of Obstetricians and Gynecologists recommends a minimum of 14 visits for a full-term (40-week) pregnancy with no complications.

²⁴As of June 2005, IHS's *Indian Health Manual* indicates that for patients who are more than 90 minutes away, facilities may pay other providers to deliver primary care services.

Table 3: Maximum Travel Distance to Services Offered by 10 Facilities

Maximum travel distance (in miles)	Number of facilities
91 to 180	3
60 to 90	5
Under 60	2

Source: GAO analysis of facility information, as of June 2005.

Two facilities reported having made other arrangements for patients to obtain primary care when travel distances to facilities were particularly long. One facility used contract care funds to pay providers to deliver primary care services to patients who were 75 miles from the facility until funding constraints eliminated this option. Similarly, another facility paid to deliver primary care services to patients more than 25 miles from the facility until funding constraints made it necessary to restrict this option to children and elders.

Although long travel distances to reach health care facilities create access problems for rural populations in general, for some Native Americans, a lack of transportation compounded the difficulty of obtaining care. Officials at 9 of the 13 facilities reported that transportation to reach services was a challenge for certain tribal members, due in part to high rates of unemployment and the consequent inability of many members to afford a vehicle or pay for other transportation. While facility officials noted that some transportation programs were offered to tribal members, they did not reach all in need. For example, transportation services in two coverage areas were limited to groups such as the elderly, disabled, individuals experiencing medical emergencies, or members of a particular tribe.

Certain Ancillary and Specialty Services Were Generally Offered, but Gaps in Other Services Were Common

Certain ancillary and specialty services were not always available to Native Americans, primarily due to gaps in services offered at nearly all of the 13 facilities. We found that certain ancillary and specialty services were offered through direct or contract care by 11 or more of the 13 facilities we visited. However, although outpatient mental health care was offered by all 13 facilities, some reported that demand for services outstripped their capacity. We also identified gaps in certain ancillary and specialty services at the 13 facilities, including services to diagnose and treat conditions that were neither emergent nor acutely urgent. Most facilities that did not offer the services on site lacked the funds to pay for them through contract care.

Certain Ancillary and Specialty Services Were Offered, but Access to Some of These Services Was Not Assured

Certain ancillary services—laboratory, some diagnostic imaging and testing, pharmacy, and emergency medical transportation—were offered through direct or contract care by 11 or more of the 13 facilities we visited. We also identified four specialty services that were offered by almost all of the facilities (see table 4). In most cases, services were offered on site at the facilities rather than through contract care. For example, 11 or more of the 13 facilities we visited had a laboratory, pharmacy, X-ray machine, electrocardiograph, and mental health counselors on site.²⁵

Table 4: Ancillary and Specialty Services Offered by 11 or More of the 13 IHS-Funded Facilities

Ancillary services	Specialty services
Laboratory and pathology services <ul style="list-style-type: none"> Preventive screenings, including tuberculosis and fasting glucose tests Initial evaluations for pregnancy, diabetes, heart failure 	Medical care <ul style="list-style-type: none"> Ob/gyn
Diagnostic imaging and testing <ul style="list-style-type: none"> X-ray, electrocardiography, mammography, amniocentesis, prenatal ultrasound 	Dental care <ul style="list-style-type: none"> Root canals
Pharmacy	Vision care <ul style="list-style-type: none"> Cataract surgery, retinopathy screening
Emergency medical transportation	Behavioral health care <ul style="list-style-type: none"> Outpatient mental health care and substance abuse treatment services

Source: GAO analysis of facility information, as of June 2005.

Although outpatient mental health care services were offered by all facilities, four facilities reported that demand for mental health care outstripped their capacity. For example, one facility cited a need for two to three times the amount of psychiatric care it was able to offer. An official at another facility commented that the facility was able to provide only crisis-oriented care. Another facility reported that it expected to cut mental health services by 20 percent in fiscal year 2005, as reserves that had previously supported these services had been depleted.

²⁵At all eight of the federally operated facilities we visited, at least some behavioral health services were operated by tribes rather than by the federal facilities. For purposes of this report, we included these tribally operated services as being associated with the medical facilities.

Gaps in Ancillary and Specialty Services Were Common for Diagnosis and Treatment of Nonurgent Conditions

We found that gaps in ancillary and specialty services were common, occurring at 12 of the 13 facilities. The most frequent gaps were for services aimed at the diagnosis and treatment of medical conditions that caused discomfort, pain, or some degree of disability but that were not emergent or acutely urgent (see table 5). In some cases, services were offered to certain groups but not others. For example, four facilities offered eyeglasses only to children or older adults.²⁶ In other cases, services were significantly delayed; for example, one facility said that adults could wait as long as 120 days to get approval for eyeglasses.

Table 5: Examples of Gaps in Ancillary and Specialty Services

Category of service	Facilities reporting gaps	Examples of specific gaps
Specialty consultations for nonemergent or acutely urgent cases	11	Consultations for arthritis, acne, allergies, gastrointestinal ailments
Specialty dental care	11	Orthodontics, cast inlays or crowns, dentures, periodontal surgery
Treatment for chronic pain	11	Evaluation and treatment for back pain
Durable medical equipment and adaptive devices	11	Canes, braces, wheelchairs, prostheses, adjustable beds, lifts, eyeglasses
Diagnostic imaging for nonemergent or acutely urgent cases	10	CT scans for chronic sinusitis, magnetic resonance imaging (MRI) for knee injuries
Elective surgery	10	Ear tube surgery, tonsillectomy, back surgery, knee replacement
Cancer screenings	7	Sigmoidoscopy or colonoscopy to screen for colon cancer
Behavioral health care	6	Inpatient substance abuse treatment, inpatient mental health care

Source: GAO analysis of facility information, as of June 2005.

