

April 2013

INDIAN HEALTH SERVICE

Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services



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Why GAO Did This Study

IHS 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 external providers. Hospitals are required to accept Medicare rates from federal and tribal CHS programs, while physicians and other nonhospital providers are paid at either billed charges or negotiated, reduced rates. The Patient Protection and Affordable Care Act requires GAO to compare CHS program payment rates with those of other public and private payers. GAO examined (1) how payments to physicians by IHS's federal CHS programs compare with what Medicare and private health insurers would have paid for the same services, (2) physicians' perspectives about how a cap on payment rates could affect them, (3) hospitals' perspectives about how the MLR requirement affected them, and (4) IHS and tribal officials' perspectives about the MLR requirement and a potential cap on nonhospital services. GAO compared 2010 physician claims data for federal CHS programs with the Medicare Physician Fee Schedule and claims from private insurers. GAO also spoke to a nongeneralizable sample of 10 physicians and 9 hospitals that interacted frequently with IHS and spoke to IHS and tribal officials where these providers practiced.

What GAO Recommends

Congress should consider capping CHS program payments for nonhospital services, including physician services, at rates comparable to other federal programs. Should Congress cap payments, we recommend HHS direct IHS to monitor access to care.

View [GAO-13-272](#). For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

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What GAO Found

The Indian Health Service's (IHS) federal contract health services (CHS) programs primarily paid physicians at their billed charges, which were significantly higher than what Medicare and private insurers would have paid for the same services. IHS's policy states that federal CHS programs should purchase services from contracted providers at negotiated, reduced rates. However, of the almost \$63 million that the federal CHS programs paid for physician services provided in 2010, they paid about \$51 million (81 percent) to physicians at billed charges and about \$12 million (19 percent) to physicians at negotiated, reduced rates. Payments for other types of nonhospital services followed similar trends, with about \$40 million out of \$52 million (77 percent) paid at billed charges. GAO estimated that IHS's federal CHS programs paid two times as much as what Medicare would have paid and about one and a quarter times as much as what private insurers would have paid for the same physician services provided in 2010. If federal CHS programs had paid Medicare rates for these services, they could have used an estimated \$32 million in savings to pay for many of the services that IHS is unable to fund each year. Savings for the overall CHS program may be even higher, as this analysis does not include other types of nonhospital services or the CHS program funding that goes to tribal CHS programs, which the Department of Health and Human Services' (HHS) Office of Inspector General found also paid for nonhospital care above Medicare rates.

Although the 10 physicians GAO interviewed were among those most frequently paid by federal CHS programs, 8 said their CHS program payments constituted 10 percent or less of their total payments. Some physicians identified ways that capping CHS program payments for nonhospital services, including physician services, at Medicare rates could benefit the CHS program and physician practices. However, other physicians were concerned that reducing payment rates to Medicare levels could negatively affect their practices.

Seven of nine hospitals GAO interviewed said the Medicare-like rates (MLR) required by statute had little negative effect, generally because they already had contracts with the CHS program to be paid Medicare rates. While two hospitals previously paid by the CHS program at or near billed charges said they were financially affected by the MLR requirement, both said it had not affected their delivery of care to CHS program patients.

IHS and tribal officials GAO interviewed said the MLR requirement for hospital services generated savings that allowed CHS programs to expand access to health care. They said that a cap on nonhospital service payments, including physician services, could have benefits and challenges. Most IHS officials indicated that it was unlikely they could negotiate many more contracts. Some tribal officials said that some physicians might think Medicare rates were too low and decide to no longer accept tribal patients, although they agreed that a cap at these rates could save money. IHS officials noted, however, that they would not be able to implement a cap for nonhospital services, including physician services, unless the agency received explicit statutory authority to do so.

HHS stated in its comments that it concurred with GAO's conclusions and recommendation and added that imposing a cap at Medicare rates would allow IHS to fund additional services.

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Abbreviations

BCBSNM	BlueCross BlueShield of New Mexico
CAH	critical access hospital
CHEF	Catastrophic Health Emergency Fund
CHS	contract health services
CHSDA	CHS Delivery Area
CMS	Centers for Medicare & Medicaid Services
DOD	Department of Defense
EMTALA	Emergency Medical Treatment and Active Labor Act
HHS	Department of Health and Human Services
IHS	Indian Health Service
MedPAC	Medicare Payment Advisory Commission
MLR	Medicare-like rates
OIG	Office of Inspector General
VA	Department of Veterans Affairs

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United States Government Accountability Office
Washington, DC 20548

April 11, 2013

Congressional Addressees

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), is charged with providing health care services to the approximately 2.1 million American Indians and Alaska Natives who are members or descendants of federally recognized tribes.¹ These services are provided through direct care at federally or tribally operated facilities—such as hospitals and health centers. When services are unavailable at these facilities, the facilities may use IHS contract health services (CHS) program funds to pay for patients to obtain services from external providers, including hospitals and office-based physicians. The CHS program at each individual facility may be federally or tribally operated and is responsible for managing program funds. However, our prior work has found that available CHS program funds have not been sufficient to ensure access to care for American Indians and Alaska Natives.² In 2005, we reported that the CHS program was not able to pay for all eligible services, and that these gaps sometimes resulted in diagnosis and treatment delays that could exacerbate the severity of a patient's condition and thus the need for more intensive treatment.³ Since then, funding for the CHS program has increased from \$498 million in fiscal year 2005 to almost \$845 million in fiscal year 2012. However, we recently reported that the CHS programs at federal and tribal facilities continue to be unable to pay for all eligible services.⁴

¹IHS 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.

²The CHS program is funded through the annual appropriations process and must operate within the limits of its appropriations. Appropriations to IHS for the CHS program 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.

³GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, [GAO-05-789](#) (Washington, D.C.: Aug. 31, 2005).

⁴GAO, *Indian Health Service: Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need*, [GAO-11-767](#) (Washington, D.C.: Sept. 23, 2011).

This inability to pay for all eligible care underscores the need for the agency to maximize its use of resources, and thus attention has been paid to the rates the CHS program pays external providers. Providers set billed charges—the amounts they bill before any negotiated rates are applied—but the payments they receive vary by payer. Historically, the CHS program paid providers for services at either their billed charges or at lower rates negotiated with the providers. In comparison, Medicare and private insurance are two of the largest sources of revenue for many providers.⁵ Medicare pays providers according to a formula that includes several factors, such as geographic location, and private insurers typically have contractual arrangements with providers under which they negotiate lower payment rates for services on behalf of their members or beneficiaries. In 1986, IHS issued a policy stating that it should not contract to pay more for services than other federal programs and that it would contract to purchase services only with providers that agreed to accept negotiated rates no higher than those paid by Medicare,⁶ which covered almost 49 million people in 2011. The policy also stated that it should only use noncontracted providers in certain situations. However, in 1999, HHS's Office of Inspector General (OIG) reported that the CHS program continued to pay most providers at rates that were higher than those paid by Medicare.⁷ It also reported that, because of the nature of care provided (often specialty or emergency services), IHS was not always able to consider costs when purchasing services from providers and that, because of the voluntary nature of the policy, many providers did not respond to IHS's requests to negotiate reduced rates.

In 2003, the Congress established a payment rate cap on CHS program payments for hospital services so the program could use the resulting savings to expand patient access to care. Specifically, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required that Medicare-participating hospitals accept patients of both federally and

⁵Medicare is the federal government's health insurance program for individuals aged 65 and older and for individuals with certain disabilities or end-stage renal disease.

⁶51 Fed. Reg. 23,540 (June 30, 1986). The policy stated that while tribal programs were encouraged to adopt cost-containment measures, the policy applied only to federal CHS programs.

⁷Department of Health and Human Services, Office of Inspector General, *Review of the Indian Health Service's Contract Health Services Program* (Washington, D.C.: Jan. 21, 1999).

tribally operated CHS programs and accept payment at no more than Medicare rates—referred to as Medicare-like rates (MLR)—for services provided.⁸ IHS implemented this MLR requirement in July 2007. This requirement did not apply to physician services, including those provided in hospitals, or to services by providers at other nonhospital service locations.⁹ For care in these other settings, physicians and other nonhospital providers would continue to be paid at either their billed charges or at negotiated rates below their billed charges.

In a September 2009 follow-up report, the OIG found that about 71 percent of payments for nonhospital claims were paid at rates higher than the Medicare rates.¹⁰ It also reported that both federal and tribal CHS programs faced challenges trying to negotiate lower rates with providers, especially in rural areas with few providers. On the basis of these results, the OIG recommended that IHS seek legislative authority to cap CHS program payments for nonhospital providers. In a September 2009 study, IHS estimated that from fiscal years 2006 through 2008, federal CHS programs paid a total of about \$195 million to nonhospital providers, which was about \$85 million more than if these services had been paid at the Medicare rates. As of January 2013, IHS had not addressed the OIG’s recommendation to seek legislative authority to cap CHS program payments to nonhospital providers.

The Patient Protection and Affordable Care Act requires GAO to study the amounts paid for health care furnished by providers under the CHS program, including a comparison with the rates paid by other public and private payers.¹¹ To respond to this mandate, this report examines

⁸Pub. L. No. 108-173, § 506, 117 Stat. 2066, 2294-95 (2003).

⁹Other nonhospital providers, for which the MLR requirement does not apply, include independent laboratories, ambulatory surgical centers, and independent ambulance providers.

¹⁰Department of Health and Human Services, Office of Inspector General, *IHS Contract Health Services Program: Overpayments and Potential Savings* (Washington, D.C.: September 2009).

¹¹This work was also identified in a March 2009 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. 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. § 199 (2009).

(1) how payments to physicians by IHS's federal CHS programs compare with what Medicare and private health insurers would have paid for the same services, (2) physicians' perspectives about how a federally required cap on payment rates could affect them, (3) hospitals' perspectives about how the MLR requirement has affected them, and (4) IHS and tribal perspectives about the effect of the MLR requirement on hospitals and the potential effect of a MLR requirement on nonhospital services.

To examine how payments to physicians by IHS's federal CHS programs compare with what Medicare and private health insurers would have paid for the same services, we obtained paid federal CHS program claims from IHS for health care services provided in calendar year 2010, the most recent year for which the most complete data were available. These claims data did not include claims paid by tribal CHS programs.¹² We examined payments for physician and other nonhospital services, which were not subject to the MLR requirement. We excluded services for which the patient had another form of insurance, because the CHS program is generally a payer of last resort and the federal CHS programs' payments would have reflected only the remaining balances after payments from the primary payers. There were 372,840 nonhospital services where federal CHS programs were the primary payer; payments for these services constituted about 44 percent of total payments for all services provided by federal CHS programs in 2010. From this group of nonhospital services, we isolated physician services. Specifically, we excluded nonhospital services that were not covered by the 2010 Medicare Physician Fee Schedule.¹³ We also excluded services provided by anesthesiologists because the information collected by IHS about these services did not contain all of the information necessary to

¹²The federal CHS programs account for approximately 46 percent of total CHS program payments, and their claims are administered by a single fiscal intermediary that contracts with IHS. We did not examine claims data from the tribal CHS programs, which account for the remaining 54 percent of total CHS program payments. Tribal CHS programs operate their programs independently and do not use a single fiscal intermediary.

