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Report to Congressional Addressees

September 2011

INDIAN HEALTH SERVICE

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

GAO-11-767

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GAO Accountability * Integrity * Reliability

Highlights

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

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.

Contents

Abbreviations

CHEF	Catastrophic Health Emergency Fund
CHS	contract health services
EMTALA	Emergency Medical Treatment and Active Labor Act
FDI	Federal Disparity Index
FEHBP	Federal Employees Health Benefits Program
HHS	Department of Health and Human Services
IHS	Indian Health Service
OIG	Office of Inspector General

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

September 23, 2011

Congressional Addressees

Access to health care services for American Indians and Alaska Natives has been a long-standing concern.[1] The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), is charged with providing health care to the approximately 1.9 million American Indians and Alaska Natives who are members or descendants of federally recognized tribes.[2] These services are provided at federally or tribally operated health care facilities,[3] which receive IHS funding and are located in 12 geographic regions overseen by IHS area offices.[4] These IHS-funded facilities vary in the services that they provide. For example, some facilities offer comprehensive hospital services, while others offer only primary care services. When services are not available at these facilities, the agency's contract health services (CHS) program may pay for services from external health care providers, including hospital- and office-based providers. The CHS program is administered at the local level by individual CHS programs generally affiliated with IHS-funded facilities in each area. These individual CHS programs may be federally or tribally operated.

[1]See, for example, GAO, *Indian Health Service: Basic Services Mostly Available; Substance Abuse Problems Need Attention*, GAO/HRD-93-48 (Washington, D.C.: Apr. 9, 1993); and *U.S. Commission on Civil Rights, Broken Promises: Evaluating the Native American Health Care System* (Washington, D.C.: September 2004).

[2]IHS defines an Indian tribe as any Indian tribe, band, nation, group, Pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the programs and services provided by the United States to Indians because of their status as Indians.

[3]Under the Indian Self-Determination and Education Assistance Act, as amended, federally recognized Indian tribes can enter into self-determination contracts or self-governance compacts with the Secretary of Health and Human Services to take over administration of IHS programs for Indians previously administered by IHS on their behalf. Self-governance compacts allow tribes to consolidate and assume administration of all programs, services, activities, and competitive grants administered throughout IHS, or portions thereof, that are carried out for the benefit of Indians because of their status as Indians. In contrast, self determination contracts allow tribes to assume administration of a program, programs, or portions thereof. See 25 U.S.C. §§ 450f(a) (self determination contracts), 458aaa-4(b)(1) (self-governance compacts).

[4]IHS's 12 area offices are: Aberdeen, Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

These federal and tribal CHS programs determine whether or not to pay for the referral of a patient to an external provider or pay an external provider for a service already provided. IHS requires that patients meet certain eligibility and administrative requirements to have the services paid by the CHS program. In addition, the CHS program, which is funded through the annual appropriations process, must operate within the limits of its appropriations. Therefore, committees associated with each CHS program meet at least weekly to review cases and approve payment based on the relative medical need of each case. When the requirements have not been met or funds are not available, CHS programs defer or deny requests to pay for services. Services for which patients otherwise meet necessary requirements, but for which CHS program funds are not available for payment, are known as unfunded services.

Limits on available resources have affected the specific types of services available to American Indians and Alaska Natives through the CHS program. For example, in a 2005 report examining 13 IHS-funded health care facilities, we reported that primary care services were generally offered at the facilities, but certain specialty and other services were not always directly available to American Indians and Alaska Natives.[5] These facilities also generally lacked funds to pay for all of these services through their CHS programs. We also noted that, in some cases, gaps in services resulted in diagnosis or treatment delays that exacerbated the severity of a patient's condition and required more intensive treatment.

Funding for the CHS program has increased significantly, from $498 million in fiscal year 2005 to $779 million in fiscal year 2010. Despite the funding increases over this period, IHS reported an increase in the number of services denied by CHS programs due to a lack of funding. IHS uses the number of services that were deferred or denied due to a lack of funds by the CHS programs to develop an estimate of the additional funds needed for the CHS program. However, IHS and other stakeholders have questioned whether these data on unfunded services represent the extent of need. For example, IHS has acknowledged that little is known about the extent of unfunded services for tribal CHS

[5]GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, GAO-05-789 (Washington, D.C.: Aug. 31, 2005).

programs. Just for federal CHS programs, IHS has estimated that $360 million in services were unfunded in fiscal year 2008.[6]

The Patient Protection and Affordable Care Act requires GAO to study the adequacy of federal funding for the CHS program.[7] IHS does not maintain comprehensive data and information about the program that would be relevant to assessing the adequacy of federal funding. As discussed with the committees of jurisdiction, we examine (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.

To examine the extent to which IHS ensures the data it collects on unfunded services are accurate to determine a reliable estimate of CHS program need and the extent to which federal and tribal CHS programs report having funds available to pay for contract health services, we administered a Web-based survey to the 66 federal CHS programs identified by the area offices. We administered the survey between October 2010 and January 2011 and received completed survey responses from all 66 federal CHS programs. We also administered a mixed-mode survey—both Web-based and by mail—to the 177 tribal CHS programs identified by the area offices. We administered the survey between September 2010 and January 2011 and received completed survey responses from 103 of the tribal CHS programs, for a response rate of 58 percent. Because we did not receive responses from all tribal CHS programs and because there is variability among programs due to the flexibility tribes and tribal organizations have in administering their programs, the results from our survey of tribal CHS programs are not generalizable to all tribal CHS programs. In addition, we conducted two

[6]In fiscal year 2008, IHS received about $579 million for the CHS program.

[7]This work originated as a request from the Senate Committee on Indian Affairs and individual members prior to the enactment of the Patient Protection and Affordable Care Act, which provided for the enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009. The act also requires GAO to complete other work on aspects of the CHS program, including funds distribution and claims payment. See Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935 (2010) (enacting S. 1790, as reported by the Committee on Indian Affairs in the Senate in December 2009, into law with amendments); S. 1790, 111th Cong. §§ 137, 199 (2009).

site visits to IHS's Oklahoma City and Portland area offices, interviewed officials from IHS and each of IHS's 12 area offices to discuss oversight of the CHS program, and spoke with tribal health advocacy groups. We also examined IHS oversight—such as the provision of policy and guidance—conducted to ensure that CHS programs consistently and completely record and report unfunded services data. We compared these oversight activities to the standards described in the *Standards for Internal Control in the Federal Government* and the *Internal Control Management and Evaluation Tool*.[8] We also reviewed our cost estimating guide to assess procedures for determining a reliable estimate for budgetary purposes.[9]

To examine the experiences of external providers in obtaining payment from the CHS program, we interviewed representatives from hospitals and office-based health care providers in selected IHS areas. We selected four areas based on their per capita CHS funding for fiscal year 2009 and dependency on CHS funds for hospital services.[10] The four areas we selected were Bemidji, Billings, Phoenix, and Oklahoma City,[11] which represent areas that were above or below average for each of our selection criteria. Within these four areas, we selected 16 hospitals and 7 office-based providers from a list of providers that were identified by federal CHS programs in our survey and by other experts as interacting frequently with IHS's CHS program. Given the small number of providers in our sample and our process for selecting them, the results from these interviews are not generalizable to all providers interacting with the CHS

[8]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999); and *Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

[9]GAO, *GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs,* GAO-09-3SP (Washington, D.C.: March 2009).

[10]We measured dependency using an IHS measure of patient access to an IHS-funded hospital. Patients in some areas do not have access to an IHS-funded hospital. Therefore, IHS distributes additional CHS funds to such areas, because patients in these locations are more dependent on the CHS program to receive hospital-based services.

[11]The Bemidji area includes locations in Indiana, Minnesota, Michigan, and Wisconsin; the Billings area includes locations in Montana and Wyoming; the Phoenix area includes locations in Arizona, California, Nevada, and Utah; and the Oklahoma City area includes locations in Oklahoma, Kansas, and Texas.

program. We asked providers about their experiences obtaining effective and timely communication related to the payment process, such as training or guidance on determining patient eligibility for CHS program payment of services, and determining the status of claims or receiving payment, and compared their experiences with the standards described in the *Standards for Internal Control in the Federal Government* and the *Internal Control Management and Evaluation Tool*.[12] We asked providers a standard set of open-ended questions and we did not independently validate their reported experiences, but we did discuss many of the issues they raised with IHS officials. (See app. I for more details on our scope and methodology.)

We conducted this performance audit from January 2010 to September 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

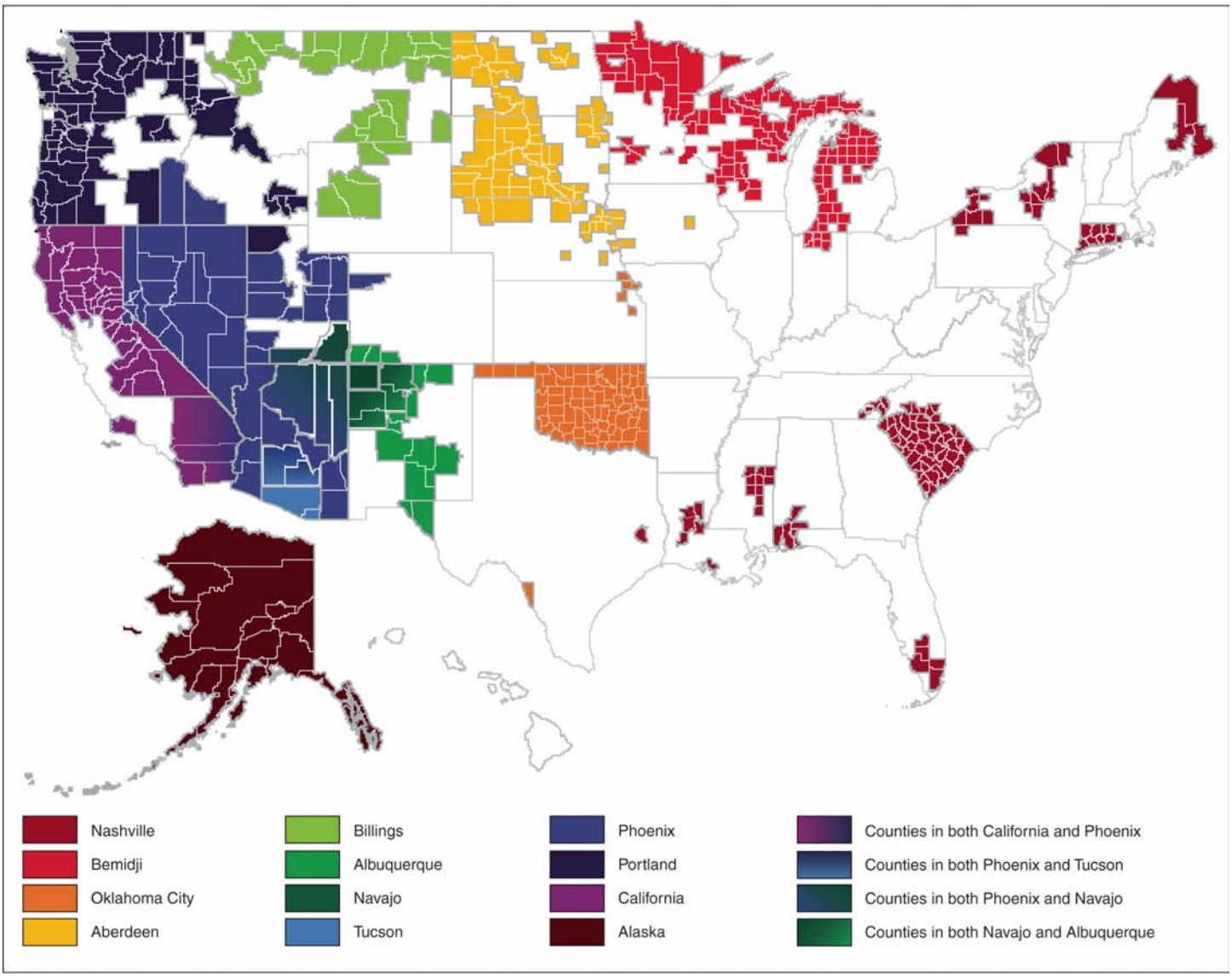
IHS oversees the CHS program through 12 area offices. Federal and tribal CHS programs in each of these areas pay for services from external providers if services are not available directly through IHS-funded facilities, if patients meet certain requirements, and if funds are available. IHS conducts an annual assessment to estimate CHS program need. To perform its needs assessment, IHS requests data from area offices and individual CHS programs on health care services they were unable to fund.

[12]GAO/AIMD-00-21.3.1 and GAO-01-1008G.