Notes: Gaps were identified when a facility did not offer one or more services on site or through contact care or offered services only to some patients.

One facility we visited did not report any gaps in services.

²⁶One of these facilities, which offered eyeglasses to adults over age 55, stopped doing so in 2005.

We found significant gaps in both dental and inpatient behavioral health care services offered at IHS-funded facilities or through contract care.

- Of the five specialty dental services we inquired about, three (cast inlays or crowns, dentures, and orthodontics) were entirely unavailable at most of the facilities.²⁷ Some facilities offered these services only to certain groups. For example, one facility offered cast inlays and crowns only to children.
- Inpatient behavioral health care services were either not offered or limited. Six facilities did not offer inpatient mental health care treatment to all patients. Four of these six facilities did not offer inpatient substance abuse treatment to all patients.²⁸ Moreover, three of the nine facilities that did offer inpatient substance abuse treatment offered only partial services—rehabilitation but not detoxification.²⁹

Facilities Lacked Staff, Equipment, and Contract Care Funds to Offer Certain Ancillary and Specialty Services

Most of the facilities we visited lacked the equipment necessary for certain ancillary services and had few medical specialists on site. Most lacked such diagnostic equipment as mammography machines, CT scanners, MRI scanners, and echocardiographs. Ten facilities, including one hospital, reported having three or fewer types of specialists on site.³⁰ Most facilities did not regularly refer patients to other IHS-funded facilities for care they could not offer on site.

Ancillary and specialty services that were unavailable on site or at other IHS-funded facilities could be obtained only through contract care, which was rationed by 12 of the 13 facilities on the basis of relative medical need. Five facilities reported that they were unable to pay for any services that were not deemed emergent or acutely urgent (services categorized as priority level I services in IHS headquarters' guidance), and two others paid for only a few additional services, such as cancer screenings. The

²⁷Root canals and periodontal surgery were offered by 11 and 7 facilities, respectively.

²⁸We defined inpatient treatment as treatment beyond an initial 72-hour stay.

²⁹One of the three facilities that did not offer detoxification noted that it could be obtained through a county-operated program.

³⁰The medical specialty services most commonly reported on site at the 13 facilities were podiatry and ob/gyn, which were offered at 9 and 7 facilities, respectively. Specialists reported on site at few facilities included ear, nose, and throat specialists (4 facilities), orthopedists (3 facilities), nephrologists (3 facilities) and cardiac specialists (2 facilities). Two facilities reported having no specialists on site.

remaining six facilities paid for varying levels of care beyond the emergent or acutely urgent level, but only one of the six was able to pay for all of the care we inquired about (see app. II).

Officials noted that in some cases gaps in services resulted in diagnosis or treatment delays that exacerbated the severity of a patient's condition and created a need for more intensive treatment. For example, tribal health board members at one facility described the case of an elderly woman who had complained of back pain and was diagnosed with cancer only when one of her legs broke. Tribal representatives at another facility cited the example of a young man whose lung condition was only properly diagnosed when, after months of treatment for pneumonia, he went to an emergency room and was found to have a tumor that killed him 3 weeks later. Officials also noted that as a result of gaps in such specialty services as orthopedics and behavioral health care, some Native Americans were living with painful and debilitating conditions.

Service gaps not only varied among facilities, but also varied over time for particular facilities, depending on the demand for contract care. Facility officials said that demand for contract care could affect where they drew the line between services that met medical priority criteria and those that did not.³¹ For example, one facility reported that the definition of emergent and acutely urgent services narrowed over the course of the year as contract care funds were depleted. At facilities that reviewed requests for contract care or budgeted for this care on a quarterly, monthly, or weekly basis (as most did), approval of a particular service depended in part on its priority relative to the others that came up for review at the same time.

In some cases, patients faced challenges accessing the care that was offered through contract care or at other IHS-funded facilities. At seven facilities, patients had to travel more than 60 miles from the facility to obtain some kinds of specialty care—for example, gastroenterology, cardiology, and high-risk obstetrics—that were available only in larger cities. Access also depended on non-IHS providers' willingness to provide

³¹The process for determining the relative medical priority of services was similar at most facilities. Generally, clinicians assigned a priority level to each referral, based on their assessment of the acuity of the patient's condition. These referrals were then reviewed by other clinicians or administrators to determine whether the services requested were of a high enough priority to be paid for. Bills for services obtained without prior approval, such as emergency room care, were also reviewed. Some facilities maintained lists of deferred services and reviewed them again as more funds became available.

contract care. Few of the IHS-funded facilities we visited mentioned difficulties arranging contract care. However, 10 of the 15 contract care providers we interviewed, which included health systems, hospitals, and physician groups, reported denials or delays of payment by IHS, and some had terminated or were considering terminating their relationship with IHS as a result. One obstetrician who was owed about \$60,000 stopped seeing IHS patients until most of his outstanding bills were paid. Two providers were considering terminating their relationship with IHS-funded facilities. Two other providers reported that physicians in their system or in the area had closed their practices to IHS patients. In some cases, the withdrawal of a single provider may affect patients' access to care. For example, staff of a physician specialty group that had threatened to stop serving IHS patients said that if it had done so, these patients would have had to travel an additional 75 miles for care, as this group was the only provider of its type in the vicinity that was willing to serve IHS patients.