¹³The Medicare Physician Fee Schedule contains fees for each of over 7,000 physician services, such as office visits, surgical procedures, and tests. Each service is identified by a single billing code from the Healthcare Common Procedure Coding System, which is a standardized coding system that physicians use to bill for procedures provided in the delivery of health care. A single claim may contain multiple services. Other nonhospital services, such as ambulatory surgical center services, are priced by Medicare using different methodologies.

determine comparable Medicare rates. There were 246,273 remaining physician services where federal CHS programs were the primary payer, constituting about 24 percent of total payments for all services provided by federal CHS programs in 2010.¹⁴ For each physician service, we compared the CHS program payment amount to the corresponding rate on the 2010 Medicare Physician Fee Schedule. When determining the Medicare rates, we priced the services as they were identified in the CHS program claims and we did not independently verify the accuracy or completeness of the CHS program claim information.¹⁵ As Medicare does, we adjusted the payment rate for a given service according to the physician's geographic location and the service setting, such as whether the service was provided in a hospital or a physician's office.¹⁶ We also compared the CHS program payments for physician services with those of private insurers. To estimate the rates that private insurers paid, we obtained the Truven Health Analytics MarketScan® Commercial Claims and Encounters Database, which contains claims paid by 100 insurers and includes enrollees located in 50 states in 2010. To account for any variation in payments due to geographic location, we compared only those physician services from the federal CHS program claims data that were provided in the same county as those in the private insurance claims data. Of the 246,273 total physician services in the federal CHS

¹⁴These physician services comprised about 55 percent of the nonhospital services for which the CHS program was the primary payer.

¹⁵In addition, when pricing these services, we applied Medicare payment modifiers that were also used by IHS's fiscal intermediary when paying contracted physicians at Medicare rates. These modifiers included modifiers for the technical and professional components, as well as modifiers for assistant at surgery, bilateral surgery, and co-surgeon. In addition, we applied Medicare's diagnostic imaging adjustment, which requires that payment for certain imaging services under the Medicare Physician Fee Schedule not exceed what Medicare pays for these services performed in hospital outpatient departments. We did not apply Medicare policies that aim to reduce inappropriate payments, such as those developed by the National Correct Coding Initiative, Medicare incentive payments, such as bonuses for services provided in a Health Professional Shortage Area, or Medicare coverage policies, such as national coverage determinations.

¹⁶IHS's claims processing system does not collect the information necessary for us to determine whether a physician service should be paid at facility (such as a hospital) or nonfacility (such as a physician's office) Medicare rates. When paying contracted physicians at Medicare rates, IHS categorizes all physician claims as nonfacility, even if they were provided in a facility. Therefore, we used a combination of other variables to approximate whether the service was provided in a facility. This methodology may not have identified all facility claims. Since Medicare generally pays less for services provided in a facility, our estimate of what Medicare would have paid for these same services may be higher than we would have estimated if this information were available.

program claims data, we identified 231,099 (about 94 percent) services that were paid for by private insurers in the same counties. For each county, we calculated an average rate paid by private insurers for a service and compared that average rate with the federal CHS programs' payment for that service. We priced the services as they were identified in the CHS program and private insurer claims and we did not independently verify the accuracy or completeness of either payer's claim information. We assessed the reliability of IHS's federal CHS program claims data, the Medicare Physician Fee Schedule data, and the Truven Health Analytics MarketScan® Commercial Claims and Encounters Database by reviewing documentation and discussing the database with knowledgeable officials. We also performed data reliability checks, such as examining the data for missing values and obvious errors, to test the internal consistency and reliability of the data. After taking these steps, we determined the data were sufficiently reliable for our purposes.

To examine physicians' perspectives about how a federally required cap on payment rates could affect them, we interviewed a sample of 10 physicians paid by federal CHS programs for services provided in 2010.¹⁷ To identify physicians located on or near reservations, we limited our selection to those physicians located in counties designated by IHS as CHS Delivery Areas (CHSDA).¹⁸ Of these, to ensure that our sample was geographically diverse and contained physicians who interacted frequently with federal CHS programs, we divided the physicians into groups according to their urban or rural location¹⁹ and identified the top 25 percent of physicians according to their volume of paid CHS program services provided in 2010. This gave us a list of 101 rural physicians and a list of 757 urban physicians who interacted the most frequently with

¹⁷For the purpose of these interviews, the term "physician" refers to an entity, rather than an individual. The entities that we selected using CHS program claims data could have been a single physician or a physician group. After we initially contacted the selected entity, we were directed to the most appropriate individual to interview about payment issues. These identified individuals included the physician, the physician's billing staff, or administrative staff.

¹⁸Residence in a CHSDA is generally a requirement for individuals to have their services paid through the CHS program. (See fig. 1 for a map of counties designated by IHS as CHSDAs.)

¹⁹We identified counties as urban or rural according to the U.S. Department of Agriculture's rural-urban continuum coding system. Specifically, we defined urban counties as those with a population of 20,000 or more. We defined rural counties as those with a population of less than 20,000.

federal CHS programs. From each list, we selected 4 rural physicians and 6 urban physicians, 2 of whom we selected from among the top 5 percent of each list on the basis of their claims volume.²⁰ The physicians we interviewed represented a range of specialties, including radiology, cardiology, ophthalmology, surgery, and primary care. Of the 10 physicians we selected, 5 worked in group practices, 3 in solo practices, 1 was a rural health clinic, and 1 was a billing-services company that provided those services to the selected physician and more than 60 other clients. Given the small number of physicians in our sample and our process for selecting them, the results from these interviews are not generalizable to all physicians interacting with the CHS program. We asked physicians a standard set of open-ended questions and did not independently validate their reported experiences.²¹

To examine hospitals' perspectives about how the MLR requirement has affected them, we interviewed officials from a sample of 10 hospitals that were paid by federal CHS programs for services provided in 2010. As with our selection of physicians, we limited our selection to those hospitals located in CHSDAs and divided the hospitals into groups according to their urban or rural location.²² Then, we identified the top 25 percent of hospitals according to their volume of paid CHS program services provided in 2010. This gave us a list of 27 rural hospitals and a list of 34 urban hospitals that interacted the most frequently with federal CHS programs. From each list, we selected 5 hospitals, 2 of which we selected from among the top 5 percent of each list on the basis of their claims volume. At each hospital, we interviewed officials identified as knowledgeable about that hospital's finances and interactions with CHS programs. While we interviewed 10 hospitals, we reported on the perspectives of 9 because the officials at 1 hospital had limited

²⁰We planned to select 5 physicians from each list. Because of a low response rate among rural physicians, we ultimately interviewed 4 rural physicians and 6 urban physicians.

²¹Although these physicians were selected on the basis of their interactions with federally operated CHS programs, their comments could pertain to either federal or tribal CHS programs, as some physicians interacted with both types of programs and we did not ask them to differentiate between program type during the interviews.

²²We identified counties as urban or rural according to the U.S. Department of Agriculture's rural-urban continuum coding system. Specifically, we defined urban counties as those with a population of 20,000 or more. We defined rural counties as those with a population of less than 20,000.

experience with CHS programs. Given the small number of hospitals in our sample and our process for selecting them, the results from these interviews are not generalizable to all hospitals interacting with CHS programs. We asked hospitals a standard set of open-ended questions and did not independently validate their reported experiences.²³

To examine IHS and tribal perspectives about the effect of the MLR requirement on hospitals and the potential effect of a MLR requirement on nonhospital services, we interviewed IHS area office officials to obtain their perspectives on payment rates, patient access to care, and rate negotiation efforts. We selected the six area offices—Aberdeen, Albuquerque, Bemidji, Billings, Navajo, and Oklahoma City—from which our interviewed hospitals and physicians received payment for the majority of the services they provided to the federal CHS programs in 2010.²⁴ These six area offices represented 84 percent of payments by federal CHS programs in 2010. We also interviewed tribal officials, including representatives of tribal CHS programs, from several of these areas and the California area, where all CHS programs are tribally operated. Given the small number of tribal officials in our sample and our process for selecting them, the results from these interviews are not generalizable to all tribes interacting with CHS programs. We asked the tribal and IHS area office officials a standard set of open-ended questions and did not independently validate their reported experiences.

We conducted this performance audit from November 2011 to April 2013 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.

²³Although these hospitals were selected on the basis of their interactions with federally operated CHS programs, their comments could pertain to either federal or tribal CHS programs, as some hospitals interacted with both types of programs and we did not ask them to differentiate between program type during the interviews.

²⁴IHS's 12 area offices are Aberdeen, Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

Background

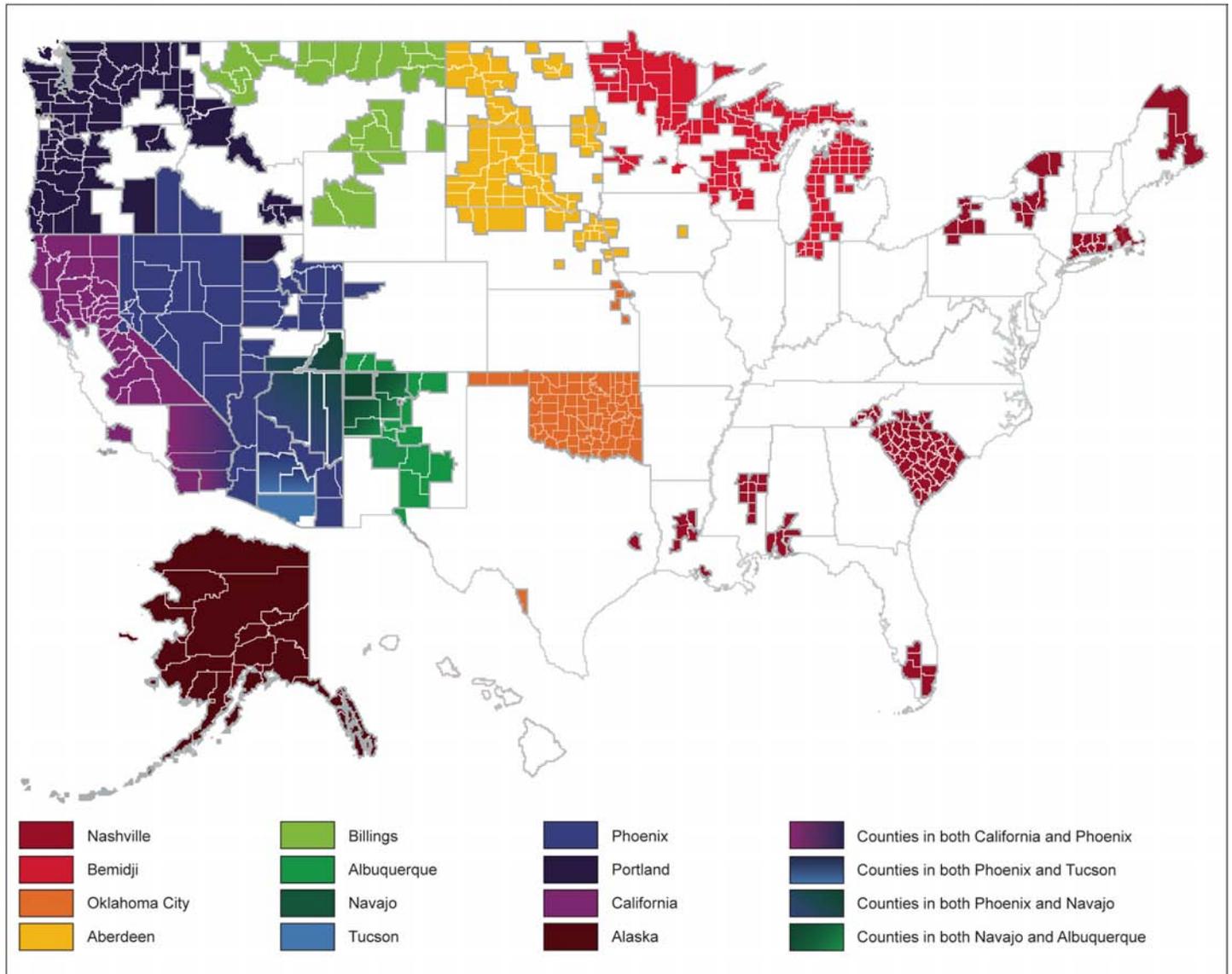
IHS oversees the CHS program through 12 area offices. The federally and tribally operated facilities in each of these areas use CHS program funds to purchase health care services from external hospitals, physicians, and other providers. Medicare-participating hospitals are required to accept CHS program patients at rates no higher than the rates paid by the Centers for Medicare & Medicaid Services' (CMS) Medicare program, while federal and tribal CHS programs pay physicians and other nonhospital providers at either their billed charges or at reduced rates an IHS area office or tribal CHS program negotiates with them. Other federal health care programs—administered by the Department of Defense (DOD) and the Department of Veterans Affairs (VA)—have adopted Medicare rates as the basis for their standard payment rate for both hospital and nonhospital services.

