



September 2019

INDIAN HEALTH SERVICE

Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections

Highlights of GAO-19-612, a report to congressional requesters

Why GAO Did This Study

IHS provides care to American Indians and Alaska Natives through a system of health care facilities. The Patient Protection and Affordable Care Act (PPACA) provided states with the option to expand their Medicaid programs, and created new coverage options beginning in 2014, including for American Indians and Alaska Natives. GAO was asked to review how PPACA has affected health care coverage and services for American Indians and Alaska Natives. In this report, GAO describes (1) trends in health insurance coverage and third-party collections at federally operated and tribally operated facilities from fiscal years 2013 through 2018, and (2) the effects of any changes in coverage and collections on these facilities.

To address these objectives, GAO analyzed IHS data on coverage, third-party collections, and PRC. GAO interviewed IHS officials from headquarters and all 12 area offices, as well as from 17 facilities selected to include a mix of federally operated and tribally operated hospitals and health centers in states that both had and had not expanded their Medicaid programs as of September 2018. GAO interviewed officials from 11 federally operated IHS facilities and 6 tribally operated facilities.

GAO provided a draft of this report to the Secretary of Health and Human Services for comment. The Department did not have any comments on the draft report.

View GAO-19-612. For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

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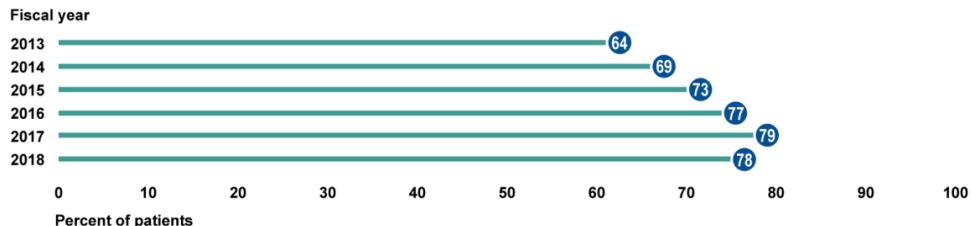
INDIAN HEALTH SERVICE

Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections

What GAO Found

GAO's analysis of Indian Health Service (IHS) data shows that from fiscal years 2013 through 2018, the percent of patients at federally operated IHS hospitals and health centers that reported having health insurance coverage increased an average of 14 percentage points. While all federally operated IHS facilities reported coverage increases, the magnitude of these changes differed by facility, with those located in states that expanded access to Medicaid experiencing the largest increases. Federally operated IHS facilities' third-party collections—that is, payments for enrollees' medical care from public programs such as Medicaid and Medicare, or from private insurers—totaled \$1.07 billion in fiscal year 2018, increasing 51 percent from fiscal year 2013. Although exact figures were not available, tribally operated facilities, which include hospitals and health centers not run by IHS, also experienced increases in coverage and collections over this period, according to officials from selected facilities and national tribal organizations.

Average Percent of Patients at Federally Operated IHS Facilities Reporting Health Insurance Coverage, Fiscal Years 2013 through 2018



Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-612

Note: Data represent patients' self-reported coverage information at each of the 73 federally operated IHS hospitals and health centers, averaged across the facilities, and do not reflect coverage through the Department of Veterans Affairs.

Increases in health insurance coverage and third-party collections helped federally operated and tribally operated facilities continue their operations and expand the services offered, according to officials from 17 selected facilities. These officials told GAO that their facilities have been increasingly relying on third-party collections to pay for ongoing operations including staff payroll and facility maintenance. Officials at most facilities with increases in third-party collections also stated that they expanded their onsite services, including increasing the volume or scope of services offered by, for example, adding new providers or purchasing medical equipment. Increased coverage and collections also allowed for an expansion in the complexity of services provided offsite through the Purchased/Referred Care (PRC) program, which enables patients to obtain needed care from private providers if the patients meet certain requirements and funding is available. According to IHS and facility officials, increases in coverage have allowed some patients to access care offsite using their coverage, and an expansion of onsite services has reduced the need for some patients to access PRC. Officials GAO interviewed from federally operated and tribally operated facilities stated that facilities' expansion of onsite and offsite services has led to enhancements in patients' access to care in some instances.

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Abbreviations

AI/AN	American Indian and Alaska Native
IHS	Indian Health Service
PPACA	Patient Protection and Affordable Care Act
PRC	Purchased/Referred Care

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

September 3, 2019

The Honorable Frank Pallone, Jr.
Chair
Committee on Energy and Commerce
House of Representatives

The Honorable Raul Ruiz, M.D.
House of Representatives

The Indian Health Service (IHS) is responsible for providing health care for over two million American Indians and Alaska Natives (AI/AN) who are members or descendants of federally recognized tribes.¹ According to IHS, its mission is to raise the physical, mental, social, and spiritual health of AI/AN to the highest level. IHS provides health care services to AI/AN either directly through a system of federally operated IHS facilities or indirectly through facilities that are operated by tribes or others.² As of February 2019, IHS, tribes, and tribal organizations operated 46 hospitals and 353 health centers as well as a range of other types of health facilities—of which 24 hospitals and 50 health centers were federally operated IHS facilities. With almost 5 million outpatient visits in fiscal year 2017, federally operated IHS facilities provide mostly primary and emergency care, as well as some other services, and are located in ten of IHS's twelve geographic areas.³ In certain circumstances when needed

¹Federally recognized tribes have a government-to-government relationship with the United States and are eligible to receive certain protections, services, and benefits by virtue of their status as Indian tribes. The Secretary of the Interior publishes annually in the Federal Register a list of all tribal entities that the Secretary recognizes as Indian tribes. As of February 2, 2019, there were 573 federally recognized tribes. See 84 Fed. Reg. 1200 (Feb. 1, 2019).