Factors Associated with Variations in Service Availability Included Facility Structure, Location, and Funding

From our visits to facilities and interviews with IHS area officials, we found that differences in the availability of services among facilities were associated primarily with three distinct factors: how a facility was structured, where it was located, and the amount of reimbursements and tribal contributions it received. In terms of facility structure, we found differences in the amount and range of services available on site, depending on the type of facility (whether it was a hospital, health center, or health station), its age, and whether it was tribally or federally operated. Facilities located in remote areas faced challenges in recruiting and retaining staff, which reduced the services these facilities were able to offer. Those facilities that received greater amounts of funding from reimbursements or tribes were able to expand service availability by, for example, hiring additional staff.

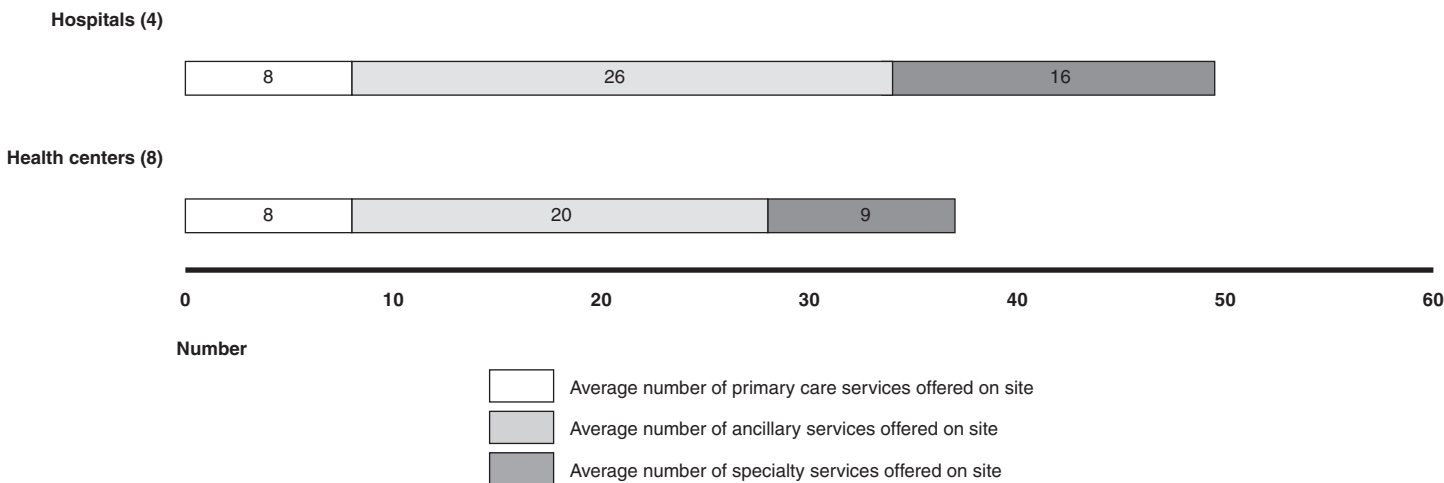
Facility Structure Was Associated with Variations in Service Availability

From our visits to facilities, we found that the broader array of on-site services at hospitals compared with health centers increased the overall availability of services³² (see fig. 4 for the services offered at the hospitals and health centers). While the average number of primary care services offered on site was the same at the hospitals and health centers, the average number of ancillary and specialty services offered on site differed.

³²Of the services about which we inquired, the health station reported offering 3 of 9 primary care services, 15 of 31 ancillary services, and 2 of 33 specialty services on site.

The hospitals generally offered more types of ancillary services on site—such as mammography—than did the health centers. Three hospitals also offered some specialty services on site—such as some obstetric services—that were not offered on site at the health centers we visited. IHS officials noted that its hospitals are located where service populations are large enough to make it professionally and financially possible to offer more services.

Figure 4: Average Number of Services Offered on Site by Type of Facility



Source: GAO analysis of information from 13 IHS-funded facilities, as of June 2005.

Notes: This analysis summarizes information on 71 services—including 9 primary care services, 32 ancillary services, and 30 specialty services—about which we inquired. We also visited one health station, which reported providing 3 primary care services, 15 ancillary services, and 2 specialty services.

Services at hospitals were also offered for more hours per week than were services at other facilities, which resulted in differences in the availability of urgent care. The hospitals had emergency rooms open 24 hours a day and 7 days a week and were available for urgent care services. In contrast, the health centers were generally open from 8:00 a.m. to no later than 5:30 p.m., Monday through Friday. When the health centers were closed, urgent care was generally available at non-IHS facilities. Not all of the health centers paid for nonemergency services provided by these facilities.

We found that in general the five newer facilities—those with buildings constructed after 1990—had more space to offer additional types of services to more patients than did the eight older facilities. Officials from the facilities we visited reported that the age of their building was linked

to building design, space, and resources, which affected both the range of services facilities offered as well as Native Americans' access to these services.³³ For example, officials at two of the newer health centers reported that they had more examination rooms than they had had in their old buildings, which allowed one facility to add new specialty providers, see additional patients, and reduce wait times. According to an IHS headquarters official, prior to 1988, IHS-funded facilities were constructed with one examination room per primary care provider. From 1988 to early 2005, the standard number of examination rooms per provider for new construction was two, and as of April 2005, the standard number was two and one half. In addition to the benefits of an improved design and more space, area officials explained that when new buildings are constructed with IHS funds, those facilities generally receive increased funds for staff and equipment,³⁴ which allows the facilities to provide additional types of services or serve more patients.