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 IHS designates as CHSDAs. Residence in these counties is generally a requirement for obtaining contract health services.) About 46 percent of CHS program funds are distributed by IHS to federal CHS programs, and the other 54 percent to tribal CHS programs. 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.²⁵

²⁵Under 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 because of their status as 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. 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).

Figure 1: Counties Designated as CHS Delivery Areas (CHSDA) in the 12 IHS Areas



Source: GAO analysis of IHS information.

Notes: While CHSDAs are typically counties, the city of Elton, Louisiana is also designated as a CHSDA in the Nashville area. Information is as of January 2013.

Funds permitting, federal and tribal facilities use CHS program funds to pay for eligible patients to receive 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. Patients must meet certain requirements to have their services paid for by the CHS program. For example, patients must be members of federally recognized tribes and live in specific areas. If these requirements are met, CHS program committees at each federal or tribal facility evaluate the medical necessity of each patient case and assign it a priority level.²⁶ Facilities first pay for the highest priority services. If there are other health care resources available to the patient, such as Medicare, Medicaid, or private health insurance, these resources must first be used to pay for services before the CHS program covers any remaining costs because the CHS program is generally the payer of last resort.²⁷ For federal CHS programs, once the service has been approved and the care provided, providers obtain payment for CHS program services by sending their claims to IHS's fiscal intermediary, BlueCross BlueShield of New Mexico (BCBSNM). BCBSNM processes claims for all of the federal CHS programs. The tribal CHS programs process their own claims or contract with a fiscal intermediary of their choosing; a small number of tribal programs contract with BCBSNM.

CHS Program Payment Rates

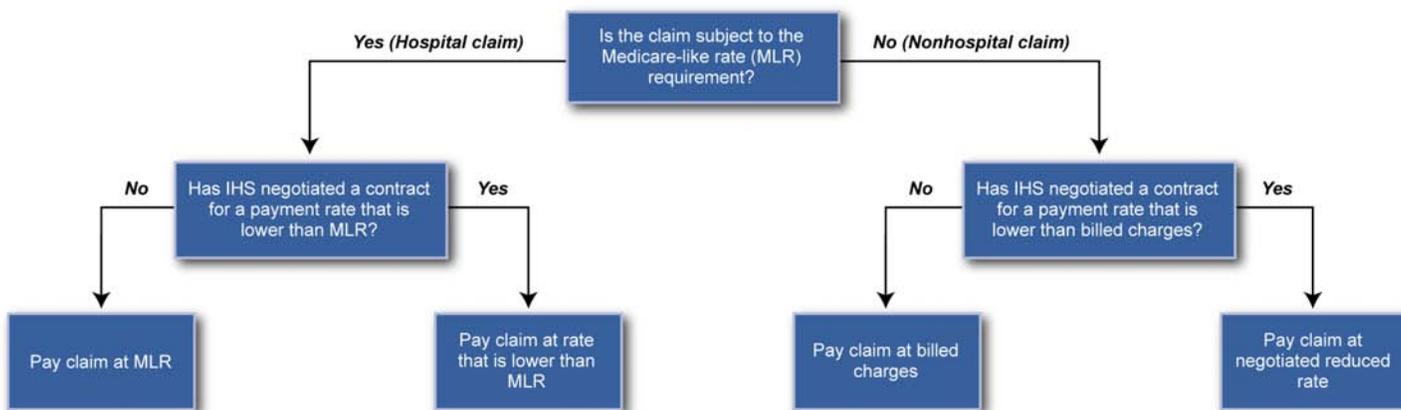
The rate that a CHS program pays a provider is determined by several factors, including whether the provider is a hospital subject to MLR reimbursement or the provider has negotiated reduced payment rates with IHS or the tribe. (See fig. 2.) CHS program payments for hospital services—inpatient and outpatient services provided in Medicare-participating hospitals—are subject to the MLR requirement. IHS generally calculates the MLR using the same methodology that Medicare uses to pay its claims, so the amount the CHS program pays for a service

²⁶IHS 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. Priority level I services are the highest priority services and include emergent/acute care services, such as trauma care, acute/chronic renal replacement therapy, obstetrical delivery, and neonatal care.

²⁷See 25 U.S.C. §§ 1621e, 1623; 42 C.F.R. § 136.61. 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.

generally equals the amount that Medicare would pay the hospital for that same service. CHS program payments to providers for nonhospital services—including services provided by hospital- and office-based physicians—are not subject to the MLR requirement.²⁸ Each CHS program pays these providers at their billed charges unless the IHS area office has negotiated with the provider for a reduced rate. Each IHS area office can negotiate contracts with the providers that serve the CHS programs in its geographic area. Tribally operated facilities are independent and may negotiate their own contracts with providers. However, IHS officials said that when they negotiate with providers, they may ask those providers to honor the negotiated rates when they interact with tribal CHS programs.

Figure 2: Overview of IHS’s Process for Determining CHS Program Payments



Source: GAO analysis of IHS documents.

In 1986, IHS issued a policy advising area offices to negotiate rates no higher than Medicare rates.²⁹ In discussing the need for the policy, IHS noted that paying providers for CHS program services at billed charges resulted in a depletion of funding that often required the postponement of needed care for American Indians and Alaska Natives. The agency also noted that IHS should not pay more than other federal agencies for the

²⁸Other types of nonhospital services include those provided by independent laboratories, free-standing ambulatory surgical centers, and independent ambulance providers.

²⁹51 Fed. Reg. 23,540 (June 30, 1986).

same services. The agency recommended that area offices identify and prioritize high-volume providers with whom to negotiate lower rates.³⁰ In addition, the agency indicated that contracts negotiated with providers for payments at rates higher than those paid by Medicare, such as a discount off billed charges or a percentage above Medicare rates, would be approved by IHS on a case-by-case basis. Further, the agency stated that CHS programs should only use providers that do not have a contract with the CHS program in two situations: if a patient needs emergency care and if the patient's health requires that the services be rendered by a noncontract provider. However, IHS has since stated it has not been possible to negotiate contracts with each of the providers that the CHS program uses because of limitations in area office contracting staff and some providers not being willing to enter into a contract.³¹

Federal CHS Program Payments for Services Provided in 2010

For services provided in calendar year 2010, IHS's federal CHS programs paid \$262.8 million to 6,113 providers for services for 66,750 patients. Of these payments, federal CHS programs paid \$104.0 million (about 40 percent of total payments) for hospital services where the CHS program was the primary payer and about \$114.7 million (about 44 percent of total payments) for nonhospital services where the CHS program was the primary payer.³² Of these payments for nonhospital services, the federal CHS programs paid \$62.5 million (about 55 percent) for hospital- and office-based physician services.³³ (See fig. 3.)

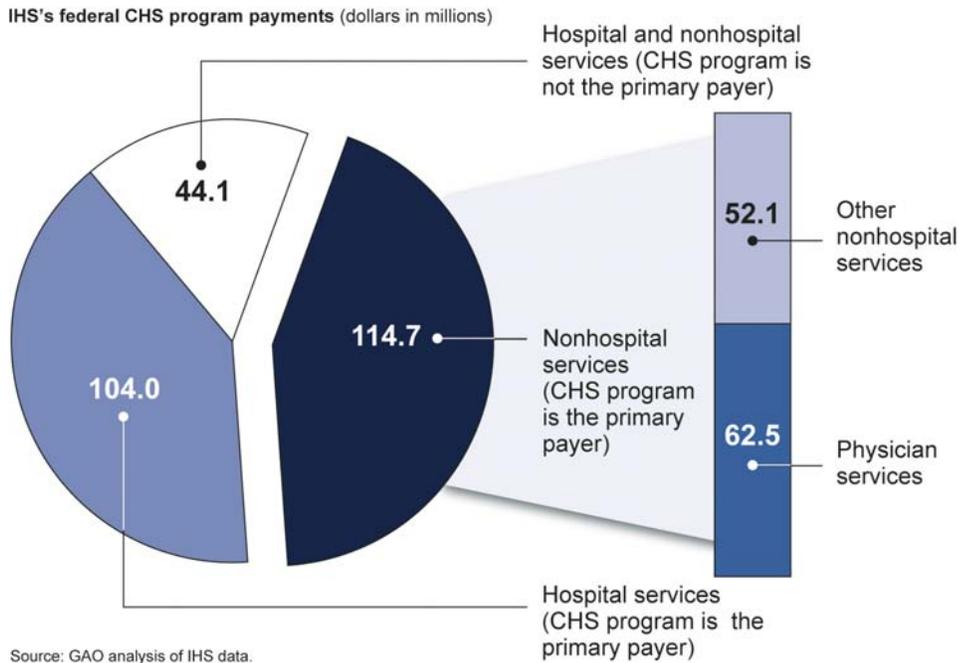
³⁰Indian Health Manual, ch. 5, Acquisition Management, pt. 5, Management Services.

³¹56 Fed. Reg. 10,566 (Mar. 13, 1991).

³²Federal CHS programs paid the remaining \$44.1 million (about 17 percent of total payments) for hospital and nonhospital services where the CHS program was not the primary payer. CHS program patients may qualify for other forms of insurance and, as the CHS program is the payer of last resort, the program is sometimes not the primary payer. However, the majority of payments from federal CHS programs to providers are for services for which the CHS program is the primary payer.

³³We isolated physician services by excluding other nonhospital services that were not covered by the 2010 Medicare Physician Fee Schedule. We also excluded services provided by anesthesiologists.

Figure 3: Total Payments by IHS's Federal CHS Programs for Services Provided in 2010



Note: In the figure, the sum of the payments for the "other nonhospital services" and the "physician services" does not total to \$114.7 million because of rounding.

Access to Care through Other Federal Programs That Purchase Health Care at Medicare Rates

CMS uses Medicare payment methodologies that take many factors, such as the type and location of service delivery, into account when calculating hospital and physician payments for a given service.³⁴ CMS periodically reassesses the specific Medicare payment rates to adjust for increases in the cost of delivering care. The Medicare Payment Advisory Commission (MedPAC) has stated that the goal of Medicare payment policy should be to keep payment rates low enough to ensure efficient use of taxpayer funds, but high enough to ensure that patient access to care is not

³⁴About one-quarter of Medicare beneficiaries are covered by Medicare Advantage, rather than the traditional Medicare program. Under Medicare Advantage, CMS provides private insurance plans with a monthly amount per beneficiary that is adjusted to reflect beneficiary health status.

negatively affected by reduced provider participation.³⁵ Overall, CMS paid \$549 billion in 2011 for care provided to Medicare's almost 49 million beneficiaries.

Other federal health care programs also use these Medicare methodologies as the basis for the rates they pay providers. For example, reimbursement rates for civilian providers under TRICARE, DOD's health care program, are generally limited to Medicare rates.³⁶ Beginning in fiscal year 1991, in an effort to control costs, the Congress directed DOD to gradually implement this methodology by lowering its reimbursement rates to Medicare amounts by no more than 15 percent each year, and current law requires DOD to use Medicare payment methodologies to the extent practicable.³⁷ Prior to this, DOD payment rates were, on average, 50 percent higher than Medicare rates. In addition, VA has implemented a similar rate cap to lower costs for services from non-VA providers.³⁸ VA pays for hospital and physician services at Medicare rates, and beginning in February 2011, in an effort to help contain costs, the agency required that Medicare rates be used to pay for other types of nonhospital services, such as laboratory, home health, and hospice services.³⁹ VA anticipated that payment at Medicare rates for these other nonhospital services would save it more than 50 percent relative to its current payments. In issuing the final rule describing this change,⁴⁰ the agency indicated that a goal of the rate cap was to align its payment structure

³⁵Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2012).