²Under 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 Director of IHS to take over the administration of IHS programs previously administered by IHS on their behalf. See generally 25 U.S.C. §§ 5301-5423. In fiscal year 2019, IHS allocated over 60 percent of its appropriations to tribes and tribal organizations to operate part or all of their own health care programs through self-determination contracts and self-governance compacts. Under the Indian Health Care Improvement Act, IHS also awards contracts and grants to non-profit urban Indian organizations that provide health care and referral services to urban Indians; however, this report does not include a review of such facilities.

³The twelve IHS areas are Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

health care services are not available at federally operated or tribally operated facilities, care may be obtained from private providers and paid for through IHS's Purchased/Referred Care (PRC) program.

AI/AN have experienced long-standing problems accessing needed health care services and have historically had poorer health than the U.S. general population, as evidenced by a shorter average life span and higher incidence of certain medical conditions—many of which can be mitigated through access to effective preventive primary care services. In prior reports we have noted that IHS has not been able to pay for all eligible health care services, leading to an unmet need for health care among AI/AN.⁴ In February 2017, GAO added federal management of programs that serve Indian tribes and their members to our High Risk List because inadequate oversight hindered IHS's ability to ensure that Indian communities have timely access to quality health care, among other reasons.⁵

Like most federal agencies, IHS receives funding through annual appropriations, which it uses to fund federally operated and tribally operated facilities throughout the country. These facilities may also bill public programs such as Medicaid (the federal-state health insurance program for certain low-income individuals), Medicare (the federal health insurance program for persons aged 65 and over, and certain others), and the Department of Veterans Affairs (which provides health care services for veterans), as well as private insurance, for care provided to patients.⁶ Federally operated and tribally operated facilities are allowed to retain collections from these payers—referred to as third-party collections—without an offset to any other appropriations made to IHS.⁷ Unlike funds made available through annual appropriations acts, which generally must be obligated during the fiscal year for which they were

⁴GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, [GAO-05-789](#) (Washington, D.C.: Aug. 31, 2005), and *Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need*, [GAO-11-767](#) (Washington, D.C.: Sept. 23, 2011).

⁵The recommendations GAO identified in this high-risk area are neither reflective of the performance of programs administered by tribes nor directed at any tribally operated programs and activities. See GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, [GAO-17-317](#) (Washington, D.C.: Feb. 15, 2017).

⁶25 U.S.C. §§ 1621e(a), 1621f(a).

⁷See 25 U.S.C. § 1621(b).

appropriated, third-party collections are available to facilities until expended.

Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) provided opportunities to expand coverage of AI/AN through Medicaid and private health insurance.⁸ PPACA also provided that IHS is the payer of last resort for all health services provided at federally operated and tribally operated facilities—meaning that enrollees' health insurance coverage should pay for care, to the extent of its liability, before IHS. Increased AI/AN enrollment in health insurance such as Medicaid may increase revenue for federally operated and tribally operated facilities, even if the patient population remains constant, if those with coverage seek care at such facilities. Health insurance may also provide AI/AN with options to obtain care outside of federally operated or tribally operated facilities, including more comprehensive health services, if such options exist in their community.

In 2013, we reported that most AI/AN were potentially eligible for expanded coverage created by PPACA, but action was needed to increase enrollment.⁹ You asked us to review how PPACA has affected AI/AN access to health care. In this report we describe, for fiscal years 2013 through 2018,

1. trends in health insurance coverage among AI/AN populations served by federally operated and tribally operated facilities as well as trends in third-party collections at these facilities, and
2. the effects of any changes in health insurance coverage and third-party collections on federally operated and tribally operated facilities.

To describe trends in health insurance coverage among AI/AN populations served by federally operated and tribally operated facilities,

⁸Specifically, PPACA provided states with the option to expand Medicaid eligibility to certain adults with incomes below a threshold; required the establishment of health insurance exchanges; and provided certain AI/AN with cost sharing exemptions for private health insurance plans purchased on the health insurance exchanges. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. For purposes of this report, references to PPACA include the amendments made by the Health Care and Education Reconciliation Act of 2010.