CHS Program Organization

IHS manages the CHS program through a decentralized system of 12 area offices, which oversee individual CHS programs in 35 states where many American Indian and Alaska Native communities are located. (See fig. 1 for a map of the counties included in the 12 areas. Residence in these counties is generally a requirement for obtaining contract health services.)

Figure 1: Counties in the 12 IHS Areas



Source: GAO analysis of IHS information, as of July 2011.

IHS headquarters is responsible for overseeing the CHS program. Among other things, it sets program policy and distributes CHS program funds to the 12 area offices. The 12 area offices then distribute funds to CHS programs within their respective areas, monitor the CHS programs, establish procedures within the policies set by IHS, and provide programs with guidance and technical assistance. About 46 percent of CHS funds are distributed to federal CHS programs and the other 54 percent to tribal CHS programs.[13] Tribal CHS programs must meet the same statutory and regulatory requirements as federal CHS programs, but they are not generally subject to the same policies, procedures, and reporting requirements established for federal CHS programs.[14]

Federal and tribal CHS programs pay for services from external providers if the services are not available at IHS-funded facilities. The services purchased include hospital, specialty physician, outpatient, laboratory, dental, radiology, pharmacy, and transportation services. While programs may have agreements or contracts with providers, they are not required for a provider to be paid. For example, a CHS program may have a contract with a nearby hospital or specialty providers, such as an orthopedic practice, to provide services to American Indians and Alaska Natives served by the CHS program. However, in the event of an emergency, patients have the option of visiting the nearest available provider, regardless of whether that provider has any prior relationship with the CHS program.

Patients must meet certain eligibility, administrative, and medical priority requirements to have their services paid for by the CHS program. (See table 1.) To be eligible to receive services through the CHS program, patients must be members of federally recognized tribes and live in specific areas. In addition, patients must meet specific administrative requirements. For example, if there are other health care resources

[13]Most CHS program funds are allocated according to historical funding levels that are typically adjusted annually for inflation and population growth.

[14]Tribal CHS programs are able to supplement their CHS program funds received from IHS with reimbursements from Medicare, Medicaid, and private insurance for services provided at their tribal health care facilities. Tribal CHS programs are also able to supplement their CHS funding with tribal funds earned from tribal business or enterprises. See 25 U.S.C. § 1621f.

available to a patient, such as Medicaid and Medicare,[15] these resources must pay for services before the CHS program because the CHS program is generally the payer of last resort.[16] If a patient has met these requirements, a program committee (often including medical staff) that is part of the local CHS program evaluates the medical necessity of the service. IHS has established four broad medical priority levels of health care services eligible for payment and a fifth for excluded services that cannot be paid for with CHS program funds. Each area office is required to establish priorities that are consistent with these medical priority levels and are adapted to the specific needs of the CHS programs in their area. Federal CHS programs must assign a priority level to services based on the priority system established by their area office. Funds permitting, federal CHS programs first pay for the highest priority services (priority level I: emergent/acutely urgent care), and then for all or only some of the lower priority services they fund. Tribal CHS programs must use medical priorities when making funding decisions, but unlike federal CHS programs, they may develop a system that differs from the set of priorities established by IHS.

[15]Medicaid is a jointly funded federal-state health care program that covers certain low-income individuals and families. Medicare is the federal government's health care insurance program for individuals aged 65 and older and for individuals with certain disabilities or end-stage renal disease.

[16]See 25 U.S.C. §§ 1621e, 1623; 42 C.F.R. § 136.61 (2010). There are certain exemptions to the CHS program's designation as a payer of last resort. For example, certain tribally funded insurance plans are not considered alternate resources and the CHS program must pay for care before billing the tribally funded insurance plan. The CHS program must also pay for care provided to eligible American Indians and Alaska Natives before the crime victim compensation program, a federal program that provides compensation to victims and survivors of criminal violence.

Table 1: Requirements for Approving Care for CHS Funding

Category	Requirement[a,b]
Eligibility	• Individual is a member or descendant of a federally recognized tribe or maintains close social and economic ties with the tribe. • Individual lives on a federally recognized Indian reservation or within the designated service delivery area for the CHS program.
Administrative	• Any available alternate source of payment for care, such as Medicare, Medicaid, or private insurance, for which an individual is eligible, must be used before the CHS program will pay. • IHS-funded facility is not reasonably available and accessible to provide the care. • Prior approval is obtained for non-emergency services. • For emergency services, the CHS program is notified within 72 hours of the care being provided or within 30 days for elderly and disabled persons.
Medical Priority	Each area office is required to establish priorities that are consistent with IHS's medical priority levels and that are adapted to the specific needs of the CHS programs in their area. In contrast, tribes have flexibility to create their own priorities, which can differ from IHS's. Below are the medical priority levels established by IHS.[c] • Priority level I, includes emergent/acutely urgent care services, such as trauma care, acute/chronic renal replacement therapy, obstetrical delivery and neonatal care. • Priority level II, includes preventive care services, such as preventive ambulatory care, routine prenatal care, and screening mammograms. • Priority level III, includes primary and secondary care services, such as scheduled ambulatory services for nonemergent conditions, elective surgeries, and specialty consultations. • Priority level IV, includes chronic tertiary and extended care services, such as rehabilitation care, skilled nursing facility care, and organ transplants. • Priority level V, includes excluded services, such as cosmetic plastic surgery and experimental procedures, that programs may not pay for with CHS program funds.

Source: GAO analysis of IHS's Indian Health Manual and regulations, which can be found at 42 C.F.R. §§ 136.23, 136.61 (2010).

[a]If eligibility, administrative, and medical priority requirements have been met, but funds are not available, care is to be deferred or denied.

[b]There are also certain exceptions to these requirements.

[c]Funds permitting, federal CHS programs first pay for all of the highest priority services, and then all or some of the lower priority services, but CHS program funds may not be used to pay for priority level V services.

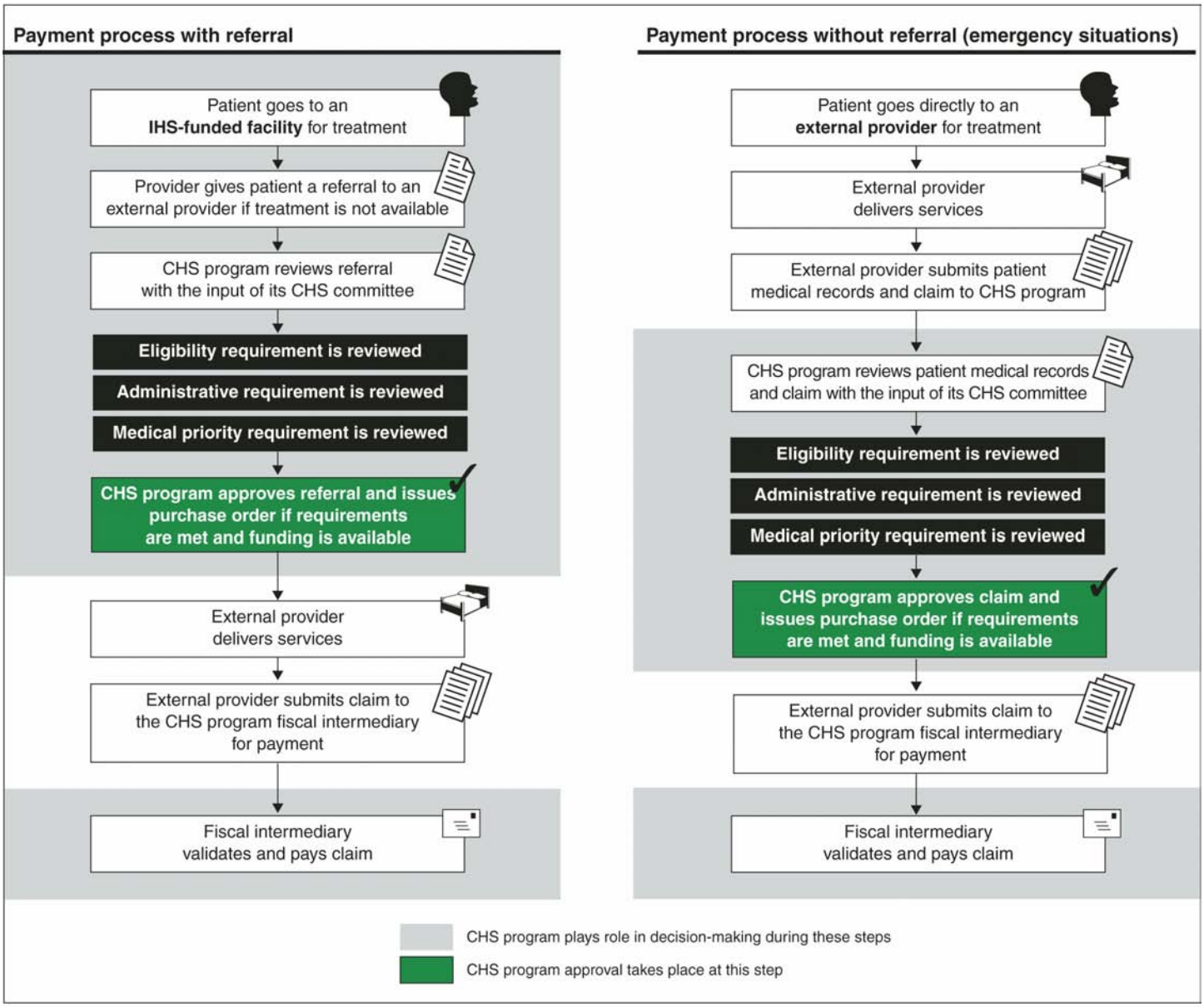
There are two primary paths through which patients may have their care paid for by a federal CHS program. The subsequent sections generally describe these two paths, which IHS officials told us federal CHS programs are expected to follow. First, a patient may obtain a referral from a provider at an IHS-funded health care facility to receive services from an external provider, such as a hospital or office-based physician. That referral is submitted to the CHS program for review. If the patient meets the requirements and the CHS program has funding available, the services in the referral are approved by the CHS program and a purchase

order is issued to the external provider and sent to IHS's fiscal intermediary.[17] Once the patient receives the services from the external provider, that provider obtains payment for the services in the approved referral by sending a claim to IHS's fiscal intermediary. Second, in the case of an emergency, the patient may seek care from an external provider without first obtaining a referral. Once that care is provided, the external provider must send the patient's medical records and a claim for payment to the CHS program.[18] At that time, the CHS program will determine if the patient meets the necessary program requirements and CHS funding is available for a purchase order to be issued and sent to the fiscal intermediary. As in the earlier instance, the provider obtains payment by submitting a claim to IHS's fiscal intermediary. Patients seeking to have their care paid for by tribal CHS programs follow similar pathways, but these programs have certain flexibilities. For example, while some tribal CHS programs also contract with IHS's fiscal intermediary to pay claims, they may also utilize other arrangements. (See fig. 2 for an overview of these two paths for a patient to access the CHS program.)

[17]IHS contracts with BlueCross BlueShield of New Mexico to serve as its fiscal intermediary to validate and pay all federal CHS program claims.

[18]Before submitting a claim for payment to the CHS program, IHS expects the external provider to seek reimbursement from any alternate resources available to the patient.

Figure 2: Two Paths for Patient Care to Be Funded by a Federal CHS Program



Source: GAO interviews with IHS officials and analysis of IHS documents.

Within either of these pathways, if the CHS program determines that the patient's service does not meet the necessary requirements or funding is not available, it denies CHS funding. It may also defer funding a service. The CHS program may issue a deferral when CHS funds are not available for a service but the patient has otherwise met the eligibility and administrative requirements.[19]

Needs Assessment for the CHS Program

IHS conducts an annual assessment to estimate the CHS program's unmet need, which helps inform its budget request for the CHS program. To gather information for its needs assessment, IHS headquarters sends an annual request for information to each of the 12 area offices asking them to report information from the federal and tribal CHS programs in their respective areas. The annual request contains a template that asks each area office to provide, among other things, summary counts of deferrals and denials that were recorded by the CHS programs in their areas. For example, each area office is asked to provide areawide totals of the number of new deferrals that remained unfunded at the end of the fiscal year. They are also to provide summary counts of denials that have been issued for each of eight categories of denial reasons, regardless of the type of service denied. The eight categories generally correspond to the CHS program's eligibility, administrative, and medical priority requirements.[20] Although funding for a service may be denied for multiple reasons, programs are required to categorize each denial by a single primary reason.