In addition, the range of services facilities offered depended in part on whether the facilities we visited were tribally or federally operated.³⁵ Because tribally operated facilities are not required to follow the medical priorities established by IHS for contract care, tribally operated facilities were able to make different judgments about the allocation of the funding. For example, all of the three tribally operated health centers offered eyeglasses. In contrast, only one of the five federal health centers offered eyeglasses—and only to children. Another tribal facility offered some nonemergency ancillary services, such as MRI scans for patients with nonemergent conditions, such as seizures, while the federal facilities generally offered those services only to patients with emergent or acutely urgent conditions. One tribal facility used its flexibility in setting medical priorities to deny certain care that federal facilities are required to offer. Specifically, this facility, which had an emergency room, did not pay for any emergency room services at outside facilities. In contrast, federal facilities are required to pay for emergency room services for patients who require emergency care at a hospital that is not funded by IHS.

³³The construction dates for the 13 facilities ranged from the 1930s to 2004.

³⁴In cases where IHS provides grant funds to a tribe for construction of a small facility, IHS does not provide funds for staff and equipment.

³⁵We visited five tribally operated facilities and eight federally operated facilities.

According to facility and area officials, flexibility in setting medical priorities for contract care helped tribal facilities, especially those with smaller populations, manage available funds. One tribal hospital we visited reported that if the facility were required to offer emergency services through contract care, one catastrophic case could eliminate its entire contract care budget. According to officials, the facility had accrued \$3.5 million in unpaid contract care bills when under federal operation. When the tribe took over operations in 1994, it paid portions of this debt for 3 years. The tribe revised its medical priority system in part by restricting emergency care to what is available at the tribally operated facility and expanding coverage of contract care referrals for diagnostic services. In the California area, where all of the facilities are tribally operated and there are no IHS-funded hospitals, contract care budgets for small tribes were sometimes less than \$40,000. Area officials reported that facilities with budgets of that size may not guarantee that emergent and acutely urgent care, such as obstetrical deliveries, would be offered.

Location Affected the Services Facilities Could Offer

Of the 13 facilities we visited, 6 facilities were located in frontier counties and 7 in less remote, nonfrontier counties.³⁶ Officials from 5 of the 6 facilities in frontier counties cited challenges in recruiting and retaining health care professionals, which affected the services these facilities could offer. Officials from 3 of these facilities reported that a shortage of housing for health care workers on the reservations and in nearby communities contributed to the problem. Area officials added that facilities in isolated areas also lacked educational and recreational opportunities for employees and their families. Facility officials reported such position vacancies as pharmacists, dentists, dental assistants, and X-ray and laboratory technicians. Some of these positions remained vacant for several years. For example, one facility reported that it had taken 8 years to fill a dentist position that became vacant again in December 2004.

Facilities located in remote areas also more frequently reported high transportation costs, particularly for emergency medical services, which decreased contract care funds for other services. For example, lacking the needed care on site, three of the six facilities located in remote counties reported having to transport patients by helicopter or airplane to other

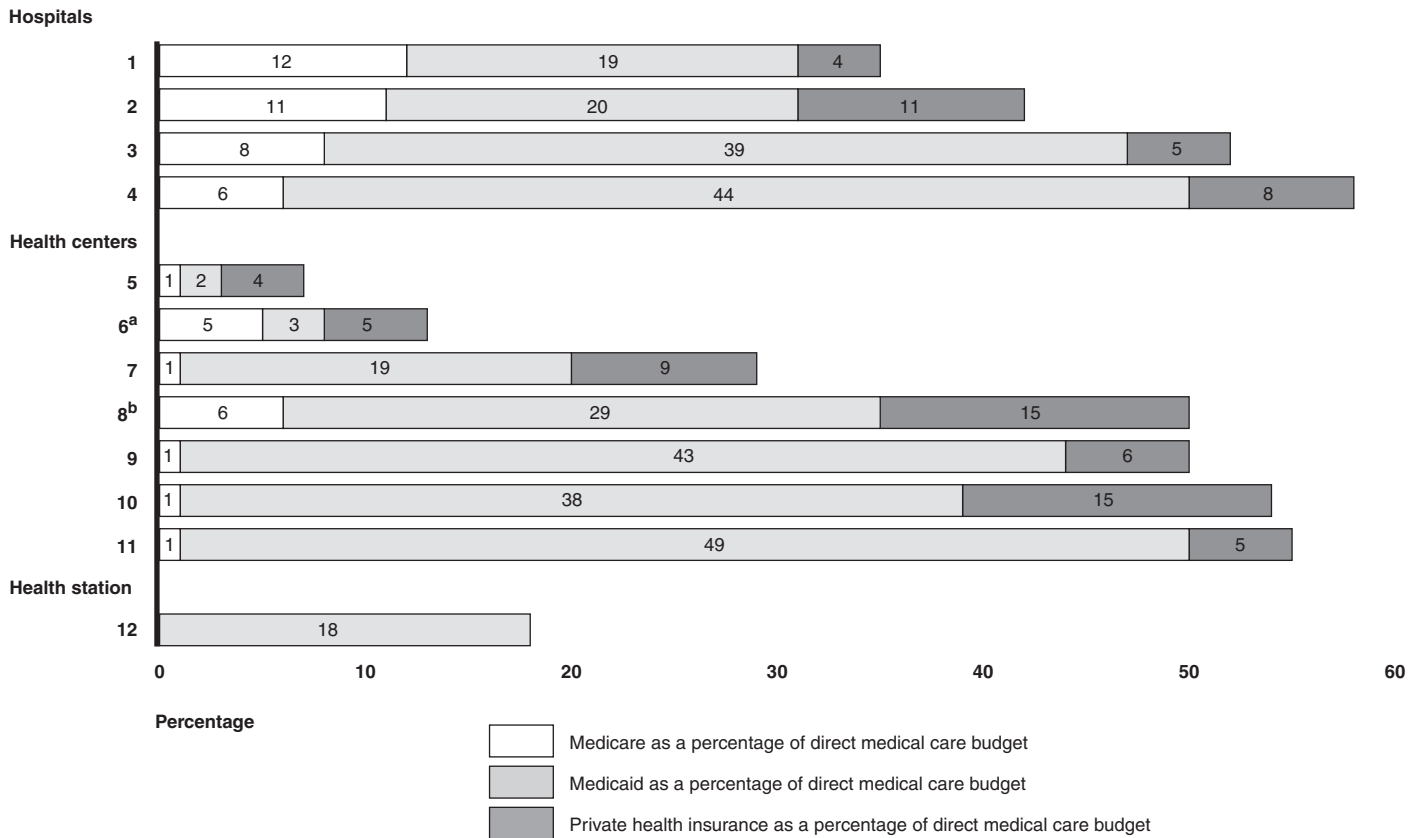
³⁶The Frontier Education Center designates a county as “frontier” based on a scoring system that computes points based on a county’s population density, distance to the closest “market” for services, and travel time to that market.