⁹GAO, *Indian Health Service: Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment*, GAO-13-553 (Washington, D.C.: Sept. 5, 2013).

we analyzed IHS data representing the self-reported health insurance status of patients seeking care at all 73 federally operated IHS hospitals and health centers that were in operation from fiscal years 2013 through 2018.¹⁰ We also analyzed IHS data on the amount and source of third-party collections at all IHS facilities—including hospitals, health centers, health clinics or other types of facilities—that were federally operated throughout this period.¹¹ We assessed the reliability of these data by reviewing related documentation, interviewing IHS officials, and examining the data for missing values and outliers. On the basis of these steps, we concluded that the data were sufficiently reliable for the purposes of our reporting objective. Similar aggregate data on trends in health insurance coverage and collections at tribally operated facilities are not available because these facilities are not required to report coverage and collections data to IHS. For information and context on trends in coverage and collection at federally operated and tribally operated facilities, we interviewed officials from IHS headquarters and all 12 area offices, as well as those from 17 facilities, which we selected to include a mix of federally operated and tribally operated facilities, including hospitals and health centers ranging in size and location and those operating in states that had expanded their Medicaid programs as of September 2018 as well as those that had not.¹² In total, we interviewed officials from 11 federally operated facilities and 6 tribally operated

¹⁰While there were 74 federally operated IHS hospitals and health centers in operation as of fiscal year 2018, one of these did not routinely provide billable services during this time period, according to IHS officials, and is not included in our analysis. The 73 federally operated IHS hospitals and health centers included 47 facilities located in 11 states that had expanded Medicaid as of September 2018, and 26 located in 8 states that had not.

¹¹Our analysis of IHS's third-party collections at federally operated facilities reflects collections at all such facilities in operation from fiscal years 2013 through 2018, including the 73 federally operated hospitals and health clinics included in our analysis of changes in coverage. The collections data were provided to us in an aggregated format that included 40 federally operated service units (which may contain one or more facilities) as well as 45 individual facilities such as hospitals, health centers, and smaller health clinics. Service units may cover a number of small reservations, or, conversely, some large reservations may be covered by several service units.

¹²We interviewed officials from the following 11 federally operated IHS facilities: Blackfeet Community Hospital, Cass Lake Hospital, Chemawa Indian Health Center, Claremore Indian Hospital, Lawton Indian Hospital, Not-Tsoo Gah-nee Indian Health Center, Phoenix Indian Medical Center, Red Lake Hospital, White Earth Health Center, Whiteriver Indian Hospital, and Yakama Indian Health Center. We also interviewed officials from the following six tribally operated facilities: Cow Creek Health and Wellness Center, Inchelium Community Health Center, Jamestown Family Health Clinic, San Carlos Apache Healthcare Corporation, San Poil Valley Community Health Center, and Yellowhawk Tribal Health Center.

facilities across 7 states, with 14 facilities located in states that expanded Medicaid, and 3 located in states that had not. Our findings from these interviews cannot be generalized to all federally operated or tribally operated facilities. For context, we also interviewed officials from the National Indian Health Board, five area Indian health boards which we selected to include a mix of areas with predominantly tribal facilities as well as those with federally operated and tribally operated facilities, as well as officials from the National Congress of American Indians and the Tribal Self-Governance Advisory Committee.¹³

To describe the effects of any changes in health insurance coverage and third-party collections on federally operated and tribally operated facilities from fiscal years 2013 through 2018, we interviewed IHS officials, including those at headquarters and all 12 area offices, as well as officials from the 17 selected facilities. We also interviewed officials from the five selected area Indian health boards, and the three selected national tribal organizations. We asked these officials to identify the effects of changes in coverage and collections. Our findings from these interviews cannot be generalized to all federally operated or tribally operated facilities. We also analyzed IHS data on the scope of care provided through IHS's PRC program from fiscal year 2015—the first year data were available—through fiscal year 2018.¹⁴ This IHS data reflect care provided through IHS-administered PRC programs, which represented 39 percent of total PRC appropriations in fiscal year 2018; similar data on the scope of care provided through tribally-administered PRC programs, which account for the remaining portion of PRC appropriations, were not available because such data are not required to be reported to IHS. We assessed the reliability of these data by interviewing IHS officials and examining the

¹³The National Indian Health Board is a nonprofit organization that represents tribal governments—both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from the Indian Health Service (IHS). Among other things, it provides policy analysis and advocacy on AI/AN health issues. Area Indian health boards are organizations that advocate for the health needs of tribes in geographic regions that largely align with those supported by IHS's area offices. We interviewed officials from the Alaska Native Health Board, California Rural Indian Health Board, Inter Tribal Council of Arizona, Inc., Northwest Portland Area Indian Health Board, and United South and Eastern Tribes, Inc. The National Congress of American Indians is a nonprofit organization that promotes the economic development and health and welfare in AI/AN communities, among other things. The Tribal Self-Governance Advisory Committee provides information, education, advocacy and policy guidance for implementation of self-governance within IHS.

¹⁴Fiscal year 2015 represents the first year that IHS collected national data on the scope of care provided through IHS-administered PRC programs.

data for missing values and outliers. On the basis of these steps, we concluded that the data were sufficiently reliable for the purposes of our reporting objective.