IHS uses the data recorded by the individual CHS programs and collected by the area offices to develop an estimate of the CHS program's unmet need. (See fig. 3.) To develop its estimate, IHS headquarters adds the total number of reported deferrals and the total number of denials reported in one of eight IHS-defined denial categories: "care not within

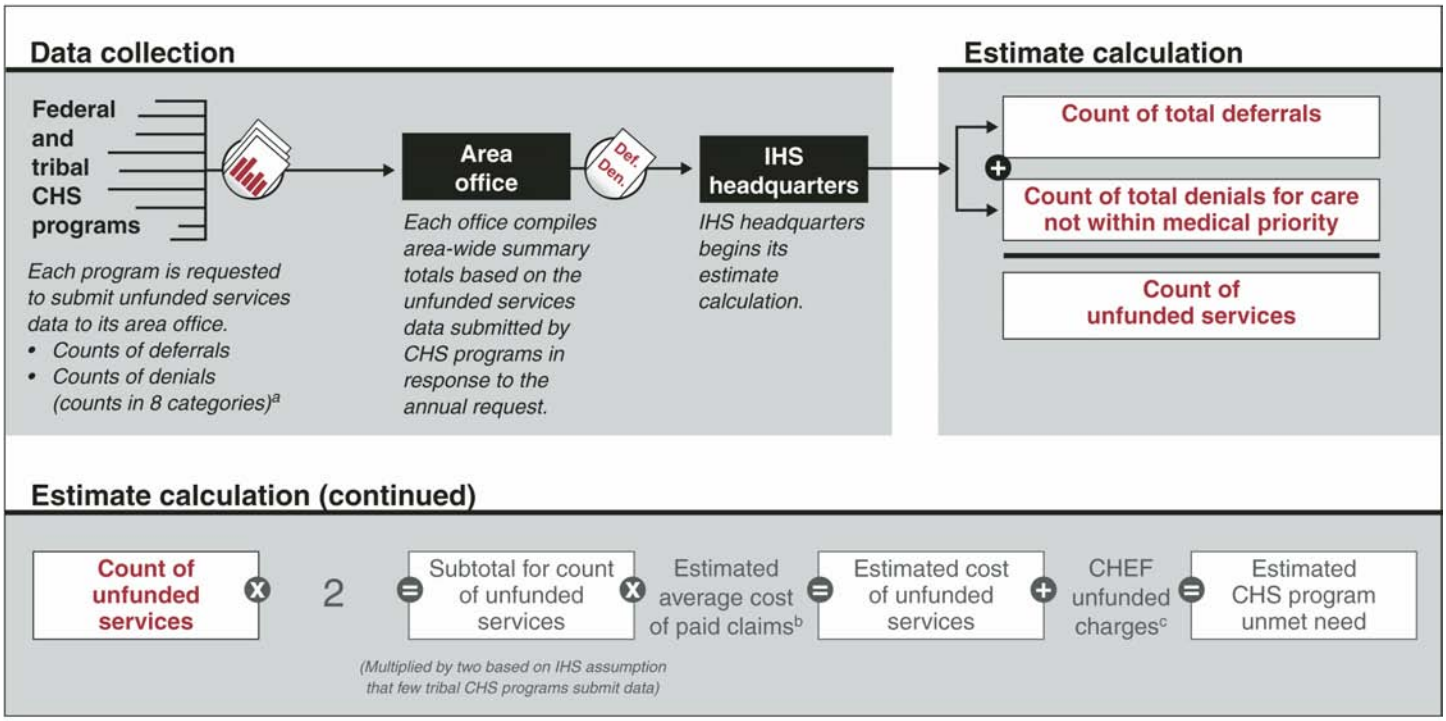
[19]Deferrals may be authorized later if additional funds become available. IHS policy requires that deferred services be for elective care, rather than emergent or urgent care. Programs may not defer payment for services already rendered, only for services that have not been received.

[20]The eight categories of denial are: (1) eligible but care not within medical priority, (2) eligible but alternate resource available, (3) patient ineligible for CHS, (4) emergency notification not within 72 hours, (5) non-emergency prior approval not authorized, (6) patient resides outside CHS delivery area, (7) IHS facility available and accessible, and (8) all other denials.

medical priority." According to IHS, CHS programs are only to record a denial as "care not within medical priority" to indicate that the patient met eligibility and administrative requirements, but the care requested was not within one of the medical priority levels for which funding was available. For example, a program that determines it only has funding available to pay for care designated as priority level I may deny a request to pay for care designated as priority level II because the care requested was not within the medical priority for which funding was available. Although IHS requests that the area offices report data from both federal and tribal CHS programs, it cannot require tribal CHS programs to report these data. Therefore, IHS officials told us they make an assumption in their assessment of program need that most tribal CHS programs do not report deferral and denial counts to the area offices. Because tribal programs receive about half of IHS's CHS funding, and because IHS believes that tribal CHS programs' experiences are similar to federal programs, IHS takes the data reported by area offices and multiplies them by two to calculate an estimate of the total number of deferrals and denials for the entire CHS program. IHS then multiplies this count of deferrals and denials by an estimated average cost per claim (calculated using a weighted average of the costs for inpatient and outpatient paid CHS claims) to develop an estimate of the funds needed for the CHS program. To this estimate, IHS adds data from the CHS program's Catastrophic Health Emergency Fund (CHEF), a fund that IHS headquarters administers to reimburse CHS programs for their expenses from high-cost medical cases.[21] Specifically, IHS adds the total billed charges from services for which CHS programs sought reimbursement from IHS headquarters through CHEF, but that CHEF was unable to fund. (See app. II for further discussion of CHEF.)

[21]CHEF was established by the Indian Health Care Amendments of 1988 to meet the medical costs associated with treating catastrophic illnesses or victims of disasters. See 25 U.S.C. § 1621a.

Figure 3: IHS Process for Collecting Unfunded Services Data and Estimating the CHS Program's Unmet Need



Source: GAO interviews with IHS officials and analysis of IHS documents.

[a]The eight categories of denial are: (1) eligible but care not within medical priority, (2) eligible but alternate resource available, (3) patient ineligible for CHS, (4) emergency notification not within 72 hours, (5) non-emergency prior approval not authorized, (6) patient resides outside CHS delivery area, (7) IHS facility available and accessible, and (8) all other denials.

[b]IHS estimates an average cost per claim by calculating a weighted average of the costs for inpatient and outpatient paid CHS claims. IHS then multiplies this estimate by the count of deferrals and denials.

[c]The Catastrophic Health Emergency Fund (CHEF) is administered by IHS headquarters to reimburse CHS programs for their expenses from high cost medical cases. IHS adds the total billed charges from services for which CHS programs sought reimbursement from IHS headquarters through CHEF, but that CHEF was unable to fund.

IHS's Oversight of Data Collection Does Not Ensure the Accuracy of the Data Used for Estimating CHS Program Need

Due to deficiencies in IHS's oversight of data collection, the unfunded services data on deferrals and denials that IHS used to estimate program need are incomplete and inconsistent. IHS does not have complete deferral and denial data from all federal and tribal CHS programs to estimate CHS program need. While IHS headquarters told us that area offices submit a report on unfunded services from their federal and tribal CHS programs in response to the annual request,[22] these reports did not include data from all federal or tribal CHS programs. Of the 66 federal CHS programs that responded to our survey, 5 reported that they did not submit any deferral or denial data to their area offices in response to IHS's annual request in fiscal year 2009. IHS officials acknowledged that they did not follow up with federal CHS programs to ensure they submitted data. Although not required, tribal programs may choose to submit deferral and denial data to IHS and the agency asks the area offices to include tribal data in their annual reports. Of the 103 tribal CHS programs that responded to our survey, 30 indicated that they collected data on unfunded services and submitted these data to their area offices in response to IHS's annual request in fiscal year 2009.[23] IHS officials acknowledged that the agency needed to provide more outreach and technical assistance to tribal programs to submit data in response to IHS's annual request. For example, they told us that an area office used such efforts during one fiscal year and was successful at eliciting data submissions from more tribes. By not encouraging the reporting of unfunded services data from all programs, IHS's data collection activities are not consistent with the *Standards for Internal Control in the Federal Government*, which state that an organization's management should provide reasonable assurance of the reliability of its reporting data for the agency to achieve its goals—in this instance, IHS's goal to appropriately

[22]IHS headquarters officials told us they obtain these data through the annual request because they do not have the capability to directly access the CHS programs' data through the Resource and Patient Management System, an information technology system that CHS programs can use to record approved, deferred, and denied requests for contract health services or claims for payment. In addition, the individual CHS programs are not required to use the system to record data on unfunded services and some programs reported to us that they did not use the system to record either deferrals or denials.

[23]Overall, 49 of the 103 tribal CHS programs that responded to our survey reported collecting data on unfunded services. Forty-four tribal CHS programs did not collect data, with the two most common reasons reported being staffing shortages (17) and technology limitations (14). The remaining tribal CHS programs did not provide a response or did not wish to share this information.

determine CHS program need. As we have also previously reported, the ability to generate reliable estimates is a critical function for agency management; having accurate data contributes to the reliability of the estimate.[24]

Second, IHS's report template was not designed to allow the agency to collect complete information for estimating need because it did not distinguish between the federal and tribal CHS programs that did report data. Because IHS headquarters only requested areawide totals in its report template, IHS officials were unable to determine which CHS programs reported data from the area reports that were submitted. IHS officials told us they did not know how many federal or tribal CHS programs reported data, although they estimated that most of the data were from federal programs and only a small percentage were from tribal programs. To account for the lack of complete data from tribal programs, when conducting its needs assessment, IHS doubled the count of unfunded services it received from the area offices. However, this means that any data received from tribal programs were being doubled along with the federal data, contributing to an unreliable estimate of need. For example, in fiscal year 2009, one area office reported a total of 4,858 denials for "care not within medical priority," which IHS doubled to account for the lack of complete data from tribal programs. However, we determined that 2,901 of the 4,858 denials were reported by tribal CHS programs.[25] IHS officials told us that they do not distinguish federal and tribal CHS program data in their annual data reporting template because they believe the data they receive from tribal CHS programs are so limited that they would not significantly affect their estimate of need.

Additionally, CHS programs inconsistently categorized a specific type of denial reason that is reported to IHS headquarters and used in its estimate of CHS program need because IHS has not provided guidance on this issue. CHS programs can deny care for multiple reasons, but IHS requires CHS programs to select a primary reason for denial. Specifically, IHS officials told us that IHS only counted those denials with a primary

[24]GAO/AIMD-00-21.3.1 and GAO-01-1008G.

[25]Further, we found that IHS's fiscal year 2009 estimate of need included deferral and denial data from areas that only contained tribal CHS programs (California and Alaska). Of the 32,309 denials for "care not within medical priority" reported by the 12 area offices in fiscal year 2009 that IHS used in its needs estimate, about 10 percent were reported by the Alaska and California area offices.

reason identified as “care not within medical priority” in its needs assessment because these services were denied solely if funds were not available.[26] However, neither IHS headquarters nor the area offices had provided guidance to federal CHS programs on how to select this primary reason for denial. Consequently, we found some area office and CHS program officials defined this type of denial reason in different ways. Officials from four area offices told us that they defined denials for “care not within medical priority” as also including services denied for administrative reasons or services that are excluded even if CHS funds are available such as cosmetic or experimental procedures. In our survey of the 66 federal CHS programs, 51 reported that they would apply this denial category if the care requested was an excluded service. One CHS program reported not knowing that a primary reason for denial existed. Because this category of denial was the only denial reason IHS used in its estimate, inconsistencies in how this denial reason was categorized by CHS programs have directly affected IHS’s estimate of need.

Some CHS programs also inconsistently recorded deferrals because IHS has not provided guidance about how it uses deferral data in its needs assessment. IHS officials told us that both deferral and denial data were used in IHS’s needs assessment. However, officials from one area office reported that their understanding was that only denials were counted in IHS’s needs assessment. In our survey of the 66 federal CHS programs, we found that 15 reported recording a decision to defer a service as both a deferral and a denial (making the count of denials inaccurate). Because IHS uses both deferrals and denials to estimate need, the inconsistent recording of deferrals would directly affect IHS’s estimate of need. IHS did not have a written policy documenting how the deferral and denial data it requests annually from the CHS programs would be used in its needs assessment and IHS officials told us they had not provided training to

[26]IHS distributed guidance that updated its definition for the denial reason “care not within medical priority” while our federal survey was being fielded. Specifically, the definition was changed from “The medical care you received is not within the CHS medical priorities. Medical priorities must be established when funding is limited” to “CHS is limited to services that are medically indicated and within the established IHS Medical Priorities. The medical service(s) you were provided did not fall within these priorities based on the medical information received and reviewed by the IHS medical provider. Therefore, your request for payment of these services is not approved.” IHS indicated that this change did not affect the way denials are categorized by CHS programs and it did not affect how the agency uses these denials in its needs assessment.

area offices or CHS programs on how to complete the annual request.[27] However, this lack of guidance is inconsistent with the *Standards for Internal Control in the Federal Government*, which notes that formally documented policies and procedures provide guidance that, among other things, helps to ensure that staff perform activities consistently across an agency.[28]

IHS officials have also identified weaknesses in the deferral and denial data that they used to estimate CHS program need. For example, they told us the data did not capture complete information on needed services that were not requested of the CHS programs because patients may have been discouraged from presenting for care or providers may have chosen not to write referrals if they believed funds were not available to pay for services.[29] IHS officials also told us that these data did not capture data on the extent to which tribes supplemented their CHS funds with tribal funds to avoid deferring or denying health care services.[30]

IHS has initiated steps to examine these weaknesses in its current data and explore other sources of data to estimate CHS program need. In November 2010, IHS convened an Unmet Needs Data Subcommittee as

[27]The annual request sent to the area offices asks for them to report both deferral and denial data and indicates "the data and information on Deferred Services, Denials, and CHS information from these reports will be used to support unmet CHS financial needs and in preparing budget justifications for the CHS program."