facilities. Officials at one of those facilities reported paying for 17 to 21 air transports a month at a cost of \$6,000 to \$7,000 each, which was from 17 percent to 24 percent of the facility's fiscal year 2004 contract care budget. Another facility also told us that ambulance transport was a significant contract care cost.

Service Availability Was Associated with the Amount of Reimbursements and Tribal Contributions Facilities Received

At all of the 13 facilities we visited, reimbursements from private health insurance and federal health insurance programs, such as Medicare and Medicaid, were an important source of funding for the services each facility offered. We found that the amount of reimbursements that facilities obtained varied. For the 12 facilities that provided budget information for fiscal year 2004, reimbursements constituted from 7 percent to 58 percent of direct medical care budgets, with the average being 39 percent (fig. 5 shows the proportion of facilities' direct medical care budgets that came from reimbursements). Facilities with higher reimbursements had additional funds with which they could hire staff, purchase equipment and supplies, and renovate their buildings. For example, a hospital that collected \$14.7 million in reimbursements, representing 51 percent of its direct medical care budget, funded 31 percent of its clinical providers and other staff (111 of 361 staff members) with those funds.

Figure 5: Reimbursements as a Percentage of Total Direct Medical Care Budgets, Fiscal Year 2004



Source: GAO analysis of fiscal year 2004 budget data reported by 12 IHS-funded facilities.

Note: We defined budgets for direct medical care as IHS funds allocated for the operation of hospitals and clinics plus reimbursements from Medicare, Medicaid, and private health insurance.

^aThis facility aggregated Medicare and Medicaid fee-for-service revenue. We classified this revenue under Medicare reimbursements.

^bThese budget data reflect those of the health center that we visited as well as an associated IHS-funded health center.

Facility officials reported that certain circumstances outside of their control affected their ability to obtain reimbursements. Specifically, these circumstances included changes in state Medicaid programs and the nature of the insurance offered by tribes.

- **Changes in state Medicaid programs.** Medicaid was the largest source of reimbursements in 10 of the 12 facilities and on average accounted for 65 percent of total reimbursements.³⁷ While the federal government finances 100 percent of Medicaid services provided to Native Americans at IHS-funded facilities, eligibility and benefits vary among states. Facility officials provided examples of eligibility, benefit, and administrative requirement changes that states have made in their Medicaid programs that have affected facilities' ability to obtain reimbursements. For example, one state's Medicaid program used to confer retroactive eligibility for a 3-month period; thus any service provided to a Medicaid-eligible person in the 3 months prior to their enrollment would be paid for by the Medicaid program. As of April 2003, however, the program has reduced retroactive eligibility to the beginning of the month in which eligibility was determined.
- **Nature of insurance offered by tribes.** The nature of the insurance offered by different tribes affected the amount of reimbursements available to facilities. For example, four federally operated facilities provided services to tribes with self-insured health plans. Because federally operated IHS-funded facilities are prohibited by law from billing for services covered by self-insured plans offered by tribes,³⁸ their reimbursements from private health insurance were limited. For example, private health insurance comprised less than 14 percent of total reimbursements for these four facilities. Three other facilities (two tribally operated and one federally operated) that were able to bill tribal health insurance reported collecting approximately 30 percent of total reimbursements from private health insurance. Officials at one federally operated facility also reported that reimbursements were lower when tribal employees chose not to participate in tribal health plans and instead relied entirely on IHS-funded care.

³⁷According to IHS, facilities' ability to obtain reimbursements from the Medicaid program is strongly influenced by the percentage of their patients who meet the income requirements for Medicaid coverage.

³⁸See 25 U.S.C. § 1621e(f) (2000).

In addition to reimbursements, contributions from tribes were a key source of funding for services, as 8 of the 13 facilities we visited reported obtaining tribal contributions. At 6 facilities, tribes supplemented care by providing funds for contract care, pharmaceuticals, and other operating costs. Other facilities benefited from onetime contributions. For example, two tribes used their own funds or obtained grants to build new facilities with additional examination and treatment space that allowed the facilities to offer more services. In addition to direct contributions of funds, some tribes obtained other funds to supplement IHS resources for services such as substance abuse treatment. Officials from 3 of the 8 federally operated facilities reported that tribes did not provide additional funding for services.

Facilities Used a Variety of Strategies to Increase the Availability of Services

Facilities reported having implemented at least one of six strategies to increase the availability of services funded by IHS. The strategies most commonly used by the 13 facilities we visited included bringing specialists on site to deliver services, improving efforts to obtain reimbursements, and implementing prevention and wellness programs (see table 6 for the strategies and the number of facilities that reported using them).