³⁶In fiscal year 2010, DOD offered health care to over 9.5 million eligible beneficiaries through TRICARE. Under TRICARE, eligible beneficiaries may obtain care either from military hospitals and clinics, referred to as military treatment facilities, or from civilian providers.

³⁷See 10 U.S.C. §§ 1079(h), (j), 1086(f), (g).

³⁸See 38 C.F.R. § 17.56. VA spent approximately \$45 billion in fiscal year 2010 to provide health care to about 5 million veterans. Of this, approximately \$4 billion was paid to non-VA providers, generally for services that were not available at VA facilities.

³⁹Prior to this change, VA paid Medicare rates for hospital services and physician services covered by rates listed on the Medicare Physician Fee Schedule for participating physicians. The agency now pays Medicare rates for nonhospital services covered by other Medicare payment methodologies, such as Ambulatory Surgical Center Payment and the Clinical Laboratory Fee Schedule. If VA has negotiated a specific amount with a provider, VA will pay that amount instead of Medicare rates.

⁴⁰75 Fed. Reg. 78,901 (Dec. 17, 2010) (amending 38 C.F.R. §§ 17.52, 17.56).

with Medicare, which VA described as the federal government's standard for purchasing care from private-sector providers.

We and MedPAC have reported that Medicare beneficiaries have generally experienced few problems accessing physician services, although access problems may exist in certain situations.⁴¹ For example, in 2009, we reported that the percentage of Medicare beneficiaries who reported major difficulties accessing specialty care was the same for those living in urban areas and in rural areas in 2008—2.1 percent. We also noted that the number of physicians billing Medicare for services had increased between 2000 and 2007, suggesting that more physicians were generally willing to accept Medicare patients. Some studies have found that access-to-care problems may exist for certain types of Medicare beneficiaries, such as those in fair or poor health, racial minorities, or those living in the most remote areas.⁴² However, studies have also suggested that factors other than payment rates, such as physician capacity to accept patients and travel time, are important influences on patient access to care.⁴³ With respect to DOD's TRICARE program, we have reported that reimbursement rates and provider shortages in some locations have hindered access to care.⁴⁴ Additional studies by DOD have cited reimbursement rates as the primary reason civilian providers may be unwilling to accept TRICARE beneficiaries as patients.

⁴¹See, for example, GAO, *Medicare Physician Services: Utilization Trends Indicate Sustained Beneficiary Access with High and Growing Levels of Access in Some Areas of the Nation*, [GAO-09-559](#) (Washington, D.C.: Aug. 28, 2009); GAO, *Medicare Physician Services: Use of Services Increasing Nationwide and Relatively Few Beneficiaries Report Major Access Problems*, [GAO-06-704](#) (Washington, D.C.: July 21, 2006); and Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, D.C.: June 2012).

⁴²See, for example, [GAO-06-704](#) and Medicare Payment Advisory Commission, *Report to the Congress: Medicare and in Rural America* (Washington, D.C.: June 2001).

⁴³Medicare Payment Advisory Commission, *Report to the Congress: Medicare and in Rural America* and Center for Studying Health System Change, *Physician Acceptance of New Medicare Patients Stabilized in 2004-05* (Washington, D.C.: January 2006).

⁴⁴See, for example, GAO, *Defense Health Care: TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries*, [GAO-13-364](#) (Washington, D.C.: April 2, 2013); GAO, *Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra*, [GAO-11-500](#) (Washington, D.C.: June 2, 2011) and *Defense Health Care: Across-the-Board Physician Rate Increases Would be Costly and Unnecessary*, [GAO-01-620](#) (Washington, D.C.: May 24, 2001).

DOD and VA have each made modifications to their payment methodologies in an attempt to address concerns about access to care. For example, both agencies pay higher rates in Alaska because of concerns that providers would not accept their beneficiaries at Medicare rates. In contrast to the Medicare rates it pays elsewhere, in Alaska, VA and DOD pay providers using separate payment methodologies.⁴⁵ In prior reviews of DOD's program, we have noted that there is little evidence these increased payments improved patient access to care.⁴⁶ We noted that increased payment rates do little to address more systemic causes of limited access, such as scarcity of physicians and patient transportation difficulties.⁴⁷

We have also noted that the potential for payment rate changes to affect patient access to care points to the need to monitor beneficiary access.⁴⁸ This type of monitoring is conducted by some federal agencies paying providers at Medicare rates. For example, as part of its monitoring, CMS conducts annual surveys of Medicare beneficiaries to assess their satisfaction with care and their ability to access health care. Additionally, in fiscal year 2004, in response to concerns about certain TRICARE beneficiaries' access to care from civilian providers, the Congress directed DOD to monitor access through a survey of civilian providers.⁴⁹

⁴⁵Under the VA Alaska Fee Schedule the amount paid in Alaska for each service is 90 percent of the average amount VA actually paid in Alaska for the same services in fiscal year 2003, adjusted annually for inflation. In 2003, VA had been paying providers in Alaska at about 75 percent of their billed charges. DOD calculated that, on average in 2006, VA reimbursement rates in Alaska were 35 percent higher than DOD rates and 73 percent higher than Medicare rates. Therefore, in 2007, DOD increased its payment rates in Alaska to bring them in line with those paid by VA.

⁴⁶[GAO-11-500](#) and [GAO-01-620](#).

⁴⁷In recognition of these challenges, a task force consisting of members from several agencies—including DOD, VA, CMS, and IHS—has examined how federal agencies with responsibility for health care services in Alaska are meeting the needs of Alaskans. In September 2010, the task force issued its report recommending that, among other things, federal agencies should support the development of a uniform provider payment rate for similar services for Medicare, DOD, and VA. See *Report to Congress of the Interagency Access to Health Care in Alaska Task Force* (Sept. 17, 2010).

⁴⁸[GAO-09-559](#) and GAO, *End-Stage Renal Disease: CHS Should Monitor Access to and Quality of Dialysis Care Promptly after Implementation of New Bundled Payment System*, [GAO-10-295](#) (Washington, D.C.: Mar. 31, 2010).

⁴⁹See Pub. L. No. 108-136, § 723, 117 Stat. 1392, 1532-34 (2003), and S. Rep. No. 108-46, at 330 (2003).

As these concerns continued, DOD was further directed in fiscal year 2008 to conduct annual surveys of both beneficiaries and civilian providers to determine the adequacy of access to health care and mental health care providers for certain beneficiaries.⁵⁰

IHS's Federal CHS Program Primarily Paid Physicians at Their Billed Charges, Which Were Significantly Higher than What Medicare and Private Insurers Would Have Paid

More than 80 percent of IHS's federal CHS program payments to physicians for services provided in 2010 were paid to noncontracted physicians at billed charges, rather than to contracted physicians at negotiated, reduced rates. IHS's federal CHS program payments to these physicians were significantly higher than what we estimate Medicare and private insurers would have paid for these same services.

IHS's Federal CHS Program Paid More than 80 Percent of Total Payments to Physicians at Billed Charges for Services Provided in 2010

More than 80 percent of IHS's federal CHS program payments to physicians for services provided in 2010 were paid to noncontracted physicians at billed charges, rather than to contracted physicians at negotiated, reduced rates. With the exception of uninsured patients, who are expected to pay providers at billed charges, other public and private payers typically pay providers at lower rates.⁵¹ However, of the \$62.5 million that federal CHS programs paid physicians, they paid about \$50.5 million (about 81 percent) to noncontracted physicians at billed charges and about \$12.1 million (19 percent) to contracted physicians at negotiated, reduced rates. IHS's federal CHS program payments to other

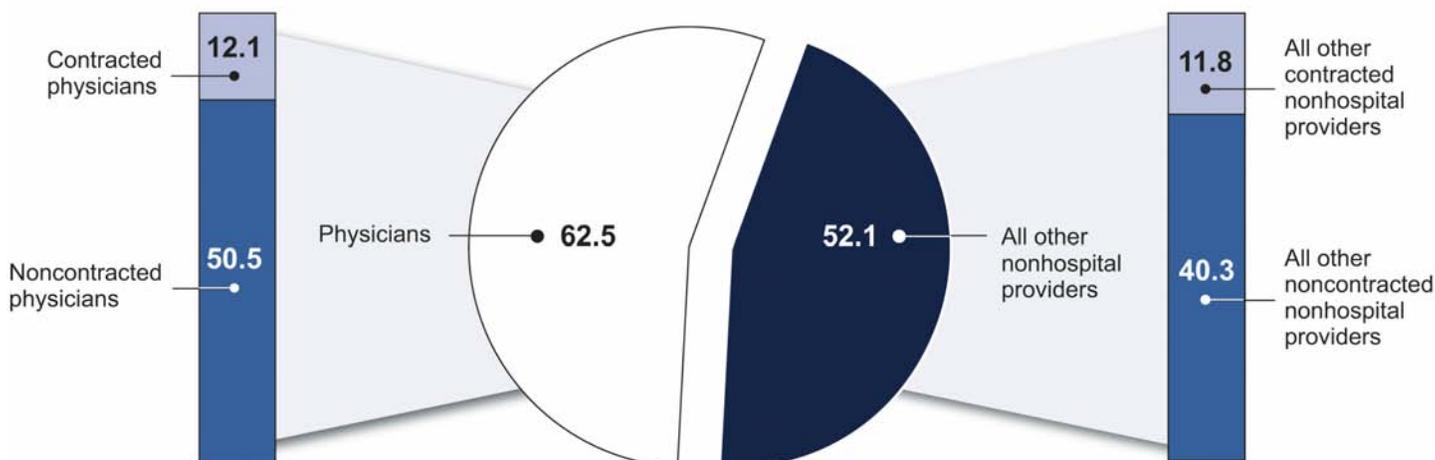
⁵⁰See Pub. L. No. 110-181, § 711(a), 122 Stat. 3, 190-191 (2008). DOD was directed to conduct these annual surveys from fiscal year 2008 through 2011. The agency has since been directed to continue these annual surveys of beneficiaries and civilian providers through 2015. See Pub. L. No. 112-81, § 721(a), 125 Stat. 1298, 1479 (2011).

⁵¹Some research indicates that uninsured patients rarely pay billed charges, and amounts charged to them may be heavily discounted based on charity care or other reduced payment programs. See GAO, *Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care*, [GAO-11-791](#) (Washington, D.C.: Sept. 23, 2011) and Mark Merlis, "Health Care Price Transparency and Price Competition," National Health Policy Forum (Mar. 28, 2007).

types of nonhospital providers for services provided in 2010 showed similar trends. Specifically, the federal CHS programs paid \$40.3 million out of a total of \$52.1 million (77 percent) to other noncontracted nonhospital providers at billed charges and about \$11.8 million (about 23 percent) to other contracted nonhospital providers at negotiated, reduced rates. (See fig. 4.)

Figure 4: Total Payments Made by IHS’s Federal CHS Programs to Contracted and Noncontracted Physicians and All Other Nonhospital Providers for Services Provided in 2010

IHS’s federal CHS program payments (dollars in millions)



Source: GAO analysis of IHS data.

Note: In the figure, the sum of the payments for contracted and noncontracted physicians does not total \$62.5 million because of rounding.