[28]GAO/AIMD-00-21.3.1.

[29]According to our surveys, 16 of the 66 federal CHS programs and 21 of the 49 tribal CHS programs that reported collecting data on unfunded services indicated that patients may be discouraged from presenting for care if they believe funds are not available to pay for services. In addition, 22 of the 66 federal CHS programs and 20 of the 49 tribal CHS programs reported that providers may choose not to write referrals when they feel it is unlikely for CHS funds to pay for services for a patient.

[30]IHS officials told us that tribal funds used to supplement CHS funding should be a part of an estimate of CHS program unmet need because tribes should not be expected to use their own funds to pay for contract health services given the federal obligation to pay for health care for eligible American Indians and Alaska Natives. In addition, they noted that not all tribes have the means to contribute financially to their CHS programs.

part of its Director's Workgroup on Improving the CHS Program.[31] The subcommittee was comprised of representatives from federal and tribal CHS programs. In a January 2011 report, the subcommittee noted that IHS's deferral and denial data had inaccuracies. While the report noted that reliably captured deferral and denial data on all patients would present the strongest evidence of need, it acknowledged that these data were incompletely and inconsistently reported by CHS programs, and recognized that this undermined the reliability of the estimated need IHS reports to the Committees on Appropriations annually in its budget justification. In February 2011, the subcommittee presented options for improving IHS's assessment of CHS program need to the Director's Workgroup.

Based on these options, the Director's Workgroup agreed that the subcommittee should explore a new methodology for estimating CHS program funding needs that relies on different sources of data. Rather than relying on deferral and denial data, the new method would use IHS's existing Federal Disparity Index (FDI). IHS calculates the FDI to estimate the disparity between its overall health care funding and the amount of funding needed to provide care to American Indians and Alaska Natives at a level comparable to the care provided by the Federal Employees Health Benefits Program (FEHBP), which is a nationwide health insurance program available to federal employees.[32] With this new method, IHS would adapt the FDI to calculate an estimate of need for each CHS program. Specifically, each IHS-funded facility would use a standardized tool to (1) calculate what proportion of services is paid for by its CHS program because these services are not available on-site at an IHS-funded facility, (2) estimate the level of CHS funding that would be

[31]IHS established the Director's Workgroup on Improving the CHS Program in March 2010, and charged it with reviewing tribal input to improve the CHS program, evaluating the existing formula for distributing CHS funds, and recommending improvements in the way CHS business operations are conducted within IHS and the Indian health system. Following an October 2010 meeting, the Workgroup made several recommendations to the Director, including the creation of a subcommittee to examine need in the CHS program.

[32]The FDI was developed by a joint tribal-IHS workgroup that met to determine the level of funding needed to provide all health care services—direct care through IHS-funded federal and tribal facilities and specialty health care through federally or tribally administered CHS programs—to American Indians and Alaska Natives at a level that is comparable to the nationwide FEHBP health insurance program available to federal employees. IHS has used the FDI to distribute health care funds received to carry out the Indian Health Care Improvement Act to the area offices.

needed to provide comparable services to those covered by FEHBP, and (3) compare that estimated level of funding to the program's actual level of funding. As a first step, each IHS area was to pilot the methodology on-site at two of its IHS-funded facilities. Once the pilots were completed, IHS officials told us the Workgroup planned to review the results of these pilots and issue a final report that contains a recommendation for the Director of IHS to consider for approval. As of September 2011, IHS officials said that they had finished the on-site pilots, but they were still making decisions about how to best adapt the FDI method to estimate CHS program need and they did not have a formal agency approved plan for implementing it. Officials indicated that they expected the Workgroup to issue a final report to the Director for approval by the end of calendar year 2011.

In addition to the proposed new method for estimating need, the Director's Workgroup agreed that actions be taken to improve the agency's collection of deferral and denial data that is currently used for that purpose. However, as of September 2011, IHS officials told us that the agency had not determined whether it would make improvements to the collection of deferral and denial data because it had not determined how such data would be used if the FDI method is adopted. But, officials said that they still see merit in using deferral and denial data to estimate CHS program need and, therefore, IHS may supplement the estimates from the FDI method with deferral and denial data from CHS programs that agency officials believe collect accurate data. IHS officials indicated that, until this decision is made, the agency will continue to collect deferral and denial data from the area offices through its annual request.

Most Federal and Tribal CHS Programs Reported They Did Not Have CHS Funds Available to Pay for All Services

Most federal and tribal CHS programs reported that they did not have CHS funds available to pay for all services for patients who otherwise met eligibility and administrative requirements in fiscal year 2009. In addition, some federal CHS programs reported using problematic funds management practices.

Most Federal CHS Programs Reported That They Did Not Have CHS Funds Available to Pay for All Services, and Some Reported Using Problematic Funds Management Practices

Of the 66 federal CHS programs that responded to our survey, 60 reported that they did not have CHS funds available to pay for all services for patients who otherwise met eligibility and administrative requirements in fiscal year 2009.[33] IHS officials told us that most CHS programs establish budgets as a way to help ensure that funds are available throughout the year.[34] However, even with this budgeting, 11 of these 60 CHS programs reported that they depleted their funds before the end of the fiscal year. Officials from three CHS programs we spoke with said their programs experienced multiple high-cost cases in the fourth quarter that depleted their funds. An official from another CHS program noted that the program is located in a rural area and the closest specialty care providers are 3 hours away by car. Therefore, if emergency care is required, the patient must be transported by air, which the CHS official said is expensive. In our survey, each federal CHS program identified the three most common categories of services it deferred or denied in fiscal year 2009. The most commonly cited categories of services were dental services, orthopedic services, vision services, and diagnostic and imaging services.[35]

The 60 federal CHS programs that reported not having CHS funds available to pay for all services in fiscal year 2009 varied in the extent to which they had funds available to pay for services in each of the priority levels. Some programs described the circumstances that influenced the extent to which they had funds available to pay for services in fiscal year 2009. (See fig. 4.)

- Thirty-nine of these programs reported having funds available to pay for all priority level I services (emergent/acutely urgent care) and some services in lower priority levels. Some of these CHS programs

[33]The remaining six programs reported having CHS funds available to pay for all services in fiscal year 2009. One of these CHS programs, for example, reported that it was unique because it only served students attending a boarding school. These six programs were located in five different IHS areas, each of which also had federal CHS programs that reported that they did not have funds available to pay for all services in that year.

[34]For example, CHS programs may budget their funding on a weekly basis.

[35]We grouped survey responses into categories of services. For example, the category of dental services includes orthodontics and prosthodontics; orthopedic services includes joint replacements and other orthopedic surgeries; vision services includes ophthalmology and optometry; and diagnostic and imaging services includes MRIs, CT scans, and X-rays.

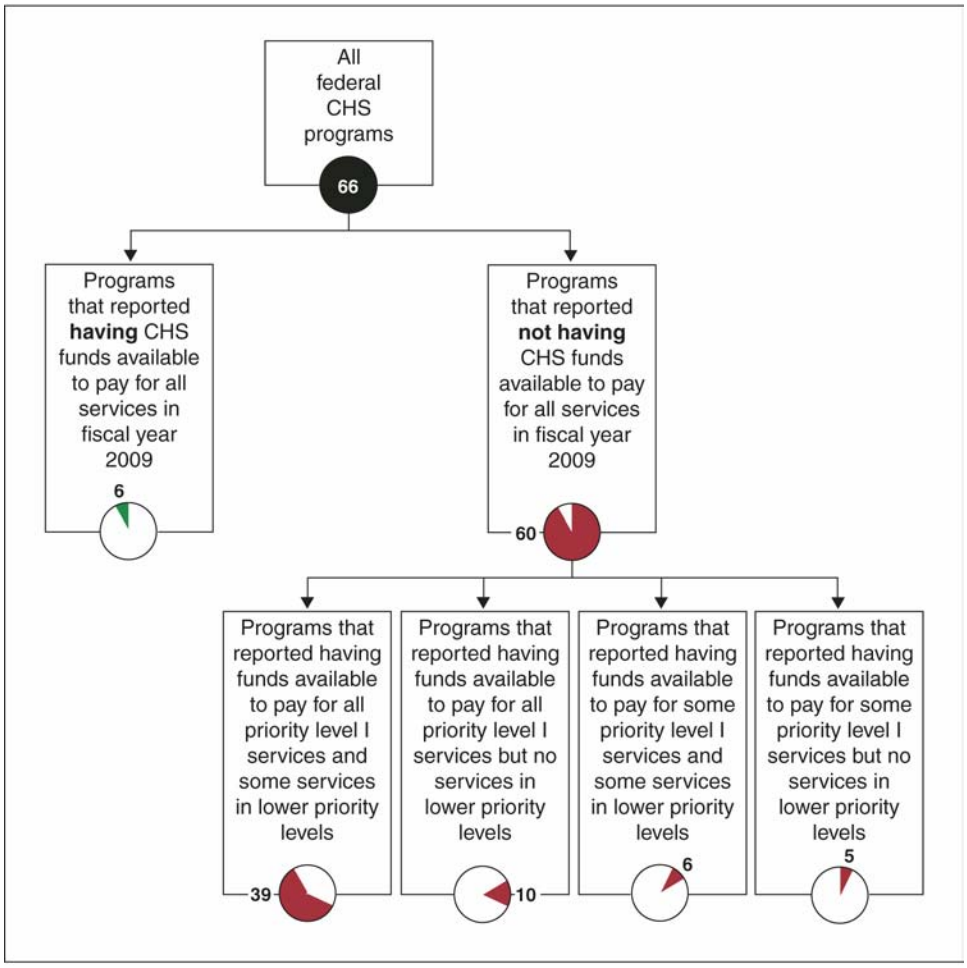
said that after purchasing all of their priority level I services, they had funds remaining at the end of the fiscal year and were able to use these funds to pay for lower priority services for patients whose services they had originally deferred or denied. For example, officials from one CHS program reported that in fiscal year 2009, they were able to use funds at the end of the fiscal year to provide eyeglasses to children and the elderly; a lower priority service that normally would not have been funded.

- Ten of these programs reported having funds available to pay for all priority level I services, but no services in lower priority levels. Some of these CHS programs reported that they never fund services beyond priority level I because their funds are so limited. An official from one of these programs noted that if a patient's case was originally deferred or denied because it was not a priority level I service but the patient's condition became more severe, the case may later be reclassified as a priority level I and the services purchased.

- Six of these programs reported having funds available to pay for some of their priority level I services and some services in lower priority levels. An official from one of these CHS programs told us that they strictly adhere to a weekly budget. For example, if they approved three high-cost cancer treatment cases one week, they may deny other priority level I cases because they do not have funds remaining to pay for these services. But, if funds in another week are sufficient to pay for all priority level I cases, they may also have funds available to pay for some lower priority services. An official from another of these CHS programs told us that staffing shortages over 2 years resulted in the program paying for services as the requests were received rather than funding them in order of medical priority. The official told us that, as a result, the CHS program paid for some priority level IV services, like durable medical equipment, even though they did not have funds available to pay for all of their priority level I services for the year.

- Five of these programs reported depleting their CHS funds before the end of the fiscal year and reported that they did not have funds available to pay for all priority level I services. One of these programs reported depleting its funds for the fiscal year in the second quarter of fiscal year 2009, two programs reported depleting their funds in the third quarter, and two programs reported depleting their funds in the fourth quarter.

Figure 4: Priority Levels for Which Federal CHS Programs Had Funds Available to Pay for Services in Fiscal Year 2009



Source: GAO survey of federal CHS programs.

