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INDIAN HEALTH SERVICE

Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program

GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-446, a report to congressional addressees

Why GAO Did This Study

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 CHS program pays for care from non-IHS providers if the patient meets certain requirements and funding is available. The Patient Protection and Affordable Care Act requires GAO to study the administration of the CHS program, including a focus on the allocation of funds. IHS uses three primary methods to determine the allocation of CHS funds to the 12 IHS geographic area offices: base funding, which accounts for most of the allocation; annual adjustments; and program increases, which are provided to expand the CHS program. GAO examined (1) the extent to which IHS's allocation of CHS funding varied across IHS areas, and (2) what steps IHS has taken to address funding variation within the CHS program. GAO analyzed IHS funding data, reviewed agency documents and interviewed IHS and area office officials.

What GAO Recommends

GAO suggests that Congress consider requiring IHS to develop and use a new method to allocate all CHS program funds to account for variations across areas, notwithstanding any restrictions now in federal law. GAO also recommends, among other things, IHS use actual counts of CHS users in methods for allocating CHS funds. HHS concurred with two of GAO's recommendations, but did not concur with the recommendation to use actual counts of CHS users. GAO believes that its recommendation would provide a more accurate count of CHS users.

View GAO-12-446. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The Indian Health Service's (IHS) allocation of contract health services (CHS) funds varied widely across the 12 IHS geographic areas. In fiscal year 2010, CHS funding ranged from nearly $17 million in one area to more than $95 million in another area. Per capita CHS funding for fiscal year 2010 also varied widely, ranging across the areas from $299 to $801 and was sometimes not related to the areas' dependence on CHS inpatient services, as determined by the availability of IHS-funded hospitals. The allocation pattern of per capita CHS funds has been generally maintained from fiscal year 2001 through fiscal year 2010. This is due to the reliance on base funding—which incorporates all CHS funding from the prior year to establish a new base each year—and accounts for the majority of funding. In fiscal year 2010, when CHS had its largest program increase and base funding was the smallest proportion of funding for any year, base funding still accounted for 82 percent of total CHS funds allocated to areas. Further, allocations of program increase funds are largely dependent on an estimate of CHS service users that is imprecise. IHS counts all users who obtained at least one service either funded by CHS or provided directly from an IHS-funded facility during the preceding 3-year period. This count therefore includes an unknown number of individuals who received IHS direct care only and who had not received contract health services.

IHS has taken few steps to evaluate funding variation within the CHS program and IHS's ability to address funding variations is limited by statute. IHS officials told GAO that the agency has not evaluated the effectiveness of base funding and the CHS Allocation Formula. Without such assessments, IHS cannot determine the extent to which the current variation in CHS funding accurately reflects variation in health care needs. While IHS has formed a workgroup to evaluate the existing formula for allocating program increases, the workgroup recommended, and the Director of IHS concurred, that the CHS Allocation Formula for distributing program increases would not be evaluated until at least 2013. The workgroup members maintained that the CHS program had only begun receiving substantial increases in fiscal years 2009 and 2010, and the full impact of these increases needed to be reviewed before making recommendations to change the formula. However, GAO found that IHS has used the formula to allocate program increases, at least in part, in 5 years since 2001. GAO also concluded that, because of the predominant influence of base funding and the relatively small contribution of program increases to overall CHS funding, it would take many years to achieve funding equity just by revising the methods for distributing CHS program increase funds. Further, federal law restricts IHS's ability to reallocate funding, specifically limiting reductions in funding for certain tribally-operated programs, including some CHS programs, and imposing a congressional reporting requirement for proposed reductions in base funding of 5 percent or more. According to IHS officials, no such IHS proposal to reallocate base funding has ever been transmitted to the Congress.