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Highlights

Highlights of GAO-11-767, a report to congressional addressees

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INDIAN HEALTH SERVICE

Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need

Why GAO Did This Study

The Indian Health Service (IHS), an agency in the Department of Health and Human Services (HHS), provides health care to American Indians and Alaska Natives. When care at an IHS-funded facility is unavailable, IHS's contract health services (CHS) program pays for care from external providers if the patient meets certain requirements and funding is available. The Patient Protection and Affordable Care Act requires GAO to study the adequacy of federal funding for IHS's CHS program. To examine program funding needs, IHS collects data on unfunded services—services for which funding was not available—from the federal and tribal CHS programs. GAO examined (1) the extent to which IHS ensures the data it collects on unfunded services are accurate to determine a reliable estimate of CHS program need, (2) the extent to which federal and tribal CHS programs report having funds available to pay for contract health services, and (3) the experiences of external providers in obtaining payment from the CHS program. GAO surveyed 66 federal and 177 tribal CHS programs and spoke to IHS officials and 23 providers.

What GAO Recommends

GAO recommends that HHS direct IHS to ensure unfunded services data are accurately recorded, CHS program funds management is improved, and provider communication is enhanced. HHS noted how IHS would address the recommendations; describing the proposed new method to estimate need. IHS's steps will address some recommendations, but immediate steps are needed to improve the collection of unfunded services data to determine program need.

View GAO-11-767. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

Due to deficiencies in IHS's oversight of data collection, the data on unfunded services that IHS uses to estimate CHS program need were not accurate. Specifically, the data that IHS collected from CHS programs were incomplete and inconsistent. For example, 5 of the 66 federal and 30 of the 103 tribal CHS programs that responded to GAO's survey reported that they did not submit these data to IHS in fiscal year 2009. Also, the format of IHS's annual request has not provided the agency with complete information to determine which programs submitted these data. In addition, individual CHS programs reported inconsistencies in how they recorded information about a specific type of unfunded service that IHS uses in its assessment of need. A reliable estimate of need will require complete and consistent data from each of the individual CHS programs. In November 2010, IHS created a workgroup to examine weaknesses in its current data and explore other sources of data to estimate need. IHS officials expect the workgroup to make a recommendation to the IHS Director by the end of calendar year 2011 that IHS adopt a new method of estimating need. As of September 2011, IHS was continuing to develop this new method and officials indicated that deferral and denial data would continue to be collected until it makes further decisions about its needs assessment methodology.

Sixty of the 66 federal and 73 of the 103 tribal CHS programs that responded to GAO's survey reported that in fiscal year 2009 they did not have CHS funds available to pay for all services for which patients otherwise met requirements. Some federal CHS programs reported continuing to approve services for patients when sufficient funds were not available; IHS officials told us they were unaware this practice was occurring. In contrast, other federal CHS programs reported using a variety of strategies to help patients receive services outside of the CHS program in order to maximize the care that they could purchase. For example, some federal CHS programs reported helping patients locate free or low-cost health care. Tribal CHS programs reported using a variety of strategies not available to federal CHS programs. For example, 46 of 103 tribal CHS programs that responded to GAO's survey reported supplementing their CHS programs' funding with tribal funds, which are earned from tribal businesses or enterprises.

Most external providers that GAO interviewed described challenges in the CHS program payment process. For example, when patients presented for emergency services, 13 of 23 providers reported challenges determining which services would be approved for payment because, unlike other payers, they cannot check a patient's eligibility electronically. Eighteen providers noted challenges receiving communications from IHS about CHS policies and procedures related to payment, including having had few, if any, formal meetings with program staff and a lack of training and guidance. IHS officials acknowledged that the complexity of the CHS program makes provider education important. Most providers said that these challenges contributed to patient and provider burden. For example, providers said they generally billed the patient when CHS programs denied payment for services, although they rarely collected payment on care billed to CHS patients. Some providers said that this uncompensated care had not significantly affected them financially, but others stated that care uncompensated by the CHS program had affected them financially by, for example, limiting their ability to purchase new equipment.