While IHS’s policy states that CHS programs should purchase services from contracted providers in most situations, a significant majority of physicians paid by federal CHS programs for services provided in 2010 did not have contracts. Specifically, of the 3,531 total physicians paid by federal CHS programs for services provided in 2010, 3,085 were noncontracted physicians paid at billed charges and 516 were contracted physicians paid at negotiated, reduced rates for at least some of their

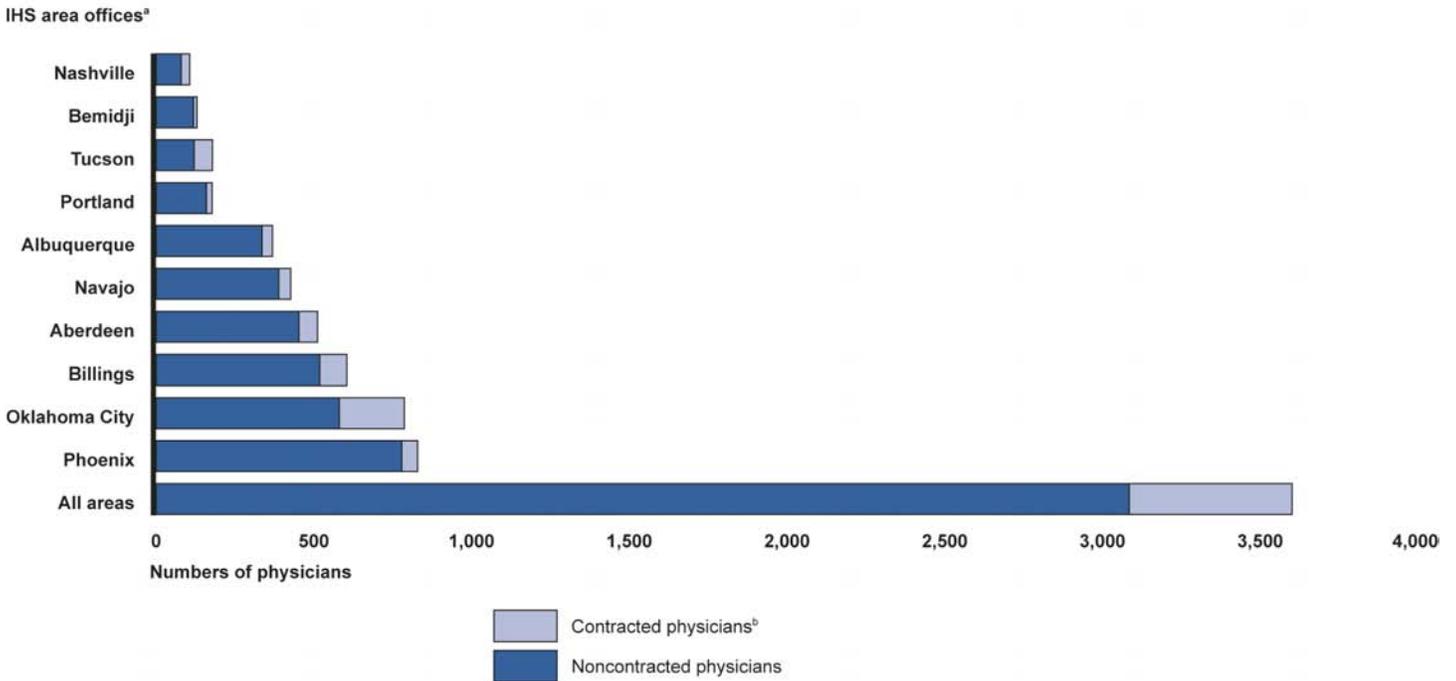
services.⁵² Although IHS's policy also states that contracting efforts should be focused on high-volume providers, the majority of these high-volume providers did not have contracts. For example, on the basis of the number of services provided, about 78 percent of the top 25 percent of physicians did not have contracts, nor did about 74 percent of the top 5 percent of physicians. In addition, an examination of the data by area office showed that noncontracted physicians constituted the majority of paid physicians in all IHS areas. Specifically, for each of the 10 IHS areas with federally operated CHS programs, noncontracted physicians constituted more than two-thirds of all physicians paid for services provided in 2010.⁵³ (See fig. 5.) For all other nonhospital providers, the numbers of contracted and noncontracted providers showed similar trends. Specifically, of the 3,590 other nonhospital providers paid for services provided in 2010, 3,145 other nonhospital providers did not have contracts and were paid at billed charges and 507 other nonhospital providers did have contracts and were paid at negotiated, reduced rates for at least some of their services.⁵⁴

⁵²The total number of unique physicians is 3,531. However, 70 contracted physicians were also paid at billed charges for some services and are included in the totals for both the contracted and noncontracted physicians. For example, a physician may have negotiated with IHS to provide a specific service at a contracted rate, but all other services provided by the physician were paid at billed charges.

⁵³Fifty-nine contracted physicians and 376 noncontracted physicians were paid for services by more than one area office. For example, some physicians practiced in a geographic area that serves federal CHS programs in multiple IHS areas.

⁵⁴The total number of unique other nonhospital providers was 3,590. However, 62 contracted providers were also paid at billed charges for some services and are included in the totals for both the contracted and noncontracted providers. For example, a provider may have negotiated with IHS to provide a specific service at a contracted rate, but all other services provided by the provider were paid at billed charges. In addition, 1,833 of the 3,590 providers of other nonhospital services also provided physician services that were covered by the Medicare Physician Fee Schedule. These providers are therefore also included in the total number of physicians.

Figure 5: Contracted and Noncontracted Physicians Paid by IHS’s Federal CHS Programs for Services Provided in 2010, by Area Office



^aFifty-nine contracted physicians and 376 noncontracted physicians were paid for services by more than one area office. For example, some physicians practiced in a geographic area that serves federal CHS programs in multiple IHS areas. The California and Alaska areas are not included in this figure because they include only tribally operated CHS programs.

^bSeventy of the contracted physicians were also paid at billed charges for some services. For example, a physician may have negotiated with IHS to provide a specific service at a contracted rate, but all other services provided by the physician were paid at billed charges. These 70 physicians are included in the totals for both the contracted and noncontracted physicians.

For those physicians whom IHS’s federal CHS programs paid under contracts for reduced rates, the programs achieved significant savings relative to the physicians’ billed charges. Specifically, the federal CHS programs paid about \$12.1 million for these services, which represented an estimated \$16.7 million (58 percent) in savings, relative to the

physicians' billed charges.⁵⁵ The percentage of savings was fairly consistent across the IHS area offices. The savings attributed to physician contracts ranged from 50.4 percent in the Aberdeen and Albuquerque Areas to 69.1 percent in the Phoenix Area. (See table 1.) IHS's federal CHS programs' savings from contracts with other nonhospital providers showed similar trends, achieving estimated savings of 68 percent, or \$25.3 million, relative to billed charges.⁵⁶

⁵⁵Officials from IHS's fiscal intermediary said that, to help them determine IHS's savings due to contracts, they encourage contracted physicians to bill federal CHS programs at their full billed charges, and then the federal CHS programs pay the providers according to their contracted rates. However, some contracted physicians instead bill federal CHS programs according to their contracted rates. In the 2010 claims data, 204 out of 516 contracted physicians billed the federal CHS programs at the same rate they were paid under their contract and received payments from IHS totaling \$512,915. Therefore, our estimate of \$16.7 million in physician contract savings, which is the difference between the physicians' billed charges and the payments received, may underestimate IHS's total savings due to contracts with physicians.

⁵⁶Officials from IHS's fiscal intermediary said that, to help them determine IHS's savings due to contracts, they encourage other nonhospital providers with contracts to bill federal CHS programs at their full billed charges and then the federal CHS programs pay the nonhospital providers according to their contracted rates. However, some nonhospital providers with contracts instead bill federal CHS programs according to their contracted rates. In the 2010 claims data, 164 out of 507 contracted nonhospital providers billed the federal CHS programs at the same rate they were paid under their contract and received payments from IHS totaling \$4,160,153. Therefore, our estimate of \$25.3 million in nonhospital provider contract savings, which is the difference between the providers' billed charges and the payments received, may underestimate IHS's total savings due to contracts with other types of nonhospital providers.

Table 1: Savings for IHS’s Federal CHS Programs Due to Physician Contracts for Services Provided in 2010, by Area Office

Area office ^a	For physicians paid under contract			
	Billed charges (dollars)	Amount paid (dollars)	Contract savings ^b (dollars)	Contract savings as a percentage of billed charges (percent)
Aberdeen	\$5,632,186	\$2,793,323	\$2,838,863	50.4%
Albuquerque	2,437,173	1,208,701	1,228,472	50.4
Bemidji	229,611	90,449	139,162	60.6
Billings	5,786,494	2,541,273	3,245,221	56.1
Nashville	121,592	48,460	73,132	60.1
Navajo	2,441,217	1,002,058	1,439,159	59.0
Oklahoma City	7,894,724	2,878,731	5,015,993	63.5
Phoenix	1,887,211	582,920	1,304,291	69.1
Portland	487,192	199,078	288,114	59.1
Tucson	1,824,129	732,603	1,091,526	59.8
Total	\$28,741,530	\$12,077,596	\$16,663,934	58.0%

Source: GAO analysis of IHS data.

Notes: Dollar values may not add to the total because of rounding.

^aThe California and Alaska areas are not included in this table because they include only tribally operated CHS programs.

^bOfficials from IHS’s fiscal intermediary said that, to help them determine IHS’s savings due to contracts, they encourage contracted physicians to bill federal CHS programs at their full billed charges and then the federal CHS programs pay the providers according to their contracted rates. However, some contracted physicians instead bill federal CHS programs according to their contracted rates. In the 2010 claims data, 204 out of 516 contracted physicians billed the federal CHS programs at the same rate they were paid under their contract and received payments from IHS totaling \$512,915. Therefore, our estimate of \$16.7 million in physician contract savings, which is the difference between the physicians’ billed charges and the payments received, may underestimate IHS’s total savings due to contracts with physicians.

IHS’s Federal CHS Programs Paid Physicians More than What Medicare and Private Health Insurers Would Have Paid for the Same Services

IHS’s federal CHS program payments to physicians for services provided in 2010 were higher than what we estimate Medicare and private insurers would have paid for these same services. These higher payments resulted from payments federal CHS programs made to noncontracted physicians at billed charges, as the CHS program generally paid contracted physicians at rates similar to Medicare.

IHS’s federal CHS programs paid, in total, two times what we estimate Medicare would have paid for the same physician services provided in 2010. Specifically, of the \$62.5 million in total payments for services provided in 2010, the federal CHS programs could have saved an estimated \$31.7 million if they paid physicians what Medicare would have paid for the same services. The federal CHS programs could have used

these savings to pay for more than double the number of physician services they provided in 2010—approximately 253,000 additional physician services (based on an average Medicare rate of \$125 per IHS physician service). Further, savings for the overall CHS program may be even higher, as this analysis does not include payments for other types of nonhospital services paid by the federal CHS programs, as well as payments by tribally operated CHS programs, which receive over half of annual CHS program funding and have also been found to pay for nonhospital services above the Medicare rates.⁵⁷ For example, a 2009 OIG report found that there was no difference between federally and tribally operated CHS programs in terms of the percentages of nonhospital claims paid above Medicare rates.⁵⁸ It estimated that federally and tribally operated CHS programs could have saved almost half of total spending on nonhospital services if nonhospital payments were capped at Medicare rates. This suggests that both federally and tribally operated CHS programs are likely to achieve significant savings if they paid physicians and other nonhospital providers according to what Medicare would have paid for the same services. The potential for savings is particularly significant in light of the CHS program's inability to pay for all needed services.