Federal CHS programs we spoke with 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, strategies noted by some CHS programs included helping patients locate free or low-cost health care or negotiating reduced rates with providers on the patient's behalf. Although CHS programs are required to identify alternate resources before approving a referral, some officials we spoke with said they have implemented additional measures to help enroll patients in alternate coverage, such as Medicare and Medicaid. For

example, one CHS program reported hiring a benefits coordinator who is responsible for helping enroll people in alternate coverage.

IHS's CHS programs are not able to pay for services for all patients who meet program requirements because they must operate within the limited funding available. Whenever a program incurs costs for services, the program incurs legal obligations to make payments. IHS does not authorize programs to incur obligations in excess of their "allowances," which are distributions of funds that IHS makes to programs from appropriations for contract health services.[36,37] According to IHS officials, programs are expected to actively manage their funds in order to maximize the care that can be purchased, and defer or deny care when sufficient funds are not available. Officials from five federal CHS programs told us, however, that they approved services when funds were depleted for a fiscal year with the understanding that providers would not be paid until the next fiscal year. For example, one of these officials reported that at the beginning of fiscal year 2009, the program owed $2 million to providers for care provided in fiscal year 2008 for which funds had not been available. At least one of these officials believed that she was not authorized to deny care due to lack of funds.

[36]Appropriations to IHS for contract health services are apportioned by the Office of Management and Budget, allotted to area office directors, and further distributed through allowances to federal CHS programs or payments to tribal CHS programs.

[37]To help ensure compliance with the Antideficiency Act, which generally prohibits federal officers and employees from incurring obligations in excess of appropriations, apportionments, and certain administrative subdivisions of funds, IHS has promulgated a funds management policy. See 31 U.S.C. §§ 1341, 1514, 1517. The existing policy provides that, even if there is no violation of the Antideficiency Act, agency officials may be subject to administrative discipline should they incur obligations in excess of the funds distributed to them. *See Indian Health Manual, Circular 95-19, Administrative Control of Funds Policy*; *Indian Health Manual, Circular 91-7, Contract Health Service Funds Control*. IHS officials told us that the *Indian Health Manual* needs to be updated to reflect current procedures for the administrative subdivision of funds, among other things, but that the agency does not consider the over-obligation of allowances to be a violation of the Antideficiency Act unless it results in an over-obligation of the related allotment.

The reports from these officials suggest significant weaknesses in funds management and violations of IHS policy creating the potential for violations of the Antideficiency Act.[38] They also suggest significant inconsistencies in the administration of federal CHS programs. When asked about this issue, IHS officials told us that they were not aware that CHS programs had approved services without available funds, but acknowledged that there had been some confusion in the past regarding programs' authority to deny care when funds were not available. They also noted that the agency guidance on funds management that is provided to CHS program staff is vague and needs to be updated and clarified. The officials told us that the agency plans to update and revise relevant IHS guidance, but had not developed a timeline for these revisions. The officials said that they have delegated responsibility to the area offices for issuing specific guidance to CHS programs, as well as conducting oversight regarding funds management and other issues. The officials, however, acknowledged that additional guidance and training from IHS headquarters for the CHS programs on funds management would be helpful.

Most Tribal CHS Programs Reported That They Did Not Have CHS Funds Available to Pay for All Services but Many Used Other Strategies to Expand Access to Care

Of the 103 tribal CHS programs that responded to our survey, most reported they did not have CHS funds available to pay for all services for patients who otherwise met eligibility and administrative requirements, with 73 reporting that they depleted their CHS funds at some point during fiscal year 2009.[39] In our survey, each tribal CHS program identified the three most common categories of services that were requested but not funded in fiscal year 2009. The most commonly cited categories of services that were requested but not funded were dental services,

[38]An evaluation of individual programs' compliance with statutes and policies regarding the obligation of funds and funds management was outside the scope of our review. We have referred these matters to the Department of Health and Human Services Office of Inspector General (OIG) for a review and appropriate action. Given GAO's responsibilities in this area, we will remain available to provide OIG with technical assistance.

[39]Of these 73 tribal CHS programs, 47 reported depleting their CHS funds before the end of the fiscal year and 26 reported they had CHS funds available to pay for at least some care all year by budgeting weekly, monthly, or quarterly.

orthopedic services, prescription drugs, diagnostic and imaging services, and hospital services.[40]

Tribal CHS programs reported using a variety of strategies not available to federal CHS programs to expand access to care. Forty-six of the 103 tribal CHS programs that responded to our survey reported supplementing their CHS programs' funding with tribal funds—funds earned from tribal businesses or enterprises.[41] For example, one tribal CHS program we spoke with used the profits from its tribally funded medical and dental clinics, which served non-IHS patients on a fee-for-service basis, to supplement its CHS funding. Of the 46 programs that reported finding it necessary to supplement their CHS programs with tribal funds, 28 reported contributing as much as was needed each year, while the other 18 reported that their tribal contributions were limited by the availability of funds from year to year. In our survey, tribal CHS programs identified the three most common categories of services paid for with tribal funds in fiscal year 2009. The most commonly cited categories of services were prescription drugs, dental services, hospital services, and orthopedic services. Five tribal CHS programs we spoke with reported using tribal funds to expand access to contract health services to individuals living outside the designated CHS delivery area, or to pay for services CHS funding would not usually cover.

Tribal CHS programs also reported supplementing their CHS funding by using reimbursements from third party payers to pay for CHS services, a strategy not available to federal CHS programs. Thirty-four of the 103 tribal CHS programs that responded to our survey reported using reimbursements for services provided at their IHS-funded facilities from third party payers such as Medicare, Medicaid, or private insurance to pay for additional services through their CHS programs. One tribal CHS program we spoke with reported that more than half of its budget relied

[40]We grouped survey responses into categories of services. For example, the category of dental services includes orthodontics and prosthodontics; orthopedic services includes joint replacements and other orthopedic surgeries; prescription drugs includes trial drugs and pain medications; diagnostic and imaging services includes MRIs, CT scans, and X-rays; and hospital services includes inpatient and emergency room services.

[41]Unlike federal CHS programs, tribal CHS programs can use funds from tribal enterprises and reimbursements from third party health care payers such as Medicare or private insurance to supplement CHS funds. Federal CHS programs are authorized to receive reimbursements from third party health care payers, but these funds offset rather than supplement IHS funding. See 25 U.S.C. § 1621f.

on funds from third party reimbursements, although officials noted that even with this supplemental funding, they were still limited to funding priority level I services only.

In addition, five tribal CHS programs we spoke with reported using strategies to expand access to care that reduced their reliance on CHS funds. For example, two programs we spoke with were able to directly enroll patients in a state-based insurance program for low-income individuals who did not qualify for Medicaid, and to pay the premiums using tribal funds. For uninsured CHS-eligible patients who are ineligible for government programs, one program reported using its IHS-allocated CHS funds to purchase private insurance coverage under a waiver from IHS.[42] Enrolling eligible patients in alternate coverage reduced the reliance on CHS funds because the CHS program would only have to pay for services to the extent they are not covered by the alternate resources. Another program was able to achieve cost savings by contracting with a third party administrator to process its CHS claims, which allowed it to access a preferred provider network that provided care at discounted rates. Officials from another program reported bringing specialty providers, such as cardiologists and ear, nose, and throat specialists on-site at their facility to save money, compared to what it would cost to pay providers in the community for individual services.

[42]Since the Patient Protection and Affordable Care Act provided for the enactment of the Indian Health Care Improvement Reauthorization and Extension Act of 2009, waivers are no longer needed and tribal CHS programs are explicitly authorized to use CHS funds from IHS to purchase private insurance. See 25 U.S.C. § 1642 (amended by Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935 (2010) (enacting S. 1790, 111th Cong. § 152 (2009))).

Most External Providers Reported Challenges with the CHS Program Payment Process That May Burden Both Patients and Providers

Most of the external providers who we interviewed reported challenges in determining patient eligibility for CHS payment of services, in obtaining CHS payment, and in receiving communications on CHS policies and procedures from IHS related to payment. Providers stated that these challenges contributed to patient and provider burdens.

Most Providers Reported Challenges Determining Patient Eligibility, in Obtaining Payment, and in Receiving Communications on CHS Policies and Procedures Related to Payment

Thirteen of the 23 providers who we interviewed reported challenges in determining whether patients presenting for care without a CHS referral were eligible to have services paid by the CHS program. Fourteen providers also reported challenges obtaining timely payment from CHS programs. Lastly, 18 providers noted challenges receiving communications from IHS about CHS policies and procedures related to payment, including having had few, if any, formal meetings with CHS staff and a lack of training and guidance.

Determining Patient Eligibility for CHS Program Payment of Services

Thirteen providers who we interviewed reported challenges determining whether patient services would be approved by the CHS program for payment. Providers interact with American Indian and Alaska Native patients if these patients bring a referral from an IHS-funded health care facility. In the case of an emergency, a patient may seek care without obtaining a prior referral. Thirteen providers said it was especially challenging to determine patient eligibility when patients presented for care without a CHS program referral. Six providers noted that for other payers with which they interact, they are able to electronically check a patient's eligibility or covered services. However, IHS officials indicated that it is not possible for providers to check electronically whether the CHS program will pay for a service. Five providers indicated that, when possible, they attempted to contact the CHS programs in order to obtain information about a patient's eligibility. However, those providers said they were generally not able to get in contact with CHS program staff. Moreover, even if a provider determined that a patient met some CHS program eligibility requirements, such as tribal membership, payment was still conditional on whether the CHS program reviewed the patient's medical record and later determined that the emergency service met medical priority requirements and funds were available. Therefore,

providers may not know if they will receive payment for services delivered to the patient until the claim they have submitted to the CHS program is reviewed. In the absence of a process to determine patient eligibility for the CHS program, 12 providers said they submit claims for payment to CHS programs for all patients who self-identified as being American Indian or Alaska Native or eligible for the CHS program.

Fourteen providers said that when a patient presented for care with a CHS program referral, the likelihood that they would receive payment for the services delivered to the patient increased. For example, one provider stated that for the care delivered to American Indian and Alaska Native patients without a CHS program referral, about 80 percent of claims were denied; in comparison, about 20 percent of claims were denied when patients had a CHS referral. IHS officials said that denials may occur for a patient who has a referral if the patient presented for care at the external provider before the referral was approved by the CHS program committee.[43] However, they also noted that there were situations in which a referral that had been approved by a CHS program committee could still be denied. For example, if a patient did not apply for alternate resources, such as Medicare and Medicaid, for which the patient was eligible or the provider did not bill other payers for which the patient was eligible, the claim may be denied for CHS payment.[44] Additionally, although CHS

[43]When a physician at an IHS-funded facility gives a referral to a patient, a copy of the referral is also sent to the CHS program committee. While a referral must be reviewed and approved by the CHS committee prior to payment, IHS officials stated that, in some instances, a patient may present for care at an external provider without first obtaining approval from the CHS program. Officials noted that it is generally indicated on the referral if it has not yet been approved.

[44]The CHS program requires that if there are other health care resources available to a patient, such as Medicaid, these resources must pay for services before the CHS program because the CHS program is generally the payer of last resort. Three providers suggested that the CHS program could play a greater role in ensuring that patients are enrolled in any alternate resources prior to care being delivered. IHS's *Indian Health Manual* states that both the CHS program and providers have a responsibility to determine whether a patient would be eligible for alternate resources. IHS officials noted that provisions in the Patient Protection and Affordable Care Act could expand the availability of alternate resources for patients whose services would otherwise have been eligible for CHS program payment. In IHS's fiscal year 2012 congressional budget justification, the agency acknowledged the need to improve patients' understanding of alternate resource enrollment and assist patients with enrollment in state and federal programs and proposed new staff positions to accomplish this. IHS anticipates that enrolling patients in alternate resources will increase the availability of CHS program funds for patients without alternate resources and improve customer satisfaction.

programs are required to consider the availability of alternate resources when deciding whether to approve a referral, IHS officials acknowledged that programs may not always take this into consideration when making their decision.

Providers reported a number of reasons for which they received denials for payment from CHS programs. While providers said that some of the denials they received were related to patient eligibility, such as a patient living outside of the CHS delivery area, which was noted by four providers, most of the denials they received were related to administrative requirements. Twelve providers indicated that one of the most common reasons for denial was that an alternate resource was available to the patient. Other common administrative denial reasons included the availability and accessibility of IHS facilities to deliver services, noted by seven providers, and failure to provide notification within 72 hours of the patient receiving emergency services, noted by six providers. Seven providers also stated that they received denials because the CHS program determined that the care was non-emergent or not within medical priority for which funding was available. In addition, eight providers stated that some denials may have occurred because CHS patients may not have had a clear understanding of CHS policies and procedures related to payment. Eight providers stated that CHS patients could benefit from education on CHS procedures, including the need to obtain a CHS program referral prior to receiving care and the understanding that a CHS program referral does not guarantee payment.