Table 6: Strategies to Increase Availability of Services Reported by 13 IHS-Funded Facilities

Strategy	Facilities reporting this strategy
Brought specialists on site	●
Improved efforts to obtain reimbursements	●
Implemented prevention and wellness programs	●
Negotiated discounts for contract care	◎
Coordinated patient care with other health services	◎
Increased use of telemedicine	○

Source: GAO analysis of information reported by 13 IHS-funded facilities, as of June 2005.

Legend:

- Reported by 9 to 13 facilities.
- ◎ Reported by 5 to 8 facilities.
- Reported by 1 to 4 facilities.

Facilities implemented these strategies in different ways. For example, to improve efforts to obtain reimbursements, four facilities had staff available to help patients apply for eligibility or reimbursement from other programs for which they were eligible. Others negotiated with state

Medicaid offices in order to be able to bill for services (see table 7 for a description of how facilities implemented the six strategies).

Table 7: Description of How IHS-Funded Facilities Reported Implementing Strategies to Increase the Availability of Services

Strategy	Description
Brought specialists on site	<ul style="list-style-type: none"> Used contract care funds to pay specialists to deliver services on site. Shared medical staff with other IHS-funded facilities to offer services not otherwise available on site.
Improved efforts to obtain reimbursements	<ul style="list-style-type: none"> Established partnerships with state Medicaid offices to facilitate enrollment in the program. Hired staff to help patients apply for non-IHS resources.
Implemented prevention and wellness programs	<ul style="list-style-type: none"> Obtained grants from IHS and other sources for a variety of prevention and wellness programs. Provided education and screenings targeted to health conditions prevalent among the patients served by the facilities, including diabetes, pregnancy, cancer, and heart disease.
Negotiated discounts for contract care	<ul style="list-style-type: none"> Reached agreements with non-IHS hospitals and physicians for discounted rates for contract care.
Coordinated patient care with other health services	<ul style="list-style-type: none"> Linked patients to other public or private health services—for example, services at Department of Veterans Affairs facilities—that were not available through the facility.
Increased use of telemedicine	<ul style="list-style-type: none"> Supplemented imaging services by, for example, sending digital pictures of diabetics' eyes to another IHS-funded facility to be read by an ophthalmologist.

Source: GAO analysis of information from 13 IHS-funded facilities, as of June 2005.

Some of the strategies were not available to, or effective for, every facility. For example, in one area that we visited, the area officials reported that facilities were not able to use contract care funds to bring in specialists unless they could provide assurances that they would be able to pay for all emergent and acutely urgent care with remaining funds. One facility stopped using contract care funds to bring in specialists because of that policy. The effectiveness of another strategy was limited by the willingness of outside providers to negotiate contracts with the facility. For example, four facilities reported that while hospitals generally agreed to offer discounted rates for contract care, physicians were not always willing to do so. Officials from two areas that we did not visit also reported that location had an impact on the effectiveness of some strategies. For some facilities in one of those areas, especially those in urban areas, it was difficult to retain billing staff needed to obtain reimbursements, because they could not match the private sector pay scale.

Agency Comments and Our Evaluation

We provided a draft of this report for comment to the Director of the Indian Health Service. We received written comments from IHS. IHS substantially agreed with the findings and conclusions of our report, but did offer comments regarding examples used in our report, as well as comments on terminology and other technical issues. The full text of IHS's comments is reprinted in appendix III.

IHS questioned certain examples supporting our findings—one about the percentage of patients at one facility that went to the emergency room for delivery without receiving any prenatal care and two other examples about the effects of gaps in services. IHS recommended eliminating those examples if they could not be further substantiated. We reviewed the information supporting the examples. With regard to the level of prenatal care, officials provided new information, which we incorporated into the report. With regard to gaps in services, we determined that the examples provided by tribal officials were consistent with the information about service availability provided by officials at the facilities in question.

IHS also provided us with comments on terminology and other technical issues. With regard to terminology, IHS commented on our use of “Native Americans,” “contract care,” and “contract care area,” and requested that these terms be replaced with abbreviations or terms used by IHS. We did not alter our use of terms, but did include footnotes indicating IHS's terminology. IHS's technical comments related to funding for new IHS facilities, the effect of income demographics on Medicaid reimbursements, cardiovascular disease death rates for Native Americans, contract care priorities, and differences between IHS hospitals and health centers were incorporated as appropriate. In some cases, we did not make the changes IHS suggested because doing so would result in technical inaccuracies. For example, we did not add “cardiovascular disease” to figure 1 as suggested by IHS because the figure highlights conditions for which mortality rates differ between Native Americans and the general population—and cardiovascular disease mortality rates are virtually the same for both populations.

As agreed with your offices, we plan no further distribution of this report until 30 days from its date, unless you publicly announce its contents earlier. At that time, we will send copies of this report to the Director of the Indian Health Service. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (312) 220-7600 or aronovitzl@gao.gov. Contact points for our Offices 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 appendix IV.



Leslie G. Aronovitz
Director, Health Care

Appendix I: GAO Methodology for Selecting IHS Areas and Facilities Visited

We used a two-tiered approach to selecting facilities for site visits, which included selecting 3 of the 12 Indian Health Service (IHS) areas and then selecting 13 facilities within those 3 areas.

In the first tier, we selected 3 of the 12 IHS areas to represent a mix in the size of the population served in the areas, geographic location, health status of Native Americans in the areas, the entities operating the facilities (tribal or federal), and the contract care dollars as a percentage of total clinical care dollars (table 8 compares the selected areas to the range across all 12 areas).