We conducted this performance audit from July 2018 through September 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Indian Health Service

IHS was established within the Public Health Service in 1955 in order to meet federal treaty obligations to provide health services to members of federally recognized AI/AN tribes primarily in rural areas on or near reservations. IHS oversees its provision of health care services through a decentralized system of 12 area offices, which are led by area directors and located in 12 geographic areas.¹⁵ IHS's headquarters office is responsible for setting national health care policy, ensuring the delivery of quality comprehensive health services, and advocating for the health needs and concerns of AI/AN people. The area offices are responsible for monitoring federally operated IHS facilities' operations and finances, and providing guidance and technical assistance.

IHS's 12 area offices oversee 168 service units which provide care at the local level through a total of 742 federally operated and tribally operated hospitals, health centers, and other health facilities. The types of services offered by these facilities vary, but most commonly include primary care

¹⁵As of fiscal year 2018, nine of these twelve IHS areas had two or more federally operated IHS facilities—Albuquerque, Bemidji, Billings, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, and Portland. In fiscal year 2018, the California area had one federally operated IHS facility and the Alaska and Tucson areas had no federally operated IHS facilities.

and emergency care, as well as some ancillary and specialty services.¹⁶ Table 1 displays the number of federally operated and tribally operated facilities as of February 2019.

Table 1: Indian Health Service Federally Operated and Tribally Operated Facilities, as of February 2019

Facility type	Federal	Tribal	Total
Hospital	24	22	46
Health centers	50	303	353
Other facilities ^a	35	308	343
Total	109	633	742

Source: Indian Health Service. | GAO-19-612

^aOther facilities include health stations and school health clinics, which provide primary care services and are open less than 40 hours a week, as well as Alaska village clinics, dental clinics, and substance abuse treatment facilities.

PRC Program

If federally operated or tribally operated facilities are unable to provide needed care, they may contract for health services from private providers through the PRC program. Patients must meet certain eligibility and administrative requirements in order to qualify for this care—including having exhausted all other health care resources available to them and living on a federally recognized Indian reservation or within a designated PRC delivery area.¹⁷

The PRC program is funded through the annual appropriations process and administered at the local level by individual PRC programs that are often affiliated with local facilities. Individual PRC programs may be federally or tribally administered, and as of fiscal year 2018, IHS administered 39 percent of PRC appropriations, and tribes administered the remaining 61 percent.

¹⁶For example, federally operated IHS hospitals range in size from 4 to 133 beds and are open 24 hours a day for urgent care needs. Federally operated IHS health centers offer a range of care, including primary care services and some ancillary services, such as pharmacy, laboratory, and X-ray, and are open for at least 40 hours a week. Other federally operated IHS facilities include health stations and school health clinics, which provide primary care services and are open less than 40 hours per week.

¹⁷PRC delivery areas typically encompass reservation and trust lands—areas located on or off a reservation, for which the United States holds title in trust for the benefit of a tribe or individual Indian—and bordering counties. AI/AN living outside of these areas, which may include many urban Indians, are therefore unlikely to be eligible for PRC.

PRC funding is limited and has traditionally been reserved for the most critical cases. IHS has established five medical priority levels. Funds permitting, federally administered PRC programs first pay for all of the highest priority services, and then all or some of the lower priority services.¹⁸ IHS's five PRC medical priority levels are

1. **Emergent and acutely urgent care services**, which include treatment for threats to life, limb, or senses;
2. **Preventive care services**, which include prenatal care and mammograms;
3. **Primary and secondary care services**, which include scheduled ambulatory services for nonemergent conditions, and specialty consultations;
4. **Chronic tertiary and extended care services**, which include rehabilitation care, skilled nursing facility care, and organ transplants; and
5. **Excluded services**, which include cosmetic and experimental procedures.

PPACA Health Coverage Expansion Provisions for AI/AN

Beginning in 2014, PPACA allowed states to expand Medicaid eligibility to non-elderly, non-pregnant adults who are not eligible for Medicare and whose income does not exceed 133 percent of the federal poverty level.¹⁹ As of September 2018, there were 32 "expansion states"—those states including the District of Columbia that chose to expand Medicaid eligibility

¹⁸Federally administered PRC programs must use these levels to prioritize funding for medical care, whereas tribally administered PRC programs may establish their own mechanisms for funding care.

¹⁹PPACA provides a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases income eligibility from 133 percent to 138 percent of the federal poverty level. See Pub. L. No. 111-148, §§ 2001(a)(1), 2002, 124 Stat. 119, 271, 279 (2010); Pub. L. No. 111-152, § 1004(e), 124 Stat. 1029, 1034 (2010) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) and 42 U.S.C. § 1396a(e)(14)(B)(I)). The federal poverty level is based on household income and family size, using the U.S. Census Bureau's poverty thresholds. For 2018, 138 percent of the federal poverty level for those residing in the contiguous United States or the District of Columbia was \$16,753 for an individual and \$34,638 for a family of four; amounts are higher for those living in Alaska and Hawaii. PPACA also permitted an early expansion option, whereby states could expand eligibility for this population, or a subset of this population, starting on April 1, 2010.

to this additional adult population—and 19 “non-expansion states”—those that had not expanded Medicaid eligibility.²⁰

PPACA also required the establishment of health insurance exchanges in 2014—marketplaces where individuals may compare and select among health insurance plans offered by participating private insurers. PPACA included a number of provisions that reduced these plans’ costs—including premiums and cost-sharing, such as deductibles and copayments—for eligible enrollees, including certain AI/AN.²¹

²⁰Specifically, the 31 states that expanded their Medicaid programs as of September 2018 were Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia.