Obtaining Payments from CHS Programs

Fourteen providers who we interviewed reported challenges obtaining timely payment from CHS programs. Seven of these providers stated that these delays occurred in obtaining a purchase order. However, six providers stated that after they obtained a purchase order from the CHS program, they received payment from IHS's fiscal intermediary in a timely manner. In fiscal year 2010, IHS reported that the average number of days between receiving a provider claim and issuing a purchase order was 82 days, 4 days more than the agency's target of 78 days for that fiscal year.[45] Of the providers who we interviewed, 12 providers stated that it has taken several months, or in some cases years, to receive

[45]After a purchase order is issued, the provider must submit a claim to IHS's fiscal intermediary, which has a contract standard to process payment to the provider within 21 calendar days of receiving a claim.

payment for CHS program claims. Seven providers said that these delays tended to occur when the CHS program's funding for the fiscal year had been depleted. According to IHS officials, delays in issuing purchase orders can be attributed to several factors, including a shortage of the CHS program staff who process purchase orders and the lengthy amount of time it takes providers to send patient medical records needed to make a determination for CHS payment.

Fourteen providers stated that the CHS program's paper-based claims process required a lot of paperwork to be submitted, such as a patient's medical records, or was otherwise time consuming. Twelve providers also stated that for some payers with which they interacted, including Medicare and Medicaid, they were able to process claims electronically, which in some cases also allowed them to electronically track a claim's status. In contrast, to obtain payment for emergency care through the CHS program, providers have had to send paper copies of patient medical records and a paper claim to the CHS program to be reviewed. Seven providers stated that this process had led to delays because CHS staff may lose paperwork and then ask the provider to resubmit the information. However, seven other providers noted that they were electronically submitting claims for payment to IHS's fiscal intermediary, or working with CHS programs to begin this process, which should reduce the amount of required paperwork.[46]

Some providers also stated that it was difficult to determine the status of claims while waiting for approval to be paid. Four providers said that when they contacted CHS program staff to determine the status of claims, the staff were not always able to provide the information. Of these providers, two said that CHS programs did not communicate the status of submitted claims. Additionally, one provider told us that one federal CHS program with which they interacted did not communicate to them when a claim had been denied.[47] Instead, the CHS program provided no

[46]According to IHS, all providers have the option to electronically submit claims to IHS's fiscal intermediary.

[47]CHS program guidelines state that if a service received by a patient is denied CHS payment, both the patient and the provider must be notified in writing of the denial with a statement containing all the reasons for the denial.

response to the provider's claim for payment.[48] IHS officials acknowledged that additional agency efforts toward improving customer service are needed to ensure that CHS program staff communicate more promptly with providers.

Receiving Communications on CHS Policies and Procedures to Receive Payment

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. For example, 10 providers stated that they had never met CHS program staff or did not meet regularly with them, although eight other providers said that they benefited from regular communications with CHS program staff, such as establishing good working relationships with CHS program staff and getting assistance in clarifying CHS program policies and procedures to receive payments. According to the *Standards for Internal Control in the Federal Government* and the *Internal Control Management and Evaluation Tool*, agency management should ensure that there are adequate means of timely and effective communication with, and obtaining information from, external stakeholders that have significant impact on the agency achieving its goals and an agency should employ many and various means of communications, such as policy and procedure manuals and Internet web pages.[49] By not ensuring that its CHS programs have timely and effective communication with external providers about CHS policies and procedures related to payment, IHS has no reasonable assurance that the agency is achieving its objectives.

The providers who we interviewed generally indicated that their understanding of the CHS program came from experience, rather than communications, including formal training and guidance from IHS. Twelve providers stated that they had at least a basic understanding of CHS policies and procedures for obtaining CHS payments. The providers we interviewed told us that the amount of training they received from IHS varied. While 3 of 4 providers in one IHS area stated that they received recent training from the staff of CHS programs or their area office,

[48]Under section 220 of the Indian Health Care Improvement Act, IHS is required to respond to a notification of a claim by a provider with either a purchase order or a denial within 5 working days after the receipt of such notification. If IHS fails to do so, it must accept the claim as valid. See 25 U.S.C. § 1621s. Examining compliance with this requirement was beyond the scope of this review.

[49]GAO/AIMD-00-21.3.1 and GAO-01-1008G.

13 providers in other areas told us that they had never received training from IHS staff or had not received training in many years. Of those 13 providers, 6 mentioned that they had not received educational materials, including guidance, about the CHS program. Instead, 6 providers stated that their knowledge of the CHS program had been self-taught or obtained from working with CHS program staff. In contrast, 7 providers stated that other payers with which they interacted provided regular on-site training, guidance manuals, or online resources that allowed them to learn about a payer's payment policies. IHS officials said that the responsibility for educating providers is delegated to the area offices. According to IHS officials, during past meetings with area office staff, they have emphasized the importance of external provider training and shared area office best practices for educating providers. IHS headquarters officials also stated that, in 2009, they developed a CHS program manual for external providers and sent it to the area offices to be distributed to providers.[50] However, IHS officials acknowledged that, given the complexity of the CHS program, additional agency efforts are needed to ensure that all IHS areas are engaged in external provider education.[51]

In the absence of training from IHS, one provider stated that it had developed its own training on the CHS program. This provider used the experience of one of its staff members who had previously worked for the CHS program to provide training to multiple health care facilities within its health system. However, that staff member had not received any training from either individual CHS programs or the area office since being hired by the provider 4 years ago and, therefore, would not have been aware of any policy changes IHS made during that time.

[50]IHS headquarters officials said that the provider manual is not available online and providers are only able to obtain a copy if it was distributed to them through the area office.

[51]From 2006 through 2010, IHS annually conducted a national training event for CHS program staff. Some of these events have included training on customer service and educating providers. IHS's Director's Workgroup on Improving the Contract Health Services Program recently identified provider education as an important issue and recommended that IHS make provider education a nationwide initiative and develop national tools. However, IHS officials told us that the agency has not yet developed a plan to implement this recommendation.

Most Providers Generally Reported That CHS Program Challenges Contributed to Patient and Provider Burden

Most providers who we interviewed generally reported that challenges with the CHS program, particularly denied payment for services, added to the burden of both patients and providers. Twenty-two providers stated that when care they provided was denied by the CHS program, they billed the patient. Of these providers, 3 stated that, because of the length of time that it took the CHS program to approve or deny a service, they started billing the patient even if a denial had not yet been received.[52] For example, 1 provider stated that they used to wait as long as 4 years for CHS programs to make claims decisions, but they now bill the patient if they do not receive communication from CHS programs within a timeframe typical to that of other payers.[53]

Twelve providers told us that, for the care denied by CHS programs that was billed to patients, either they were not able to obtain payment or patients did not apply for provider payment assistance programs. Eleven providers stated that they were only able to collect a small portion of the care billed to American Indian and Alaska Native patients or patients for whom payment was denied. Of the 12 providers who discussed how uncompensated care is classified in their financial records, all indicated that it was considered bad debt if the patient was not able to pay for services or qualify for charity care.[54] One provider estimated that it had a collections rate of about 1 percent for services billed to patients denied by the CHS program. The provider noted that while CHS patients accounted for about 30 percent of its patient population, they accounted for about 85 percent of the provider's bad debt. Ten providers stated that when the

[52]In 2005, we found that 10 of the 15 external providers that we interviewed reported that denials for or delays in payment resulted in some of the providers terminating their relationship with IHS. We noted that the termination of these relationships may affect a patient's access to care.

[53]IHS officials told us that providers should not be billing patients who are eligible for the CHS program. Under section 222 of the Indian Health Care Improvement Act, as amended by the Indian Health Care Improvement Reauthorization and Extension Act of 2009 on March 23, 2010, IHS is required to formally notify providers not later than 5 business days after receipt of notification of a claim that patients who receive authorized contract health services are not liable for any costs. See 25 U.S.C. § 1621u (amended by Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935 (2010) (enacting S. 1790, 111th Cong. § 135 (2009))). IHS officials told us that this requirement is important because they heard from patients that they were being billed for services while they were waiting for the CHS program to reimburse the providers. Officials noted, however, that the requirement to send out these notifications has created a burden for CHS program staff.

[54]Bad debt is generally defined as the uncollectible payment that the patient is expected to, but does not, pay.

patients' bill was not paid, they were turned over to collections.[55] In addition, 18 providers had a charity care program, which offered reduced charges or free care to patients who met income and other requirements and was available to patients whose care was denied for payment by the CHS program. However, 8 of these providers stated that patients for whom CHS program payment was denied generally did not apply for charity care, and 8 of the other 10 providers did not mention or did not have information on the number of patients denied by the CHS program that applied for charity care.[56]

Providers varied in whether they reported that this uncompensated care affected their operations. Ten providers, including five of the eight critical access hospitals that we interviewed,[57] reported that the amount of uncompensated care associated with the CHS program affected them financially by, among other things, limiting their ability to purchase new equipment or resulting in increased costs to other patients. One critical access hospital stated that because of the uncompensated care associated with the CHS program, it was seeking new ownership. However, four providers who we interviewed told us that the amount of uncompensated care had not significantly affected them financially. Additionally, some providers sought payment from other resources for services delivered to patients. For example, eight providers, seven of which were larger than critical access hospitals, stated that they hired a benefits coordinator or were able to get their state health benefits agency to place a benefits coordinator at their facility to assist patients in applying for alternate resources, such as Medicaid.

The providers who we interviewed told us that these burdens had varying effects on the delivery of care to patients. Nine of the 12 providers who discussed this issue with us stated that they provided care to patients regardless of their ability to obtain payment from the CHS program. In addition, the Emergency Medical Treatment and Active Labor Act

[55]Tribes and tribal organizations have testified before congressional committees about some of the consequences of a patient being billed for services denied by the CHS program, including negative effects on the patient's credit history and providers discontinuing services to patients because of nonpayment for services delivered.

[56]Two of the external providers that we interviewed did not have an application process associated with their charity care program.

[57]Critical access hospitals are limited to 25 beds and primarily operate in rural areas.

(EMTALA) requires most hospitals to provide an examination and needed stabilizing treatment, without consideration of insurance coverage or ability to pay, when a patient presents to an emergency room for attention to an emergency medical condition.[58] However, 3 of the 7 office-based providers that we interviewed said that when dealing with the CHS program, generally, they only saw patients who had obtained a CHS program referral.

Conclusions

IHS's CHS program serves as an important resource for American Indian and Alaska Native individuals who need health care services not available at IHS-funded federal and tribal facilities. Despite recent funding increases, most federal and tribal CHS programs that responded to our surveys reported that they did not have funds available to pay for all requested health care services for patients who otherwise met requirements, including emergent and acutely urgent care. However, IHS's estimate of the extent to which unmet need exists in the CHS program is not reliable because of deficiencies in the agency's oversight of the collection of unfunded services data on which it relies to develop this estimate. IHS's acknowledgement of these limitations and the early efforts of its workgroup to explore additional options for estimating need are positive steps. However, IHS has not yet completed the development of its new method for estimating CHS program need using the FDI or made a decision about how it will use deferral and denial data to help estimate CHS program need. Further, as its workgroup has noted, reliably captured deferral and denial data on all patients would present the strongest evidence of CHS program need. Therefore, it continues to be important that the agency take steps to ensure that complete and consistent deferral and denial data are collected. IHS has not provided adequate oversight to ensure that the annual reports it receives from each area office and uses to estimate unmet need include data from all of their federal CHS programs. In addition, although the agency cannot require reporting by tribal CHS programs, its efforts to provide outreach have not been sufficient to encourage such reporting from all tribal programs. Without complete reporting from federal and tribal programs, IHS does not have complete data for its estimate of unmet need. In addition, the agency's ability to determine the completeness of the data it collects and take steps to improve reporting is limited because its current

[58]See generally 42 U.S.C. § 1395dd.

template does not provide sufficient detail about which federal and tribal programs are reporting deferral and denial counts. As IHS responds to the future recommendations of its workgroup, the agency should ensure that it expeditiously addresses the weaknesses we identified in the deferral and denial data that provide the agency with information about program need.

Given the decentralized nature of the CHS program, effective guidance, training, and oversight by IHS can help ensure that policies and procedures affecting its determination of need are consistently applied across CHS programs. Our survey results suggest that current agency practices have not ensured consistent recording of unfunded services by CHS programs. Documenting how IHS uses unfunded services data to assess CHS program need could help ensure that area offices and CHS programs maintain data collection practices that contribute to the reliability of IHS's estimate of need.

Given that CHS program funds may be depleted before the end of the fiscal year, it is important that CHS programs take steps to maximize the care that patients receive. However, they should not engage in practices that risk incurring obligations in excess of the available funding. IHS officials acknowledge that the guidance that IHS provides to CHS program staff on funds management may not be sufficient to ensure that CHS programs do not engage in problematic funds management practices.