IHS's federal CHS programs paid physicians at rates that were higher than Medicare rates because they primarily paid physicians at their billed charges. Services provided by noncontracted physicians accounted for approximately \$30.5 million of the \$31.7 million in estimated total savings

⁵⁷The proportion of payments for other types of nonhospital services that were paid at billed charges was similar to physician services. Although we did not compare payments for other types of nonhospital services to Medicare rates, if we assume payment trends for these services are similar to physician services, we estimate that federal CHS programs could have saved an additional \$26.4 million for services provided in 2010. In addition, tribal CHS programs receive about 54 percent of CHS program funds and IHS officials have indicated that tribes have been less likely than federal CHS programs to contract with providers for reduced rates. If we assume that contracting and payment trends for tribal CHS programs are similar to federal CHS programs, we estimate that tribal CHS programs could have saved an additional \$68.2 million for services provided in 2010 if their physician and other nonhospital services were paid at Medicare rates. Therefore, we estimate that federal and tribal CHS programs could have saved a total of about \$126.4 million if all physician and other nonhospital services provided in 2010 were paid at Medicare rates.

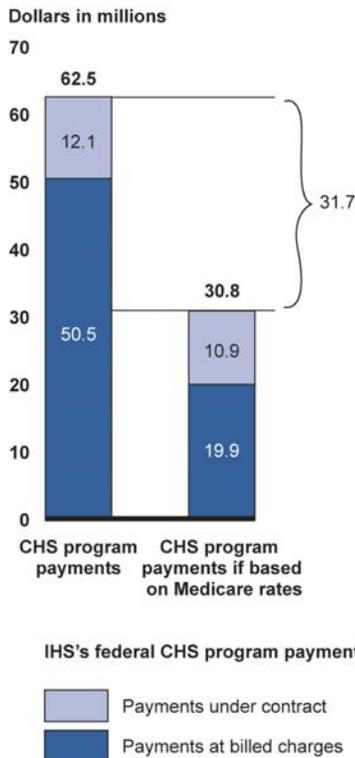
⁵⁸See Department of Health and Human Services, Office of Inspector General, *IHS Contract Health Services Program: Overpayments and Potential Savings* (September 2009).

(96 percent) for the federal CHS programs. Specifically, the federal CHS programs paid noncontracted physicians a total of about \$50.5 million at billed charges, which was two and a half times what we estimate Medicare would have paid for the same services (about \$20 million). (See fig. 6.)

Most, but not all, payments to contracted physicians were similar to what Medicare would have paid.⁵⁹ Federal CHS programs paid contracted physicians about \$12.1 million for services provided in 2010 and these payments to contracted physicians accounted for approximately \$1.2 million of the \$31.7 million in estimated total savings (about 4 percent). The federal CHS programs' contracts with physicians were sometimes for negotiated rates that exceeded what Medicare would have paid. Specifically, slightly over one-third of total payments to contracted physicians were higher than what we estimate Medicare would have paid. However, most payments to contracted physicians were equal to or lower than what we estimate Medicare would have paid.

⁵⁹We considered IHS payment amounts that were within 10 percent of the Medicare rates to be similar to the Medicare rates.

Figure 6: Comparison of Payments from IHS's Federal CHS Programs with Medicare Rates for Physician Services Provided in 2010



Source: GAO analysis of IHS and CMS data.

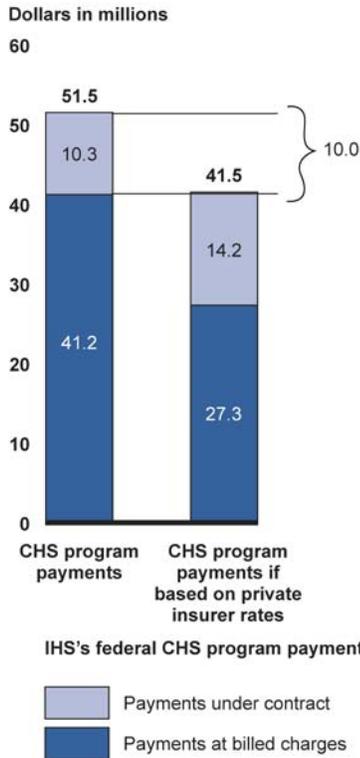
Notes: We analyzed IHS claims data and data from the Medicare Physician Fee Schedule. In the figure, the sum of the CHS program payments made under contract and at billed charges does not total \$62.5 million because of rounding.

IHS's federal CHS programs also paid more than what we estimate private insurers would have paid for the same physician services provided in 2010. Specifically, federal CHS programs paid about one and a quarter times what we estimate private insurers would have paid for the same services provided in 2010. Of those physician services for which comparable services were available at the county level in the private insurance data, the federal CHS programs paid about \$51.5 million and private insurers would have paid an estimated \$41.5 million, a difference

of \$10.0 million.⁶⁰ (See fig. 7) Similar to what we found in the Medicare comparison, most of this difference was attributable to those services for which the federal CHS programs paid noncontracted physicians at billed charges—rates that are higher than the rates paid by private insurers. Overall, these payments to noncontracted physicians totaled \$41.2 million, which was more than one and a half times as much as the estimated \$27.3 million that private insurers would have paid for these same services. However, in contrast to what we found in our Medicare comparison, when federal CHS programs were able to negotiate reduced rates with physicians, these rates were lower than what private insurers would have paid. Specifically, CHS program payments to contracted physicians totaled \$10.3 million, while private insurers would have paid an estimated \$14.2 million for these same services. This is because most of the federal CHS programs' payments to contracted physicians were paid at or below Medicare rates, which are typically lower than rates paid by private insurers.

⁶⁰To account for any variation in payments due to geographic location, we compared only those physician services from the federal CHS program claims data that were provided in the same county as those in the private insurance claims data. Therefore, of the 246,273 total physician services in the CHS program data, we identified 231,099 (about 94 percent) services that were provided by private insurers in the same counties. We were unable to compare physician services for \$11.0 million in payments from the federal CHS programs' claims to the private insurance claims because these services were not provided in the same county.

Figure 7: Comparison of Payments from IHS's Federal CHS Programs with Private Insurance Rates for Physician Services Provided in 2010



Source: GAO analysis of IHS and private insurer data.

Note: To account for any variation in payments due to geographic location, we compared only those physician services from the federal CHS program claims data that were provided in the same county as those in the private insurance claims data. Therefore, of the 246,273 total physician services in the CHS program data, we identified 231,099 (about 94 percent) services that were provided by private insurers in the same counties. We were unable to compare physician services for \$11.0 million in payments from the federal CHS programs' claims to the private insurance claims because these services were not provided in the same county.

Most Physicians We Interviewed Said CHS Program Payments Were a Small Part of Their Total Payments and Cited Both Advantages and Concerns about Capping Payments at Medicare Rates

Most of the 10 physicians whom we interviewed indicated that the CHS program represented a small portion of their practice and was not a significant source of revenue. The physicians identified advantages of capping CHS program payments for nonhospital services, including physician services, at Medicare rates, but also expressed concerns about the effect of such a cap on their finances.

Physicians We Interviewed Said CHS Program Payments Were Generally Less than 10 Percent of Their Total Practice Payments and Were Often at Medicare Rates

According to most of the 10 physicians whom we interviewed, the CHS program represented a small portion of their practice. All of the physicians we interviewed were among federal CHS programs' top 25 percent of physicians in terms of their volume of paid services in 2010. However, 8 of the 10 physicians said total CHS program payments constituted 10 percent or less of the total payments they received from all payers.⁶¹ The remaining 2 physicians said the CHS program accounted for a larger portion of their total payments. For example, payments from the CHS program constituted 39 percent of total payments for 1 physician who was located on a reservation. Payments from the CHS program to the other physician, who was located near three reservations, constituted 15 to 20 percent of total payments.

The 10 physicians we interviewed were divided between those who were paid above Medicare rates by the CHS program and those who were paid at or below Medicare rates. According to IHS 2010 claims data, federal CHS programs paid the 10 physicians we interviewed a total of about \$990,000. Four of the 10 physicians had a contract with the CHS program

⁶¹CHS program-eligible patients may have constituted a greater proportion of physicians' patient mix than patients whose services were paid for by the CHS program, as some CHS program patients have other forms of insurance, including Medicare, Medicaid, and private insurance, which would have served as the primary payer.

and were paid at or below Medicare rates.⁶² These physicians' contracts with IHS saved the program about 60 percent relative to the physicians' billed charges, which is comparable to the federal CHS programs' percentage of estimated savings across all physician contracts in that year. The other 6 physicians were paid by the CHS program at billed charges that were higher than Medicare rates. For example, 1 physician said he was paid at 133 percent of Medicare rates and another said he was paid at 250 percent of Medicare rates.

In terms of other payers, most physicians we interviewed said they received the majority of their payments from Medicare and Medicaid. Eight of the 10 physicians said their payments from Medicare and Medicaid were close to 50 percent or more of their total payments,⁶³ with private insurance and self-pay patients constituting most of their remaining payments. Two of these 8 said that, respectively, they received 50 percent and 75 percent of their total payments from Medicare alone. The remaining 2 of the 10 physicians said they received the majority of their total payments from private insurance or self-pay patients. All 10 physicians reported that they are accepting new patients from all payers, including Medicare and the CHS program.⁶⁴

⁶²Of the four physicians who contracted with IHS to be paid at or below Medicare rates, some provided a small number of services that were paid by the CHS program at billed charges.

⁶³Medicaid physician fees vary by state, but are generally less than the fees paid by Medicare in that state. See Stephen Zuckerman, Aimee Williams, and Karen Stockley, "Trends in Medicaid Physician Fees, 2003-2008," *Health Affairs*, vol. 28, no. 3 (2009).

⁶⁴This is consistent with findings from MedPAC that most physicians are accepting new patients, although fewer physicians are accepting new Medicaid patients than Medicare and privately insured patients. In addition, MedPAC reported that physicians in rural areas were more likely than those in urban areas to accept new patients of all insurance types and physicians who classified themselves in surgical or medical specialties were more likely than primary care physicians to accept new Medicare and privately insured patients. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*.

Physicians We Interviewed Identified Both Advantages and Concerns with Capping CHS Program Payments at Medicare Rates

The 10 physicians we interviewed identified advantages of capping CHS program payments for nonhospital services, including physician services, at Medicare rates, but also expressed concerns about the effect of such a cap on their finances. The 4 physicians who were already getting paid at or below Medicare rates, as well as 4 of the other physicians who were getting paid at higher billed charges, said such a cap would have little or no effect on their practices. Two of these physicians noted that there would be little effect because the CHS program is a small percentage of their practice. The remaining 2 of these 10 physicians, who were paid at higher billed charges, cited concerns that a cap could affect their finances or patient access to care.

Six of the physicians we interviewed, three of whom were paid at or below Medicare rates, said they would support a cap on CHS program payments for nonhospital services, including physician services, at Medicare rates and provided various rationales for their support. For example, one physician said that capping CHS program payments for nonhospital services at the Medicare rates is a “good idea” that would save IHS money. This physician expected that capping the CHS program payments would allow him to substantially decrease the time his practice spends negotiating with different CHS programs, especially the numerous tribal CHS programs in his area. Others noted that Medicare rates are nearly universally accepted by physicians and, therefore, physicians are familiar with the Medicare Physician Fee Schedule. One of these physicians added that paying physicians according to Medicare rates would allow all physicians to receive payment under a consistent methodology. Another physician said he negotiated a contract with the CHS program for lower, Medicare rates because, in his opinion, IHS should not be paying physicians at billed charges that are higher than the rates paid by Medicare. A physician paid by the CHS program at billed charges higher than Medicare agreed that Medicare rates were appropriate. He said that he is already receiving Medicare rates for many patients because the majority of his work is done in a hospital and many patients needing his services are older. Further, one physician noted that such a cap could increase his practice’s CHS program payment, as he currently receives Medicare Physician Fee Schedule rates from the CHS program, but a cap on payments for nonhospital services could allow him

to be paid at the higher cost-based reimbursement that he receives from Medicare.⁶⁵

Four of the physicians we interviewed, three of whom said they were paid by the CHS program at billed charges higher than Medicare, did not support such a cap and expressed varying concerns about its effect on their finances and patient access to care. Specifically, two physicians noted that if their CHS program payments were capped at Medicare rates and Medicare rates were reduced in the future, this could have a significant adverse financial effect on their practices.⁶⁶ One physician said that reducing his rates to Medicare levels would not allow him to cover his practice's costs, as his billed charges are 133 percent of Medicare rates and CHS program payments represented 39 percent of his practice. Two physicians also indicated that certain specialists might be particularly affected by a cap at Medicare rates. For example, one physician noted that there have been significant reductions in Medicare rates for certain cardiology services in recent years. The other physician said that an orthopedic practice in his area that had previously contracted with a CHS program decided to stop accepting tribal patients at Medicare rates. Two physicians also noted they use the higher payments from the CHS program and private payers to compensate for their payments from Medicare and Medicaid, which they indicated do not cover their costs for providing care.