States that had not expanded their Medicaid programs as of September 2018 were Alabama, Florida, Georgia, Idaho, Kansas, Maine, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

²¹Specifically, PPACA offers a premium tax credit for enrollees purchasing coverage on the exchange that have household incomes between 100 and 400 percent of the federal poverty level. PPACA also offers cost-sharing reductions for enrollees who qualify for premium tax credits, have household incomes between 100 and 250 percent of the federal poverty level, and enroll in a silver tier plan. In addition, AI/AN who obtain insurance through an exchange are eligible for cost-sharing exemptions if they are members of federally recognized tribes and have a household income of not more than 300 percent of the federal poverty level. Pub. L. No. 111-148, § 1402(d)(1), 124 Stat. 119, 222 (2010) (codified at 42 U.S.C. § 18071(d)(1)).

Health Insurance Coverage and Third- Party Collections at Federally Operated IHS Facilities Increased from 2013 to 2018; Tribal Facility Officials Also Reported Increases

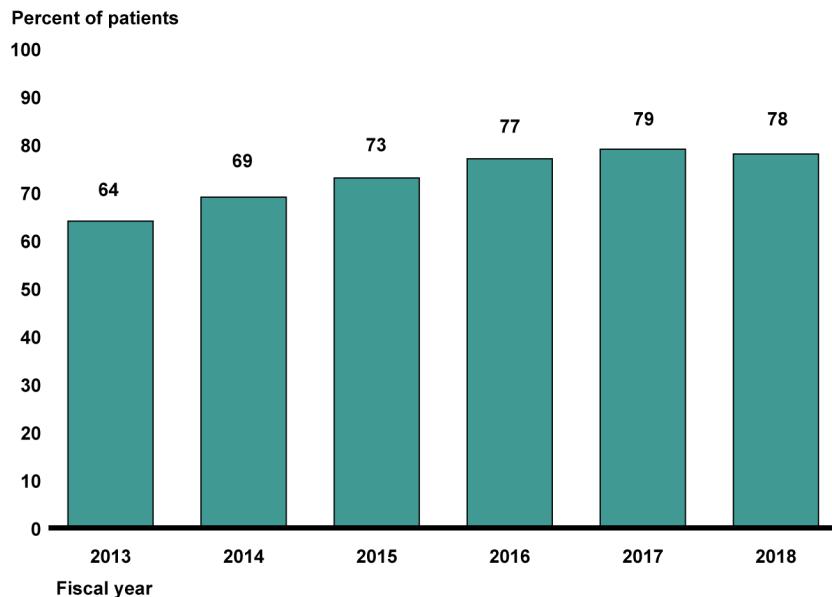
**IHS Data Show Increase
in Percent of Patients with
Health Insurance
Coverage at Federally
Operated IHS Facilities
from 2013 through 2018**

Our analysis of IHS data shows that from fiscal year 2013 through fiscal year 2018, the percent of patients at 73 federally operated IHS hospitals and health centers who reported having health insurance coverage increased an average of 14 percentage points, from 64 percent in fiscal year 2013 to 78 percent in fiscal year 2018.²² The majority of coverage gains occurred in fiscal years 2014 through 2016 (see fig. 1).²³

²²Data represent patients' self-reported coverage information collected during patient registration. Percentages from each of the federally operated IHS hospitals and health centers were averaged across the 73 facilities. Results do not reflect coverage through the Department of Veterans Affairs.

²³Trends in coverage at federally operated IHS facilities mirror those seen in the general AI/AN population. For more information about trends in health insurance coverage of the AI/AN population, see Appendix I.

Figure 1: Average Percent of Patients at Federally Operated IHS Facilities Reporting Health Insurance Coverage, Fiscal Year 2013 through Fiscal Year 2018