Table 8: Comparison of Three IHS Areas Selected by GAO to the Range across All 12 Areas

Factors considered	IHS areas			
	12 areas	Aberdeen	Oklahoma City	Portland
Estimated patients served (fiscal year 2004)	From 24,009 in Tucson to 299,622 in Oklahoma City	115,812	299,622	97,501
Age of patients (fiscal year 2001)	<ul style="list-style-type: none"> From 8.5% to 11.2% of the population under the age of 5 From 8.7% to 13.3% over the age of 54 	<ul style="list-style-type: none"> 11.2% under the age of 5 9.8% over the age of 54 	<ul style="list-style-type: none"> 9.5% under the age of 5 13.3% over the age of 54 	<ul style="list-style-type: none"> 9.1% under the age of 5 11.3% over the age of 54
Birth rate (1996 to 1998)	From 21.7 births per 1,000 people in the service population to 29.5 per 1,000	29.5 per 1,000	22.4 per 1,000	25.0 per 1,000
Leading causes of death (1996 to 1998)	Heart disease (21.6%) Cancer (15.9%) Injuries (14.0%) Diabetes mellitus (6.6%) Liver disease and cirrhosis (4.5%)	Heart disease (21.1%) Cancer (15.0%) Injuries (14.4%) Diabetes mellitus (7.5%) Liver disease and cirrhosis (6.3%)	Heart disease (28.8%) Cancer (18.7%) Injuries (8.5%) Diabetes mellitus (7.0%) Cerebrovascular diseases (4.6%)	Heart disease (19.4%) Cancer (15.6%) Injuries (14.7%) Cerebrovascular diseases (5.7%) Liver disease and cirrhosis (5.6%)
Tribally operated facilities (October 2001)	13 of 49 hospitals 172 of 231 health centers 84 of 133 health stations	0 of 8 hospitals 6 of 14 health centers 3 of 15 health stations	3 of 7 hospitals 28 of 38 health centers (0 health stations in area)	(0 hospitals in area) 8 of 15 health centers 28 of 28 health stations
Contract care dollars as a percentage of total clinical care dollars (fiscal year 2003)	From 16% in Alaska to 40% in Portland	27%	19%	40%

Source: GAO summary of IHS and U.S. Census Bureau data.

In the second tier, we selected facilities within the three areas. Facilities were selected to represent a mix in terms of the type of facility (for example, hospital or health center), whether it was tribally or federally operated, the size of its patient population, and whether the facility was located in a frontier or nonfrontier county (see table 9). The selected sites represent a mix of facility characteristics and populations served both within and across the three areas.

Table 9: Characteristics of 13 IHS-Funded Facilities Selected for Site Visits

Areas selected	Facility type	Factors considered		Estimated number of patients served by facility ^b
		Operating body	Location (frontier or nonfrontier county) ^a	
Aberdeen	Hospital	Federal	Frontier	11,918
	Hospital	Federal	Frontier	5,853
	Health center	Federal	Frontier	3,596
	Health center	Federal	Frontier	1,734
Oklahoma City	Hospital	Federal	Nonfrontier	37,978
	Hospital	Tribal	Nonfrontier	Not available ^c
	Health center	Federal	Nonfrontier	8,993
	Health center	Tribal	Nonfrontier	Not available ^c
Portland	Health center	Federal	Frontier	8,490
	Health center	Federal	Frontier	2,084
	Health center	Tribal	Nonfrontier	3,950
	Health center	Tribal	Nonfrontier	8,040
	Health station	Tribal	Nonfrontier	111

Source: GAO summary of IHS headquarters and facility information.

^aThe Frontier Education Center designates a county as “frontier” based on a scoring system that computes points based on a county’s population density, distance to the closest “market” for services, and travel time to that market.

^bBased on IHS headquarters estimates for fiscal year 2004.

^cThis facility is part of a group of tribally operated facilities for which IHS did not calculate patient counts for each facility.

Appendix II: GAO Methodology for Selecting Services

We conducted semistructured interviews with each of the 13 facilities visited to learn more about the availability of selected services. We selected these services using a two-step process—first, selecting a set of health conditions reported to be prevalent among patients served by the 13 facilities, and second, identifying diagnostic and treatment services that are generally part of the standard course of treatment for each condition. To identify these services, we reviewed clinical standards published by IHS, medical associations, and other public entities, such as the Department of Health and Human Services' Public Health Service. Table 10 shows the 77 services selected for additional data collection.¹

¹Because of inconsistencies in how facilities responded, the data for 6 of the 77 services were not used in the team's analysis.

Table 10: Patient Condition and Services Selected, as of May 2005

Patient condition	Service
Healthy	<ul style="list-style-type: none"> • Medical services • Blood lead levels (1 year) • Pap smear (>18 years) • Cholesterol level (men >35 years; women >45 years) • Mammography (>45 years) • Sigmoidoscopy (>50 years) • Thyroid function (>60 years) • Fasting glucose • Tuberculosis screening • Iron deficiency screening <p>Dental services</p> <ul style="list-style-type: none"> • Emergency care • Prophylaxis (cleaning) • Sealants • Oral examination • Amalgam restoration • Cast inlays or crowns • Root canal • Dentures • Periodontal surgery • Comprehensive orthodontics <p>Vision services</p> <ul style="list-style-type: none"> • Eye examination–child • Eye examination–adult • Eyeglasses–child • Eyeglasses–adult • Elective contact lenses • Cataract surgery • Urgent care (e.g., treatment of corneal abrasion)
Head injury	<ul style="list-style-type: none"> • Emergency medical services (ambulance) • Stabilization/emergency room care • Computerized tomography (CT) scan • Intensive care • Inpatient care