Effective communication with providers is an important element of IHS's oversight to ensure proper CHS program management. The providers we spoke with noted challenges related to their participation in the CHS program that they said created a burden for themselves and their patients. Among their concerns was a lack of timely and effective communication with the individual CHS programs to determine whether or when CHS programs would provide payment for services provided to American Indian and Alaska Native patients. Timely and effective communication between IHS and providers is especially important to ensuring efficient program operations. As acknowledged by IHS officials, the complexity of the CHS program makes this communication particularly important. The challenges that providers described—determining patient eligibility for payment, contacting CHS programs with questions about claims, and ensuring the timely receipt of payment—would be mitigated by improved CHS program processes and communications, including training.

Recommendations for Executive Action

To develop more accurate data for estimating the funds needed for the CHS program and improving IHS oversight, we recommend that the Secretary of Health and Human Services direct the Director of IHS to take the following eight actions:

- ensure that area offices submit data on unfunded services from all federal CHS programs;
- conduct outreach and technical assistance to tribal CHS programs to encourage and support their efforts to voluntarily provide data that can be used to better estimate the needs of tribal CHS programs;
- develop an annual data reporting template that requires area offices to report available deferral and denial counts for each federal and tribal CHS program;
- develop a plan and timeline for improving the agency's deferral and denial data;
- develop written guidance, provide training, and conduct oversight activities necessary to ensure unfunded services data are consistently and completely recorded by federal CHS programs;
- develop a written policy documenting how IHS evaluates need for the CHS program and disseminate it to area offices and CHS programs to ensure they understand how unfunded services data are used to estimate overall program needs;
- provide written guidance to CHS programs on a process to use when funds are depleted and there is a continued need for services, and monitor to ensure that appropriate actions are taken; and
- develop ways to enhance CHS program communication with providers, such as providing regular trainings on patient eligibility and claim approval decisions to providers.

Agency and Tribal Comments and Our Evaluation

We provided a draft of this report to HHS for review and comment and subsequently met with HHS and IHS officials to obtain additional information. In its written comments, HHS indicated steps that IHS would take to implement some of our recommendations and discussed steps the agency was taking to implement a new method for estimating CHS program need. HHS and IHS officials subsequently provided us with clarification about the status of IHS's plans for estimating program need

and HHS submitted revised written comments. HHS's letter and revised general written comments are reprinted in appendix III. We also provided tribal representatives with an opportunity to present oral comments and the representatives we spoke with primarily discussed the role of tribal programs in IHS's needs assessment process. The comments from HHS and the tribal representatives are summarized below.

In its original written comments, HHS commented that IHS is making efforts to address the problems identified in our draft report and provided additional information about the development of its new methodology for estimating program need. With regard to our first five recommendations to improve the collection of deferral and denial data from individual CHS programs, HHS agreed that these data are incomplete and inconsistent. HHS also agreed that such data could provide a reliable estimate of need if they were universally and uniformly collected. However, HHS indicated that IHS's proposed new method for estimating CHS program need by adapting its existing FDI would provide IHS with a sufficiently reliable estimate of CHS program need without relying on deferral and denial data. In our draft report, we acknowledged that IHS has taken positive steps to identify and examine the weaknesses in its current data and explore other sources of data to estimate CHS program need, such as exploring the use of the FDI method. As HHS noted in its comments, the IHS Director's Workgroup proposing this methodology has not yet issued a final recommendation to the Director of IHS for approval.

Following the receipt of HHS's original written comments, we met with HHS and IHS officials to obtain clarification about the status of IHS's plans for assessing CHS program need. The officials confirmed that the agency was continuing to develop the new method by adapting the FDI methodology to measure CHS program need. They said that the new method had not yet been formally recommended to the Director and that IHS did not have a formal agency approved plan for implementing it. IHS officials also indicated the agency had not yet determined the extent to which deferral and denial data would continue to be used by IHS headquarters to estimate program need if the FDI method is adopted. However, they indicated that until this decision is made, the agency will continue to collect deferral and denial data from the area offices.

As we noted in our draft, the FDI method would be adapted to provide IHS with an estimate of funding needed to provide care to American Indians and Alaska Natives through the CHS program at a level comparable to the care available through the health insurance program available to federal employees. IHS's Director's Workgroup previously

indicated that reliably captured deferral and denial data on all patients would present the strongest evidence of CHS program need. Given that the proposed FDI methodology is still in early development and IHS plans to continue collecting deferral and denial data, we believe that expeditious implementation of our first five recommendations is vital to ensure the data IHS uses to calculate program need are accurate. With regard to our other three recommendations, HHS described in its comments the steps that IHS would take to develop a written policy on how IHS evaluates CHS program need and provide training to CHS program officials on the process to use when funds are depleted. HHS also indicated that the IHS Director's Workgroup would be providing recommendations for enhancing communication with providers. HHS also provided us with technical comments, which we incorporated as appropriate.

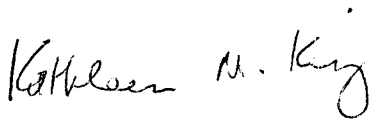
Subsequent to our conversation with HHS and IHS officials, HHS submitted revised comments to our report. In the revisions, HHS clarified that the FDI method represents one of multiple options for estimating unmet need that IHS's Director's Workgroup is considering and clarified that the development of this new methodology is still ongoing. The revisions HHS made to its written comments do not substantively change our response.

We also provided tribal representatives, including the 177 tribal CHS programs we surveyed and the three tribal advocacy groups we interviewed, the opportunity to provide oral comments on a draft of this report. Representatives from 11 tribal CHS programs and two tribal advocacy groups provided comments. The most frequent comment related to our recommendation that IHS provide outreach and technical assistance to tribal CHS programs to encourage them to submit data that can be used to assess CHS program need. Specifically, representatives from 2 tribal CHS programs stated that more technical assistance from IHS would be helpful, because it is important that the needs of the tribal programs be captured in IHS's needs assessment. A tribal advocacy group representative noted that some tribes have chosen not to collect deferral and denial data because of its cost burden. A representative from a tribal CHS program noted the added cost of tracking these data was justified by the benefit they provide to IHS's budget process. In addition, a tribal representative expressed concern that our finding on the accuracy of IHS's estimate of need could be interpreted to suggest that the actual level of need is lower than what IHS is estimating. In our report, we did not examine whether or not IHS's estimate of need over- or under-estimates the actual level of unfunded need, but rather found that the

estimate is not reliable because of deficiencies in the agency's oversight of the collection of unfunded services data.

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO web site at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or kingk@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.



Kathleen M. King
Director, Health Care

List of Addressees

The Honorable Daniel Akaka
Chairman
The Honorable John Barrasso
Ranking Member
Committee on Indian Affairs
United States Senate

The Honorable Don Young
Chairman
The Honorable Dan Boren
Ranking Member
Subcommittee on Indian and Alaska Native Affairs
Committee on Natural Resources
House of Representatives

Jeff Bingaman
Tim Johnson
Lisa Murkowski
John Thune
United States Senate

Appendix I: Scope and Methodology

In this report, we examined (1) the extent to which the Indian Health Service (IHS) ensures the data it collects on unfunded services are accurate to determine a reliable estimate of contract health services (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.

To address part of our work for our first two objectives, we administered two surveys—one each to federal and tribal CHS programs. From March 2010 through August 2010, we obtained lists of federal and tribal CHS programs from each area office, from which we identified 66 federal CHS programs and 177 tribal CHS programs. We administered a web-based survey to all of the federal CHS programs from October 2010 through January 2011. In addition, from September 2010 through January 2011, we administered a mixed-mode survey—both web-based and by mail—to all of the tribal CHS programs; this survey was blinded to maintain the anonymity of respondents. To ensure the clarity and precision of our survey questions, we pretested our federal CHS program survey with officials from IHS and our tribal CHS program survey with officials from three tribal health advocacy groups and a tribal health official. We analyzed complete survey data from all 66 federal CHS programs, for a response rate of 100 percent, and 103 of 177 tribal CHS programs, for a response rate of 58 percent.[1] The results from our survey of tribal CHS programs are not generalizable to all tribal CHS programs because we did not receive responses from all tribal CHS programs and tribal programs vary due to the flexibility tribes have in administering their programs. We relied on the data as reported by the CHS program officials who were identified as the primary contacts for the CHS program and did not independently verify these data or ask IHS to verify them. However, we reviewed all responses for reasonableness and internal consistency. For our survey of federal CHS programs, when necessary, we followed up with the program officials who completed our survey for clarification.

[1]In the case of one analysis of survey data, the federal and tribal surveys asked the respective respondents to provide the three most common health care services that were (1) deferred or denied by federal CHS programs in fiscal year 2009, (2) requested but not funded by tribal CHS programs in fiscal year 2009, and (3) purchased by tribal CHS programs with tribal funds in fiscal year 2009. In our analysis of these data, we grouped the specific reported health care services into categories of health care services for the purposes of reporting the data.

Based on these activities, we determined these data were sufficiently reliable for the purpose of our report.

We also conducted site visits to IHS area offices based in Oklahoma City, Oklahoma and Portland, Oregon in March and April, 2010. During these site visits, we interviewed area office officials and representatives from a total of four federal and eight tribal CHS programs located in those areas. In addition, we interviewed officials from IHS headquarters and each of IHS's 12 area offices to discuss oversight of the CHS program, and spoke with three tribal health advocacy groups. We also examined IHS oversight, such as the provision of policy and guidance, conducted to ensure that CHS programs consistently and completely record and report unfunded services data. We compared these oversight activities to the standards described in the *Standards for Internal Control in the Federal Government* and the *Internal Control Management and Evaluation Tool*.[2] We also reviewed our cost estimating guide to assess procedures for determining a reliable estimate for budgetary purposes.[3]

To examine the experiences of external providers in obtaining payment from the CHS program, we interviewed representatives from hospitals and office-based health care providers from selected IHS areas. We selected four areas from which to identify providers based on their fiscal year 2009 per capita CHS program funding and dependency on CHS funds for hospital services. We estimated per capita funding using the agency's fiscal year 2009 user population estimates and allocation of CHS program funds.[4] To estimate dependency, we used an IHS measure of dependency it uses to allocate certain funds to the area offices. It measures whether patients in an area have practical access to IHS-

[2]GAO/AIMD-00-21.3.1 and GAO-01-1008G. Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

[3]GAO-09-3SP.

[4]According to IHS officials, the agency does not have an estimate of the number of individuals eligible to have their care paid by the CHS program. Therefore, it utilizes a user population estimate that generally represents the count of American Indian and Alaska Native individuals who had at least one direct care or contract health service inpatient stay, ambulatory care visit, or dental visit in the last 3 years.

funded federally and tribally operated hospitals.[5] If the patients do not have access to such facilities, then they are considered to be more dependent on the CHS program for hospital services and therefore, the area receives additional funding. The four areas we selected were Bemidji, Billings, Phoenix, and Oklahoma City,[6] which represent areas that were above or below average for each of our selection criteria. (See table 3.) In fiscal year 2009, the four areas represented 43 percent of the IHS user population and received 37 percent of CHS funding.

Table 2: Categorization of Area Offices by Selection Criteria

Category	Area office	Per capita CHS program funding in fiscal year 2009	Percent of CHS-dependent operating units in fiscal year 2009[a]
Above average funding, above average CHS dependency	Bemidji	$407.35	94.1%
	Nashville	$470.84	92.0%
	Portland	$664.30	100.0%
	California	$399.34	100.0%
Above average funding, below average CHS dependency	Billings	$694.50	62.5%
	Tucson	$579.21	50.0%
	Aberdeen	$557.27	59.1%
	Alaska	$456.01	15.8%
Below average funding, above average CHS dependency	Phoenix	$323.90	72.7%
Below average funding, below average CHS dependency	Oklahoma City	$237.61	32.0%
	Navajo	$286.54	16.7%
	Albuquerque	$347.09	50.0%
Average		**$392.19**	**71.9%**

Source: GAO analysis of IHS documents.

[a]Operating units are the entities at the local level that have financial responsibility for CHS-eligible persons.

[5]According to IHS officials, the agency considers an area to have practical access to a hospital if the hospital maintains a census of more than five patients per day and is less than 90 minutes travel time for most residents of the area.

[6]The Bemidji area includes locations in Indiana, Minnesota, Michigan, and Wisconsin; the Billings area includes locations in Montana and Wyoming; the Phoenix area includes locations in Arizona, California, Nevada, and Utah; and the Oklahoma City area includes locations in Oklahoma, Kansas, and Texas.