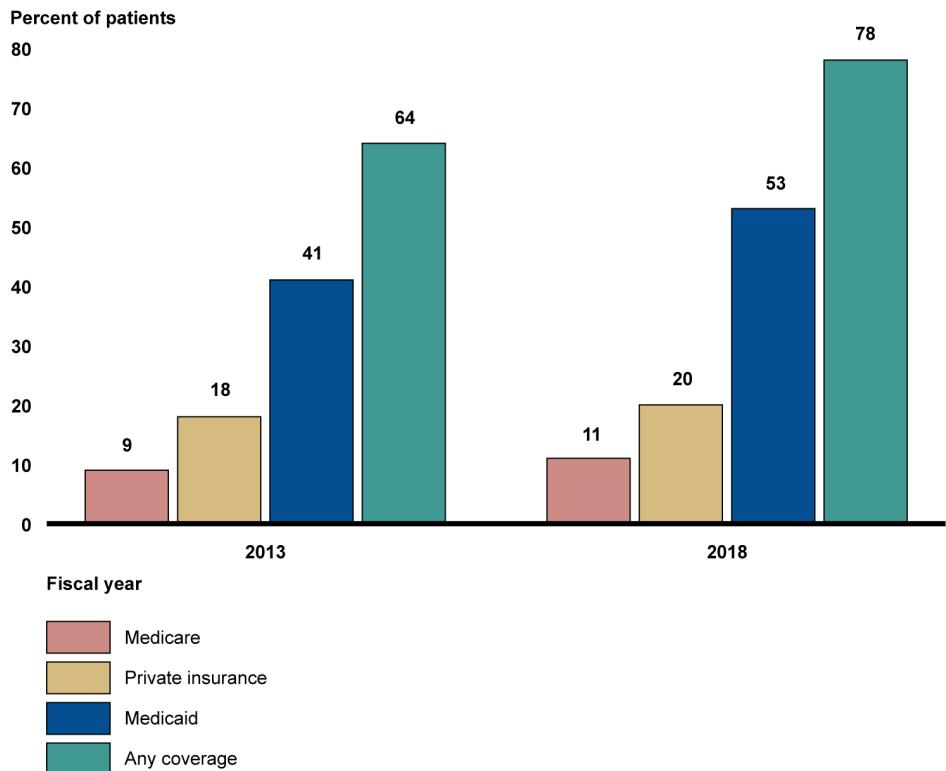
Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-612

Note: Data represent patients' self-reported coverage information at each of the 73 federally operated IHS hospitals and health centers, averaged across the facilities, and do not reflect coverage through the Department of Veterans Affairs.

Patients at federally operated IHS facilities reported obtaining health insurance coverage from several sources. The largest increase in coverage occurred among those reporting Medicaid coverage. On average, 41 percent of IHS patients in fiscal year 2013 reported they had coverage through Medicaid at some point during the year; this number increased to 53 percent in fiscal year 2018. In comparison, the percent of patients at each facility who reported having Medicare and the percent who reported having private insurance at some point during the year each increased an average of two percentage points from fiscal years 2013 to 2018.²⁴ (See fig. 2.)

²⁴Coverage type categories are not mutually exclusive and therefore do not sum to 100 percent.

Figure 2: Average Percent of Patients Reporting Health Insurance Coverage at Federally Operated IHS Facilities, by Year and Coverage Type, Fiscal Year 2013 and Fiscal Year 2018

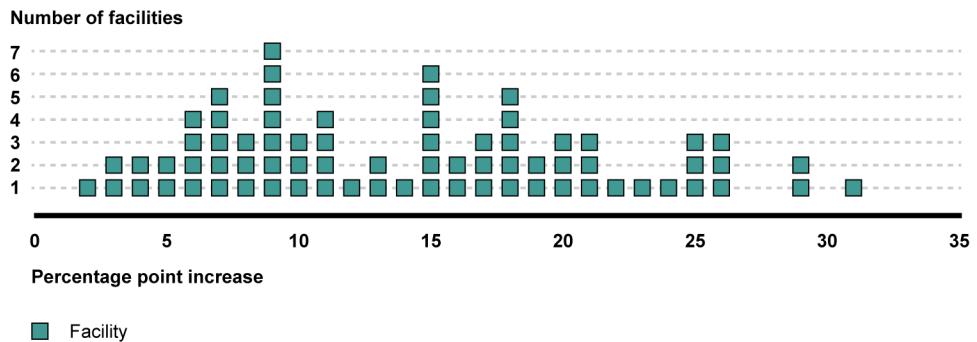


Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-612

Notes: Data represent patients' self-reported coverage information at each of the 73 federally operated IHS hospitals and health centers, averaged across the facilities, and do not reflect coverage through the Department of Veterans Affairs. Coverage type categories are not mutually exclusive and therefore do not sum to 100 percent. For example, a patient may have both Medicare and private insurance coverage. Any coverage includes patients that report having coverage through Medicaid, private insurance, Medicare, or any combination of those coverage types.

While the average percent of patients reporting health care coverage increased across all federally operated IHS facilities, our analysis of IHS data showed substantial variation in the magnitude of these increases. Specifically, from fiscal year 2013 through fiscal year 2018, increases at each of the 73 facilities ranged from a low of 2 to a high of 31 percentage points. Forty-four federally operated IHS facilities experienced an increase in the percent of patients with coverage over this time period of more than 10 percentage points (see fig. 3).

Figure 3: Distribution of Percentage Point Increase in Patient-Reported Health Insurance Coverage at Federally Operated IHS Facilities, Fiscal Years 2013 through 2018