Three physicians who did not support a cap on CHS program payments for nonhospital services, including physician services, at Medicare rates said they would support a rate cap set at a higher payment rate than Medicare but lower than billed charges. Two of the physicians suggested a cap set at a percent of their billed charges, while the third suggested a cap set at 125 to 133 percent of the Medicare rates.

⁶⁵This physician said he provides care in rural health clinics, which are paid by Medicare on the basis of their costs. The physician said these cost-based payments are three times higher than the Medicare Physician Fee Schedule payments he receives from the CHS program.

⁶⁶The Medicare Physician Fee Schedule is updated annually under the sustainable growth rate system, with the intent of limiting the total growth in Medicare spending for physician services over time. Because of rapid growth in Medicare spending for physician services, the sustainable growth rate has called for fee reductions since 2002. However, the Congress has averted such fee reductions for 2003 through 2013. Under current law, Medicare's fees to physicians are scheduled to be reduced by about 27 percent in 2014. See 42 U.S.C. § 1395w-4(d).

When we asked physicians if they had any concerns unrelated to CHS program payment rates but that have had a financial effect on their practice, all 10 cited challenges processing their CHS program payment requests or receiving timely claims payment. The physicians said, for example, that to receive payment from the CHS program they spent a disproportionate amount of time, relative to other payers, gathering paperwork in support of payment requests or monitoring the progress of those requests. Specifically, 1 physician indicated that she received the same rates as Medicare for the CHS program, but her claims processing costs for the CHS program were significantly higher than for Medicare. Physicians' concerns about claims administration echoed those that we heard from physicians as part of a 2011 report examining the CHS program.⁶⁷

⁶⁷[GAO-11-767](#).

Most Hospitals We Interviewed Indicated Little Negative Effect from the Current MLR Requirement, as They Already Had CHS Program Contracts to Be Paid at Medicare Rates

Officials from most of the nine hospitals that we interviewed indicated that the MLR requirement has had little or no financial effect on their hospital.⁶⁸ They said the CHS program accounted for a small percentage of their total payments.⁶⁹ Officials from eight of the nine hospitals said the program accounted for between 0.02 and 10 percent of their total payments;⁷⁰ officials from the other hospital said the CHS program accounted for about 14 percent of its total payments.

Officials from seven of the nine hospitals noted that the CHS program already paid them at Medicare rates prior to implementation of the MLR requirement.⁷¹ Of these seven, officials from five hospitals said the implementation of the MLR requirement has had little or no financial effect on their hospital. Officials from the other two of the seven hospitals did not experience a change in rates from the implementation of MLR, but they had concerns with Medicare payment rates in general, saying they do not cover their hospital's costs of providing patient services. For each of the two hospitals, officials said that the Medicare program accounted for a larger portion of their payments than the CHS program—29 percent and 28 percent, while the CHS program accounted for 0.02 percent.

Officials from two hospitals indicated that the MLR requirement reduced their payment rate. Officials from one of these hospitals said that, prior to the implementation of the MLR requirement, the hospital had a contract to be paid by the CHS program at 90 percent of its billed charges; an official from the other hospital said the CHS program had paid it at 100 percent

⁶⁸We interviewed officials from 10 hospitals, but we are only discussing the views of 9. We excluded 1 hospital because the officials had little knowledge of the CHS program, the rates that it paid, or if it has contracted with IHS for negotiated rates. The officials from this hospital indicated that it receives less than 3 percent of its payments from the CHS program.

⁶⁹In 2010, federal CHS programs paid these nine hospitals \$12.5 million, which was \$50.5 million less than their billed charges. Nationally, federal CHS programs paid \$119.5 million for hospital services subject to MLR and these payments were \$444.0 million less than the rate billed by hospitals.

⁷⁰In comparison, four of the hospitals indicated that Medicare and Medicaid constituted the majority of their payments (53 to 70 percent), while these payers constituted 29 to 46 percent of payments for the other five hospitals. Private insurance accounted for between 19 and 61 percent of total payments for all nine hospitals.

⁷¹This trend is similar to the overall CHS program, as, according to IHS officials, many hospitals were already being paid at or near Medicare rates prior to implementation of the MLR requirement.

of its billed charges. The official described these previous rates as “ridiculous” because no other payer they interacted with paid such high rates. Officials from both hospitals indicated that they are now paid at MLRs. Officials from both of these hospitals noted that they see most CHS program patients through the emergency room and their hospital has an obligation under the Emergency Medical Treatment and Active Labor Act (EMTALA) to treat them regardless of their ability to pay.⁷² Officials from one of the hospitals that did not experience a decrease in rates also noted its EMTALA obligation in the context of access to care.

Although officials from most hospitals we interviewed said the CHS program’s MLR payment rates generally matched the rates they received from Medicare, two hospitals designated as critical access hospitals (CAH) said there were differences.⁷³ IHS officials explained that the CHS program, like Medicare, pays CAHs using service-delivery costs that hospitals report to CMS in completed cost reports. However, unlike IHS, CMS also considers interim cost reports submitted by hospitals in calculating its Medicare payments to hospitals. IHS officials said the completed cost reports may be 18 months out of date relative to the interim cost reports.⁷⁴ Officials from these two CAHs indicated that because their most recent completed cost report may be several months out of date, they were generally paid less by the CHS program than by Medicare. One CAH official said the difference was usually a few percentage points; the other said the difference has averaged 8 percent. However, a CAH official said there was one year (2011) when the CHS program overpaid the hospital because it was using an outdated cost report. According to IHS officials, the CHS program must rely on the completed cost reports because the CHS program, unlike Medicare, does

⁷²EMTALA 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. See generally 42 U.S.C. § 1395dd.

⁷³Medicare designates some small, rural hospitals as CAHs, which allows them to be paid at higher rates under a different payment methodology.

⁷⁴Medicare pays CAHs for inpatient and outpatient services at 101 percent of reasonable costs. Hospitals report these costs through the Medicare cost report. Because there is a delay between the start of a fiscal year and when that year’s cost report is audited and finalized, hospitals submit interim reports to update their costs.

not have the funding flexibility to settle with hospitals if the interim report is later determined to need adjustment.⁷⁵

While the implementation of the MLR requirement had little financial effect on most of the hospitals that we interviewed, officials from all nine hospitals cited other factors that affected the payments they received from the CHS program. For example, officials from seven hospitals said they experienced problems having claims paid in a timely way by the CHS program or that they spent more staff time processing CHS program claims than they did for other payers.⁷⁶ Officials from two of these hospitals added that they were negatively affected when IHS made the decision to close the emergency room in local IHS facilities because this resulted in an increased patient load that placed greater pressure on their emergency rooms.⁷⁷

⁷⁵IHS requires the use of a closed or completed cost report available at the time services are provided as the basis for its payment rates to CAHs. IHS officials indicated that the CHS program does not use an interim cost report to set rates. The CHS program depletes its annual funding and IHS officials, therefore, indicated that the program is unable to retrospectively increase provider payments in response to a completed cost report updated for the year in which the services were provided. However, IHS does make retrospective adjustments to recover overpayments. See 42 C.F.R. §§ 136.30(c)(2), 136.32(b).

⁷⁶We previously reported that a selection of hospital and office-based providers described similar burdens resulting from their interactions with the CHS program, including 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. See [GAO-11-767](#).

⁷⁷IHS has also acknowledged that reductions in the availability of services at facilities operated by IHS increase the need for tribes to use the CHS program to purchase care from external providers. In its 2012 budget justification, IHS noted that due to insufficient workload or service populations, five hospitals operated through IHS funding had been or are planned to be replaced by ambulatory health centers with no inpatient services. As a result, tribes in these areas will be required to purchase inpatient care from external providers through the CHS program in order to maintain the same level of services.

IHS and Tribal Officials Said the MLR Requirement Allowed Them to Expand Access and Said That a Similar Cap for Nonhospital Services Could Have Similar Benefits

IHS and tribal officials we interviewed said that setting payments for hospital services at MLRs (as required by statute) allowed the CHS program to reduce payments and expand access to care. They also agreed that a cap on payments to nonhospital providers, including physicians, could have similar benefits, although some officials noted that these benefits may not be achieved by all CHS programs.

IHS and Tribal Officials We Interviewed Said the MLR Requirement Allowed Them to Reduce Payments to Hospitals and Expand Access to Care

IHS and tribal officials we interviewed said that the implementation of the MLR requirement in 2007 allowed the CHS program to reduce payments for hospital services. Although IHS officials told us that prior to the implementation of the MLR requirement, area offices had negotiated to pay many hospitals at Medicare rates, officials we interviewed from four of the six area offices noted that some hospitals were unwilling to negotiate reduced rates and therefore were paid at billed charges. The MLR requirement required these hospitals to accept Medicare rates. IHS officials noted that tribally operated CHS programs likely experienced more savings from the MLR requirement than federally operated CHS programs because tribally operated CHS programs were generally less successful at negotiating contracts with hospitals for reduced rates. Officials from three tribes, for example, told us that they had difficulty negotiating for reduced rates with hospitals and the MLR requirement enabled them to pay lower rates than they had been able to negotiate. Overall, the tribal officials we interviewed agreed that the MLR requirement benefited tribal programs by allowing them to achieve savings. IHS officials also indicated that the MLR requirement allowed them to devote less staff time to negotiating contracts for hospital services at lower rates.⁷⁸ One tribal official also noted that her tribe had already successfully contracted with hospitals for Medicare rates, but said

⁷⁸Officials from three area offices indicated that they continue to enter into contracts with hospitals because these contracts have other benefits, such as helping to build relationships and share patient information, which improves patient care and payment processing.

that the MLR requirement allowed the tribe to save the time and staff resources it had spent negotiating contracts.

IHS and tribal officials indicated that reduced payments from the MLR requirement allowed the CHS program to expand access to care. For example, officials from two area offices said that the lower rates from the implementation of the MLR requirement have allowed some federal CHS programs that could previously only fund high-priority (priority level I) cases to now fund both priority level I and priority level II cases—cases that would have previously been deferred or denied.⁷⁹ IHS officials indicated that the lower payment rates paid to providers under the MLR requirement have also allowed IHS to sustain the Catastrophic Health Emergency Fund (CHEF) longer than it could prior to the implementation of MLR because the higher payment rates would deplete the fund earlier in the fiscal year.⁸⁰ They said that IHS is now able to reimburse CHS programs for more high-cost medical cases under CHEF than it could prior to the implementation of the MLR requirement. In addition, IHS officials said that, prior to the implementation of the MLR requirement, hospitals were not required to accept IHS patients and would sometimes turn them away in nonemergency situations. As part of the MLR requirement, Medicare-participating hospitals are required to accept IHS patients at the MLR rates, which IHS officials said has expanded access to care for IHS patients.

IHS and tribal officials we interviewed did not identify any ongoing challenges with patient access to care related to implementation of the MLR requirement. Officials from three area offices said that they were not aware of any challenges resulting from the implementation of the MLR requirement, although officials from the other three area offices and some tribal officials said that there were some initial challenges. They said that some hospitals initially refused to accept the new rates, so CHS program staff may have had to spend time educating them about the new

⁷⁹Priority level I services include 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.