Within these four areas, we selected 23 providers—16 hospitals and 7 office-based providers—to interview. Most of these providers were identified through our survey of federal CHS programs as providers who provided the highest volume of care to CHS program users in fiscal year 2009. In addition, we also identified providers who interact frequently with CHS programs through our discussions with state hospital associations and a tribal health advocacy group. Given the small number of providers in our sample and our process for selecting them, the results from these interviews are not generalizable to all providers interacting with the CHS program. We asked providers about their experiences obtaining effective and timely communication related to the payment process, such as training or guidance on determining patient eligibility for CHS program payment of services and determining the status of claims, and compared their experiences with the standards described in the *Standards for Internal Control in the Federal Government* and the *Internal Control Management and Evaluation Tool*.[7] We asked providers a standard set of open-ended questions and we did not independently validate their reported experiences, but we did discuss many of their comments with IHS officials.

We conducted this performance audit from January 2010 to September 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[7]GAO/AIMD-00-21.3.1 and GAO-01-1008G.

Appendix II: Catastrophic Health Emergency Fund

The Indian Health Care Amendments of 1988 established the Catastrophic Health Emergency Fund (CHEF) to meet the medical costs associated with treating catastrophic illnesses or victims of disasters.[1] CHEF is administered centrally within the Indian Health Service (IHS) and reimburses federal and tribal contract health services (CHS) programs on a first-come first-served basis for CHS program cases with costs exceeding the threshold set annually within the range established by law.[2] Specifically, CHS programs pay for the services and then request reimbursement from IHS for expenses over the threshold, which was $25,000 in fiscal year 2009.[3] In fiscal year 2009, IHS reimbursed 1,223 cases at a total cost of $31 million; in fiscal year 2010, IHS reimbursed 1,747 cases at a total cost of $48 million. The top three diagnostic categories funded in fiscal year 2010 were injuries, cancer, and heart disease.

When CHEF funds are depleted, requests for reimbursement are denied by IHS. As part of IHS's needs assessment for the CHS program, the agency determines the number of CHEF requests for reimbursement that were denied and then uses the actual billed charges that were submitted by CHS programs to determine the cost of these services. In fiscal year 2009, IHS denied 1,065 cases totaling $24 million; in fiscal year 2010, it denied 865 cases totaling $14 million. However, IHS speculated that this may underestimate the need for CHEF reimbursement because additional cases may have qualified for CHEF reimbursement, but CHS programs may not have submitted a request for reimbursement due to the depletion of CHEF before the end of the fiscal year.

[1]See 25 U.S.C. § 1621a.

[2]The Indian Health Care Improvement Reauthorization and Extension Act of 2009, enacted by the Patient Protection and Affordable Care Act in March 2010, provided for IHS to set the threshold at $19,000, to be increased each year by a percentage established using a specific formula. See S. 1790, § 122, 111th Cong. 2009 (enacted by Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935 (2010)).

[3]In certain circumstances, CHS programs can submit medical bills below the threshold to IHS and then be reimbursed on an ongoing basis at 50 percent of expenses until the completion of the case.

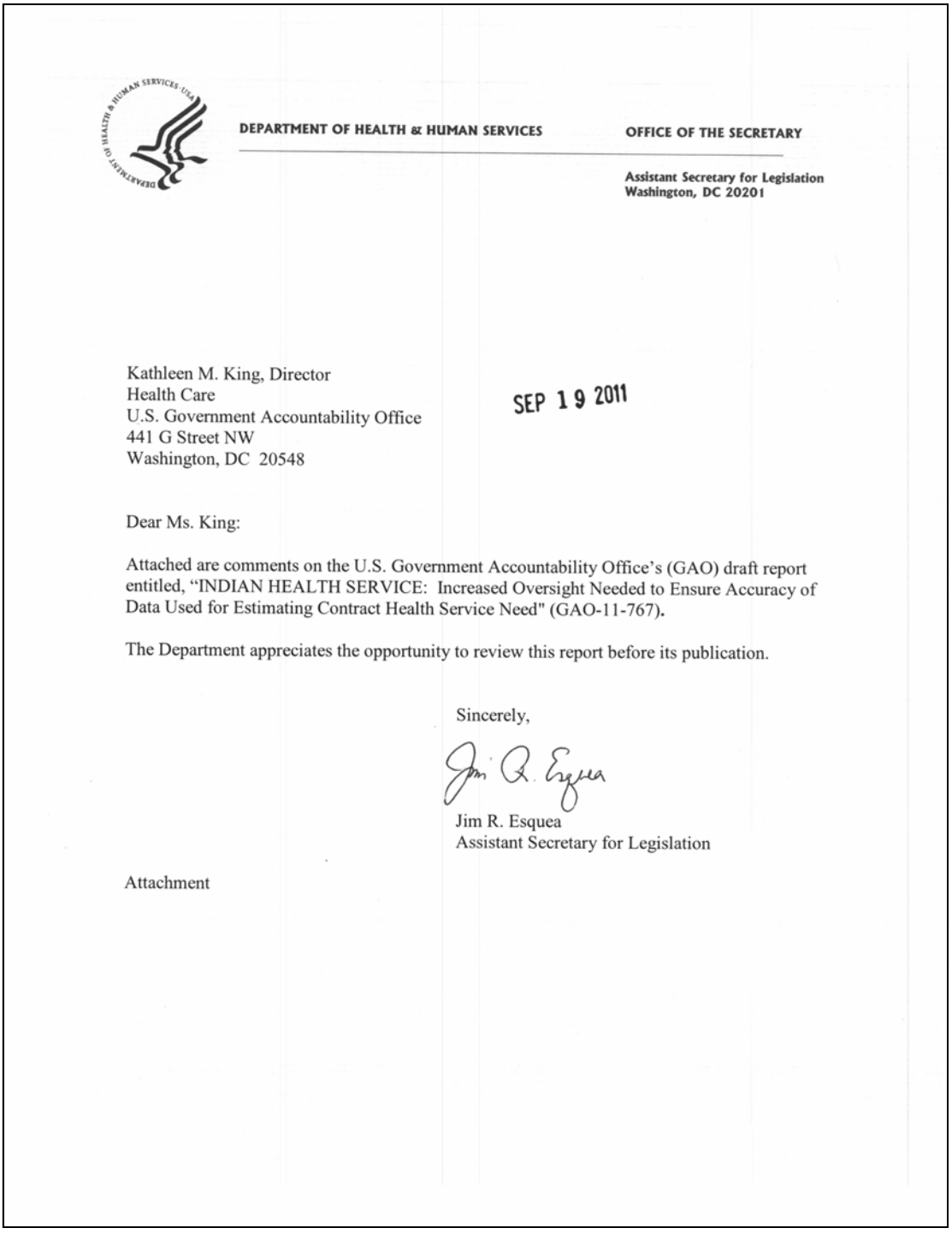
CHEF Survey Data: Federal CHS Programs

Of the 66 federal CHS programs we surveyed, 52 reported that they submitted requests for CHEF reimbursement in fiscal year 2009. Of these, 12 reported that they did not continue to submit requests for CHEF reimbursement once the CHS program learned that CHEF funds were depleted. Of the 66 federal CHS programs we surveyed, 14 reported that they did not submit any requests for CHEF reimbursement in fiscal year 2009. The most common reasons they reported for not submitting requests for CHEF reimbursement were that the CHS program did not experience any cases costing over $25,000 (8 of 14 federal CHS programs) and staffing shortages (5 of 14 federal CHS programs).

CHEF Survey Data: Tribal CHS Programs

Of the 103 tribal CHS programs who responded to our survey, 46 submitted requests for CHEF reimbursement in fiscal year 2009. Fifty-three of the tribal CHS programs reported that they did not submit requests for CHEF reimbursement. The most common reasons they reported for not submitting requests for CHEF reimbursement were that the CHS program did not experience any cases costing over $25,000 (31 of 53 tribal CHS programs) and tribal programs were unable to pay for the first $25,000 of expenses (13 of 53 tribal CHS programs).

Appendix III: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES — OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

Kathleen M. King, Director
Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

SEP 19 2011

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "INDIAN HEALTH SERVICE: Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need" (GAO-11-767).

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

Sincerely,

Jim R. Esquea

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "INDIAN HEALTH SERVICE: INCREASED OVERSIGHT NEEDED TO ENSURE ACCURACY OF DATA USED FOR ESTIMATING CONTRACT HEALTH SERVICE NEED" (GAO-11-767)

The Department appreciates the opportunity to review and comment on this draft report. The Indian Health Service (IHS) acknowledges that oversight activities related to the identification of Contract Health Service (CHS) unmet need estimates have not been carried out to the extent described in the GAO's Standards for Internal Control in the Federal Government.

Procedures described and reviewed during this engagement reflect IHS' response to questions regarding the estimated additional dollar amount needed to fund all Priority I cases (the unmet need). As cited in the report, the IHS has established a workgroup to evaluate methods to quantify the need due to increased interest in CHS program unmet need. The IHS will establish appropriate management controls once the CHS workgroup recommendation for the methodology for determining CHS unmet need is finalized.

The report states that data that IHS collected from CHS programs were incomplete and inconsistent. It concludes that "a reliable estimate of need will require complete and consistent data from each of the individual CHS programs." We agree that reporting has been incomplete and inconsistent. We agree that additional funds needed for CHS could be reliably calculated if all denied or deferred cases were universally and uniformly reported. We believe that sufficiently reliable estimates of CHS funding needs may also be calculated using methods and data that are independent of denial and deferral counts reported by individual CHS programs.

The CHS workgroup is reviewing several options for estimating the CHS need. One option under discussion that can estimate the need with reasonable, although not absolute assurance, is the Federal Disparity Index (FDI) method which is used by the IHS already to estimate resource needs for the IHS user population. The FDI based alternative approach to calculating needs is referenced on page 21-23 of your report. The FDI method can be adapted to calculate CHS resources as a sub-set of total needed health care resources. Such estimates are sufficiently reliable for annual CHS budget requests and other purposes. Adapting the FDI method for this purpose will not impose significant new data collection burdens.

GAO Recommendations

To develop more accurate data for estimating the funds needed for the CHS program and improving IHS oversight, we recommend that the Secretary of Health and Human Services direct the Director of IHS to take the following eight actions:

- *ensure that area offices submit data on unfunded services from all federal CHS programs;*
- *conduct outreach and technical assistance to tribal CHS programs to encourage and support their efforts to voluntarily provide data that can be used to better estimate the needs of tribal CHs programs;*
- *develop an annual data reporting template that requires area offices to report available deferral and denial counts for each federal and tribal CHS program;*
- *develop a plan and timeline for improving the agency's deferral and denial data;*

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "INDIAN HEALTH SERVICE: INCREASED OVERSIGHT NEEDED TO ENSURE ACCURACY OF DATA USED FOR ESTIMATING CONTRACT HEALTH SERVICE NEED" (GAO-11-767)

- *develop written guidance, provide training, and conduct oversight activities necessary to ensure unfunded services data are consistently and completely recorded by federal CHS programs;*
- *develop a written policy documenting how IHS evaluates need for the CHS program and disseminate it to area offices and CHS programs to ensure they understand how unfunded services data are used to estimate overall program needs;*
- *provide written guidance to CHS programs on a process to use when funds are depleted and there is a continued need for services, and monitor to ensure that appropriate actions are taken; and*
- *develop ways to enhance CHS program communication with providers, such as providing regular trainings on patient eligibility and claim approval decision to providers.*

Concerning the first five recommendations, the CHS workgroup is discussing options for estimating unmet need and are conducting a pilot study of one such option. The workgroup will review the pilot study and make recommendations to the IHS Director.

In response to the last three recommendations, we offer the following comments:

- The IHS will develop a written policy on how IHS evaluates CHS need and disseminate it to Area offices to ensure they understand how unfunded services data are used to estimate CHS need. This will be accomplished after the Director has approved the method for estimating CHS need.

- The IHS currently has a policy on the process to use when funds are depleted and there is a continued need for services which will be provided to all CHS program Officers. CHS program officers will provide training on the Agency's policy regarding use of funds.

- The IHS has developed a provider training manual for use in educating providers on CHS patient eligibility and claim approval processes. The Directors Workgroup on Improving CHS will provide recommendations for improving and enhancing CHS program communication with providers.

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Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Kathleen M. King, Director, (202) 512-7114 or kingk@gao.gov

Staff Acknowledgments

In addition to the contact names above, Catina Bradley, Martha Kelly, and Suzanne Worth, Assistant Directors; George Bogart; Zhi Boon; William Hadley; Giselle Hicks; Darryl Joyce; Hannah Locke; Sarah-Lynn McGrath; Jasleen Modi; Lisa Motley; Laurie Pachter; and Mario Ramsey made key contributions to this report.

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