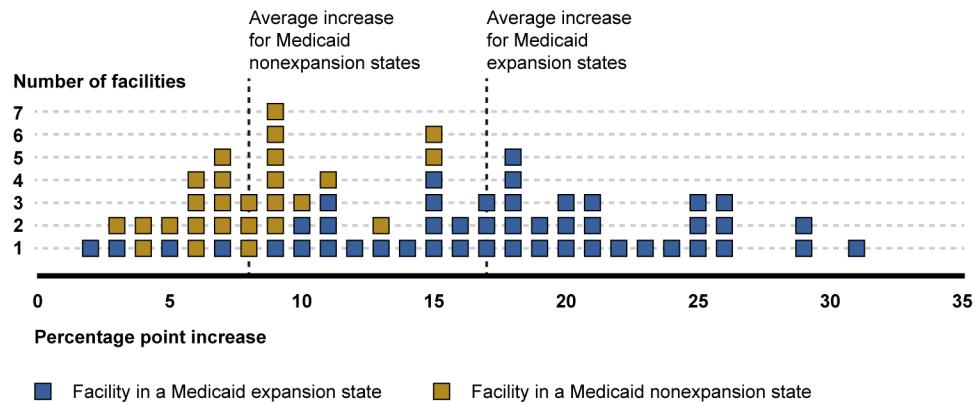
Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-612

Note: Data represent patients' self-reported coverage information from 73 federally operated IHS hospitals and health centers, and do not reflect coverage through the Department of Veterans Affairs.

Our analysis of IHS data shows that federally operated IHS facilities in states that expanded Medicaid had larger increases in health insurance coverage compared with such facilities in states that had not expanded Medicaid. Specifically, federally operated IHS facilities in Medicaid expansion states experienced an average 17 percentage point increase in patients reporting any form of health coverage, compared with an average 8 percentage point increase at federally operated IHS facilities in states that did not expand Medicaid.²⁵ However, these increases in coverage were not spread evenly among the facilities. (See fig. 4.)

²⁵Data reflect the experience of 47 federally operated IHS facilities located across 11 states that expanded Medicaid and 26 federally operated IHS facilities located across 8 states that did not expand Medicaid.

Figure 4: Distribution of Percentage Point Increase in Patient-Reported Health Insurance Coverage at Federally Operated IHS Facilities, by State Medicaid Expansion Status, Fiscal Years 2013 through 2018



Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-612

Note: Data represent patients' self-reported coverage information from 73 federally operated IHS hospitals and health centers, and do not reflect coverage through the Department of Veterans Affairs.

IHS officials we interviewed also reported that a variety of factors in addition to Medicaid expansion likely affected the number of patients at federally operated IHS facilities who reported having health insurance coverage. Specifically, officials we interviewed at all of the 11 selected federally operated IHS facilities cited efforts at their facilities that helped increase coverage, such as increasing the number of onsite patient benefits coordinators to help enroll patients in all forms of health coverage and enhancing efforts to ensure that all patients were screened for coverage. For example, one federally operated IHS facility reported renovating its office to, among other things, move the patient benefits coordinator near the waiting room, which allowed patients to be immediately screened after walking in for an appointment. Officials we interviewed at nearly all of the selected federally operated IHS facilities also noted that their outreach and education efforts about the importance of health insurance coverage may have helped to increase enrollment. Officials we interviewed at all of the selected federally operated IHS facilities said they were engaged in such activities which included broadcasting public service announcements, posting newspaper advertisements, and promoting insurance during community events. Officials from most of the 12 IHS area offices also reported collaborating with tribes to conduct outreach and education to enhance enrollment.

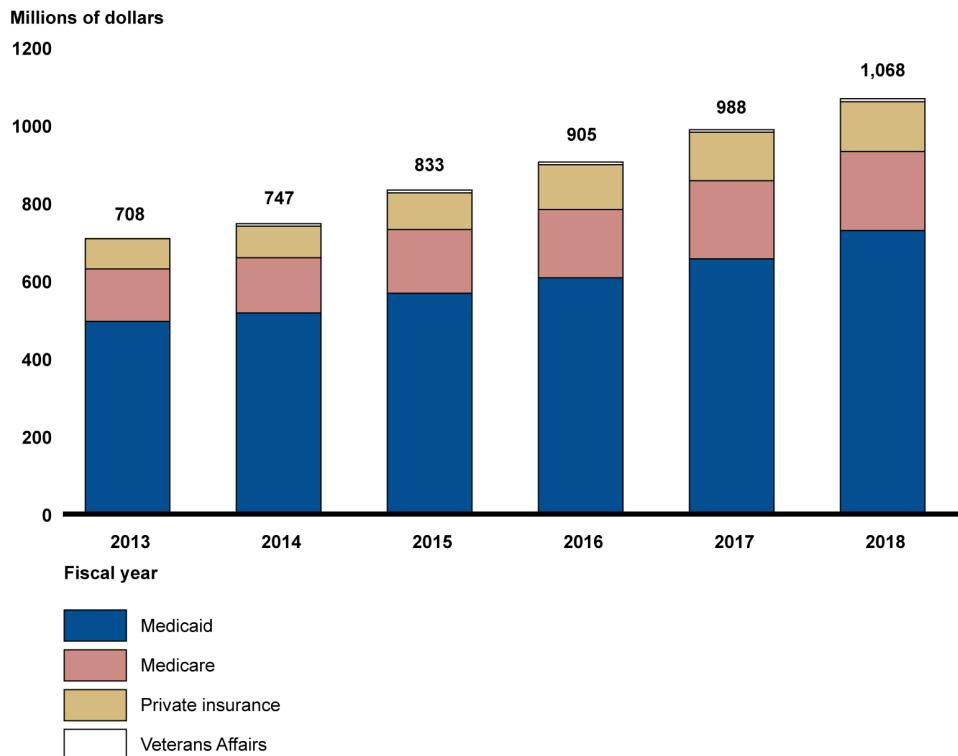
Officials at many IHS area offices also noted that external factors may have also played a role in increasing coverage levels, such as improvements in the local economy, which officials said led to increases in the number of patients with private health insurance. Additionally, entities outside of IHS also implemented initiatives to increase coverage for patients at federally operated IHS facilities. For example, IHS officials stated that some patients obtained health insurance through the health insurance exchanges, and in some cases, the tribe paid all premiums, coinsurance, and deductibles for these plans. In addition, a number of area Indian health boards worked together to develop a train-the-trainer program to disseminate information and resources to encourage enrollment and share information on the benefits of having health coverage.