⁸⁰CHEF is administered by IHS headquarters to reimburse federally and tribally operated facilities for their CHS program expenses from paying for the costs associated with treating catastrophic illness or victims of natural disasters.

requirement. They noted that the hospitals eventually accepted the required rates and it did not negatively affect patient access to care.

IHS and Tribal Officials Described Challenges Contracting with Nonhospital Providers for Reduced Rates and Said That a Cap at Medicare Rates Could Be Beneficial, despite Certain Concerns

IHS and tribal officials said CHS programs experienced challenges contracting for negotiated rates with nonhospital providers. Five of the six IHS area offices that we interviewed acknowledged that they were unlikely to be able to negotiate with many additional providers.⁸¹ Officials from all six area offices described their efforts to contract with any known nonhospital providers, which included sending contract documentation to frequently used providers or new providers in their areas. However, officials from three area offices noted that many providers do not respond. Officials from two area offices said that there can be challenges negotiating contracts in rural areas served by a single physician who may have little incentive to negotiate a reduced rate. Area office officials also noted that certain physician subspecialties, such as those providing services for cancer or kidney disease, tend to be more resistant to negotiating contracts. The officials said that this could be because these physicians see fewer CHS program patients or because the physicians believe that the lower rate would not cover their cost of doing business. These challenges are not new for the CHS program. For example, in 1991, IHS stated that it had not been possible for the program to contract with each of the 4,600 professionals that it used on a regular basis.⁸² The agency noted that it had experienced difficulty negotiating contracts because many providers were unwilling to contract and the area offices lacked the resources necessary to negotiate contracts. Tribal officials described similar challenges related to contracting. In addition, some tribal officials noted that nonhospital providers are particularly hesitant to negotiate contracts because of a history of problems getting paid in a timely way by the CHS program.

Officials from all six of the area offices said that a cap on nonhospital services, including physician services, at Medicare rates would reduce payments to providers and they believed that the overall effect for the CHS program would be positive. Officials from all six area offices

⁸¹Officials from the other area office indicated that their goal is to contract with as many providers as is feasible, but did not address whether they would be able to expand their current efforts.

⁸²56 Fed. Reg. 10,566 (Mar. 13, 1991).

specifically cited the resulting financial savings from the cap and indicated that this would allow the CHS programs to pay for more care. Officials from four area offices noted that a cap would be particularly beneficial in lowering the cost of certain high-cost nonhospital services, such as cancer treatments, dialysis, and air ambulance services. Officials from some of these areas said that providers of these services have been less likely to negotiate contracts. IHS headquarters also identified these same services as high-volume and high-cost services that could benefit from a rate cap. Officials from two area offices added that a cap based on an established fee schedule would help standardize the rates that CHS programs pay physicians, which would make it easier for programs to estimate their spending.⁸³ Officials from one area office indicated that it was time consuming to identify physicians and attempt to negotiate contracts for lower rates, and a cap would eliminate the need for these efforts.⁸⁴ However, IHS headquarters officials told us that they would not be able to implement a cap for nonhospital services, including physician services, unless the agency received explicit statutory authority to do so, because the current law requiring MLRs is limited to hospital services.

Although officials from all of the area offices we interviewed indicated that the overall effect of an MLR cap on nonhospital services, including physician services, would be positive, four of the area offices also identified potential concerns.⁸⁵ For example, four area offices noted that some rural areas have a limited supply of providers and these providers may not consider Medicare payment rates to be adequate, which could contribute to reduced patient access to care if those providers stopped seeing patients at Medicare rates. Officials from one of these area offices also noted that a nonhospital payment cap based on Medicare rates could create added expense and complexity for the CHS program because IHS's fiscal intermediary, BCBSNM, would need to calculate

⁸³According to IHS officials, CHS programs are expected to actively manage their funds in order to maximize the care that can be purchased. They said that most CHS programs establish budgets as a way to help ensure that funds are available throughout the year.

⁸⁴Officials from the other five area offices cited nonfinancial benefits of having contracts with providers, including increased continuity of care arising from the ability to refer a patient to the same facility as often as necessary; the opportunity to investigate, pursuant to contractual provisions, whether adequate and appropriate care and customer service was provided; and the ability to specify the CHS program's requirements for payment.

⁸⁵The other two area offices indicated that they did not expect a cap on nonhospital services to create any problems with patient access to care.

Medicare payment rates using the different payment methodologies used by CMS. BCBSNM officials also noted that a cap on nonhospital providers would require them to implement changes to their payment system to track and collect additional claims data.⁸⁶ Officials from one area office noted that the added complexity could be especially challenging for tribal CHS programs that do not contract with a fiscal intermediary to process their claims. Similarly, officials from one tribal area indicated that it was difficult for some tribes to learn how to calculate hospital rates when the MLR requirement was implemented, and they expected that calculating rates for nonhospital services would be more challenging.

The tribal officials that we interviewed agreed that a cap on payments for nonhospital services, including physician services, could reduce CHS program payments to providers and achieve savings, although some officials noted that these benefits may not be achieved by all CHS programs. Some tribal officials indicated that a cap on nonhospital services at Medicare rates could save them money. For example, officials from one tribe said that, because individual providers had been unwilling to contract with them, they contract with a private insurer to utilize the rates that insurer has negotiated with providers. However, the tribal officials noted that the insurer's negotiated rates are still higher than Medicare rates, so capping CHS program payments for nonhospital services at Medicare rates would allow the tribe to further lower its rates without having to contract with the private insurer. They indicated that these savings would allow them to expand patient access to care. However, officials from some tribes worried that a cap could result in access-to-care problems if physicians decided to stop seeing CHS program patients because of the lower payment rates. For example, tribal officials from one area noted that, while a cap could be beneficial for the general CHS program, it could lead to problems for certain tribes. They said that some physicians serving a large, rural tribe in their area had already chosen not to participate in Medicare because of the low payment rates. IHS headquarters officials noted that they had heard similar concerns during their discussions with tribal officials, although the tribal

⁸⁶BCBSNM officials noted, for example, that because they currently pay few nonhospital claims at Medicare rates, they generally process such claims manually. If all nonhospital claims were required to be paid at Medicare rates, they would have to update their system to capture the claims data necessary to automatically process these claims.

officials had generally been supportive of a cap to reduce CHS program payments for nonhospital services, including physician services.

IHS officials indicated that it would be important to monitor patient access to care if CHS program payment rates for nonhospital services were changed. The officials said that IHS currently tracks the number of individuals who are unable to have care funded by the CHS program because, for example, of a lack of funding. However, it does not have a mechanism, such as a survey, to obtain information about patient access to care and physicians' willingness to accept CHS program payments. They said that IHS would likely be able to monitor these issues if mechanisms were put in place prior to any changes in payment rates.

Conclusions

IHS's CHS program serves as an important resource for American Indian and Alaska Native patients who need health care services that are not available in federal and tribal facilities. However, most federally and tribally operated CHS programs are unable to pay for all needed services, which underscores the need for them to maximize the care they can purchase within available funding. The 2007 implementation of the MLR requirement for hospitals allowed IHS and tribes to reduce the cost of hospital services and use those savings to pay for more care. Nonhospital services, including physician services, were not included in the scope of the MLR requirement, and the CHS program continues to rely on the ability of area offices to negotiate contracts with individual providers for reduced rates that are lower than billed charges. Since 1986, IHS policy has stated that area offices should attempt to negotiate with providers at rates that are no higher than Medicare rates, and IHS officials we interviewed described time-consuming efforts to establish such contracts. However, in 2010, IHS still primarily paid nonhospital providers, including physicians, at their billed charges. Our findings, which indicate that IHS could have saved an estimated \$32 million out of the \$62.5 million that federally operated CHS programs spent on physician services provided in 2010, are consistent with a 2009 OIG report and a 2009 internal IHS study. If trends in payments for other types of nonhospital services and the tribal CHS programs are similar to the payments for the federal CHS program physician services that we examined, we estimate that savings from capping all nonhospital services paid by federal and tribal CHS programs at Medicare rates could be significantly higher. These savings could be used to pay for some of the many services that the CHS program is unable to fund each year.

As a steward of public resources, IHS is responsible and accountable for using taxpayer funds efficiently and effectively. Despite the OIG's 2009 recommendation that IHS seek legislative authority to cap CHS program payments for nonhospital providers, including physicians, the agency has not pursued that authority. As a consequence, while other major federal health care payers have based their payment methodologies on Medicare, IHS still pays significantly higher billed charges for many services. Setting CHS program physician and other nonhospital payments at rates consistent with Medicare and the rates of these other federal agencies would enable IHS to achieve needed savings that could be used to expand patient access to health care. Moreover, given the possibility that a change in payment rates could affect access to care in certain areas, it is important that IHS put mechanisms in place to monitor patient access to care to assess how new payment rates may benefit or impede the availability of care.

Matter for Congressional Consideration

Congress should consider imposing a cap on payments for physician and other nonhospital services made through IHS's CHS program that is consistent with the rates paid by other federal agencies.

Recommendation for Executive Action

Should the Congress decide to cap payments for physician and other nonhospital services made through IHS's CHS program, we recommend that the Secretary of Health and Human Services direct the Director of IHS to monitor CHS program patient access to physician and other nonhospital care in order to assess how any new payment rates may benefit or impede the availability of care.

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review and received written comments, which are reprinted in appendix I. HHS agreed with our conclusions and our recommendation. Specifically, HHS indicated that implementing a cap on CHS program payments to physicians and other nonhospital services at Medicare rates would enable the CHS program to fund additional services. HHS also indicated that monitoring patient access to care in light of any payment changes is essential to providing high-quality health care to American Indians and Alaska Natives.

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 website at <http://www.gao.gov>.

If you or your staff 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 II.

A handwritten signature in cursive script that reads "Kathleen M. King".

Kathleen M. King
Director, Health Care

List of Addressees

The Honorable Maria Cantwell
Chairman

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

The Honorable Don Young
Chairman

The Honorable Colleen Hanabusa
Ranking Member
Subcommittee on Indian and Alaska Native Affairs
Committee on Natural Resources
House of Representatives

Tim Johnson
United States Senate

Lisa Murkowski
United States Senate

John Thune
United States Senate

Appendix I: 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

MAR 20 2013

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

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "INDIAN HEALTH SERVICE: Capping Payment Rates for Nonhospital Services Could Save Millions for Contract Health Services" (GAO-13-272).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "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: CAPPING PAYMENT RATES FOR NONHOSPITAL SERVICES COULD SAVE MILLIONS FOR CONTRACT HEALTH SERVICES" (GAO-13-272)

The Department appreciates the opportunity to comment on this draft report.

HHS is committed to improving the Indian Health Service's (IHS) Contract Health Services (CHS) program and has developed the following response to the GAO recommendation for executive action.

Recommendation:

Should the Congress decide to cap payments for physician and other nonhospital services made through IHS's CHS program, we recommend that the Secretary of Health and Human Services direct the Director of IHS to monitor CHS program patient access to physician and other nonhospital care in order to assess how any new payment rates may benefit or impede the availability of care.

HHS Response:

We concur with GAO's conclusions and recommendation. Implementing CHS program payments for physician and nonhospital services that are consistent with Medicare will enable the CHS program to fund additional needed services. However, CHS programs at the federal and tribal facilities will continue to be unable to pay for all eligible services despite increases in CHS program appropriated funds and the potential to provide additional services, as detailed in this report. Monitoring patient access to care as a result of any changes to payment rates is essential to providing quality health care to American Indian and Alaska Native patients.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact name above, Catina Bradley, Assistant Director; Julianne Flowers; William Hadley; Sarah-Lynn McGrath; Lisa Motley; Laurie Pachter; and Michael Rose made key contributions to this report.

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