Appendix II: GAO Methodology for Selecting Services

Patient condition	Service
Type II diabetes	<ul style="list-style-type: none"> • Physical examination • Laboratory evaluation • A1C test • Foot examination by specialist (high-risk patients) • Eye examination by specialist • Test for lipid disorders • Nephropathy screening • Retinopathy screening • Medical nutrition therapy • Dialysis
Pregnant	<ul style="list-style-type: none"> • Initial physical • Initial laboratory assessment • Obstetrics–high-risk visit • Obstetrics–high-risk follow-up visit • Amniocentesis (>35 years) • Ultrasound, second trimester • Vaginal delivery • Cesarean section • Well-baby checkup
Heart failure	<ul style="list-style-type: none"> • History and physical examination • Initial laboratory assessment • Monitoring of serum electrolytes and renal functions • Electrocardiogram • Echocardiography • Cardiac catheterization • Angiotensin converting enzyme inhibitors, beta-blockers, and digitalis • Heart valve replacement or repair • Heart transplant
Osteoarthritis of the knee	<ul style="list-style-type: none"> • Analgesic/nonsteroidal anti-inflammatory drug • Physical therapy • Durable medical equipment (e.g., braces and canes) • Radiographs • Arthroscopic debridement • Total knee arthroplasty

Appendix II: GAO Methodology for Selecting Services

Patient condition	Service
Mental health disorder or substance abuse	<ul style="list-style-type: none">• Emergency services• Inpatient mental health care• Inpatient substance abuse treatment• Outpatient mental health care• Outpatient substance abuse treatment• Psychotropic medication• Medication-assisted substance abuse treatment
Colon cancer	<ul style="list-style-type: none">• CT scan of abdomen and pelvis• Surgery• Chemotherapy• Follow-up carcinoembryonic antigen tests (4 per year)• Supportive care

Source: GAO analysis of clinical standards published by IHS, medical associations, and other public entities, as of June 2005.

Appendix III: Comments from the Indian Health Service



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

AUG 01 2005

Indian Health Service
Rockville MD 20852

Ms. Leslie Aronovitz
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington DC 20548

Dear Ms. Aronovitz:

The Indian Health Service (IHS) appreciates the opportunity to comment on the Government Accountability Office (GAO) draft report, "Indian Health Service: Health Care Services Are Not Always Available to Native Americans," (GAO-05-789). The IHS substantially agrees with the findings and conclusions of the report; however, we would like to offer the following comments and suggestions that will help clarify certain issues and provide additional information on specific findings:

- The report uses the term "Native American(s)" to refer to the population we serve. We suggest the report refer to the population we serve as both "American Indians and Alaska Natives (AI/AN)" or "Indian." "Native American(s)" is too broad and not specific to our Agency.
- The report uses the term "contract care" which should be changed to "contract health services" (CHS) to be specific to the IHS CHS programs and not to be confused with other non-CHS IHS contracts.
- Page 5, first bullet, last sentence, and page 23, first sentence, second paragraph (concerning referencing newer facilities constructed after 1990). We suggest inserting the words "and funding for staff" after the words "had more space."
- Page 5, third bullet; page 27, first bullet (concerning reimbursements); and the table on page 33 (referencing the age of the service population). None of these discuss the much more important demographic issue, which is the percentage of the population at or below the poverty level. This demographic information has a very strong influence on Medicaid eligibility and, therefore, the potential for collections since, as the report indicates, Medicaid is the major source of third-party collections for the IHS user population.
- Page 7, Figure 1 (chart). The chart should include "cardiovascular disease," which is the leading cause of death for AI/ANs over the age of 45.

Now on pp. 4, 5, and 23.

Now on pp. 5 and 28.

Now on p. 7.

Page 2 - Ms. Leslie Aronovitz

Now on p. 11.

- Page 10, second paragraph, fourth line. The term “contract care area,” should be changed to Contract Health Service Delivery Area (CHSDA), since CHSDA is the official term used by the IHS.

Now on pp. 12 and 24.

- Page 11, fourth sentence, and page 24, second paragraph, last sentence. The statement that federally operated facilities are required to pay for all priority-one services is true, but if available funds at a facility are expended before the end of the fiscal year, or if a facility has insufficient funds to pay for all priority-one cases, payment is not made for all priority-one services. This is the case at many of our facilities.

Now on p. 16.

- Page 15, first full paragraph, last sentence (the statement, “Officials at another facility estimated that 65% of their maternity patients went to the emergency room for delivery without receiving any prenatal care in advance”). The IHS doubts the accuracy of this statement and without supporting reference information, we recommend removing the sentence.

Now on p. 21.

- Page 20, second paragraph. We consider the examples of gaps in patient service unsubstantiated. Without supporting reference information, we recommend removing the paragraph.

Now on pp. 22 and 23.

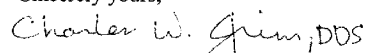
- Page 22, second paragraph (concerning the discussion of the disparity of services available between hospitals and health centers). It is true that hospitals offer more services than health centers, but the report should state that our hospitals are located where populations are large enough to make it professionally and economically feasible to offer more services.

Now on p. 24.

- Page 24, first paragraph, last sentence. This sentence could be misinterpreted to mean that this activity is at the discretion of the IHS. We recommend the following instead: “In addition to the benefits of an improved design and more space, Area officials explained that when new buildings are constructed with IHS funds, Congress appropriates increases for staff and equipment, which allow the facility to provide additional types of services and/or serve more patients.”

Should you have any questions concerning the IHS's comments, please contact Mr. Les Thomas, Office of the Director, Management Policy and Internal Control Staff, at (301) 443-2650.

Sincerely yours,



Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General
Director

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Leslie Aronovitz (312) 220-7600 or aronovitzl@gao.gov

Acknowledgments

In addition to the contact named above, Carolyn Yocom, Assistant Director; Susan Barnidge; Nancy Fasciano; and JoAnn Martinez-Shriver made key contributions to this report.

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