Total Third-Party Collections at Federally Operated IHS Facilities Increased 51 Percent from Fiscal Years 2013 through 2018

Third-party collections across all federally operated IHS facilities increased 51 percent from fiscal year 2013 through fiscal year 2018, according to our analysis of IHS data. Specifically, total third-party collections increased from \$708 million in fiscal year 2013 to about \$1.07 billion in fiscal year 2018 while the number of patients seeking care remained constant.²⁶ Medicaid collections accounted for 65 percent of the total \$360 million increase, though collections from Medicare, private insurance, and Veterans Affairs also increased during this period. For example, Medicaid collections grew 47 percent, from \$496 million in fiscal year 2013 to \$729 million in fiscal year 2018. (See fig. 5.)

²⁶According to our analysis of IHS coverage data, the number of patients seeking care at federally operated IHS facilities changed less than one-half of one percent between fiscal years 2013 and 2018.

Figure 5: Total Collections for Federally Operated IHS Facilities, by Source, Fiscal Years 2013 through 2018



Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-612

Note: Third-party collections are presented in nominal dollars.

While third-party collections at federally operated IHS facilities collectively increased from fiscal year 2013 through 2018, there was significant variation in changes for individual facilities. IHS officials we interviewed noted several reasons why third-party collections may vary over time and by location, including

- the size of the facility and any changes in the number of providers, patients, or business office staff that process billing and collections;
- the ability to collect payment from certain tribal health insurance, which may opt to not pay for services provided to enrolled members; and

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- the number of patients enrolled in Medicaid managed care plans, which may identify IHS facilities as out-of-network providers and not pay for covered services.²⁷

IHS and federally operated facility officials we interviewed noted that gains in health insurance coverage during this time period contributed to increases in collections. In addition, officials we interviewed from most of the 12 area offices and 11 selected federally operated IHS facilities described steps they took to enhance collections. More specifically, officials from seven area offices discussed initiating steps to improve billing and collections functions for federally operated IHS facilities in their area; at one area office this involved creating a new area-level position focused on revenue enhancement at federally operated IHS facilities. Additionally, officials we interviewed at six federally operated IHS facilities identified steps they took to enhance the accuracy and efficiency of facilities' collections, noting efforts such as improving training related to coding and billing. For example, officials at one of these facilities described convening a team to review why all claims related to a specific service were being rejected. The team then instituted changes to their billing procedures that resulted in the facility collecting payments for these services.

<p>Officials from Selected Tribally Operated Facilities and Tribal Organizations Described Increases in Health Insurance Coverage and Third-Party Collections at Some Tribal Facilities</p>	<p>Officials we interviewed at selected tribally operated facilities and tribal organizations—including national tribal organizations and area Indian health boards—described increases in health insurance coverage and collections at some tribally operated facilities that occurred from 2013 through 2018. Specifically, some tribal organization officials reported increases in coverage at facilities located in states that had expanded their Medicaid programs, compared with those that had not. For example, officials at one tribally operated facility noted that the percent of their patients with health coverage increased by 10 percentage points from 2013 to 2018.</p>
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²⁷According to officials from one federally operated facility, while the state Medicaid program was supposed to enroll tribal members in a fee-for-service plan that would enable enrollees to use such coverage at their facility, some tribal members had been erroneously enrolled in a Medicaid managed care plan, making it difficult for the facility to collect payment for covered services. Officials from a few tribally operated facilities and area Indian health boards also reported similar challenges.

Similar to federally operated IHS facilities, officials we interviewed from some tribally operated facilities said they focused on screening patients for coverage at the time of service, including by increasing the number of patient benefits coordinators and always having staff available to help enroll patients in coverage. These officials also noted that they conducted outreach and enrollment activities to inform patients of the importance of having coverage and benefitting from outreach and education activities conducted directly by local tribes, including through messages that emphasized the importance of coverage for the tribe and tribally operated facility. Officials from a national tribal organization told us that one tribally operated facility placed stickers on all equipment purchased with third-party collections as a way to educate patients about the benefits of having health insurance coverage and to encourage further enrollment in coverage.

Officials we interviewed at selected tribally operated facilities and national tribal organizations also described increases in third-party collections that occurred from 2013 through 2018 at many tribally operated facilities—particularly those located in Medicaid expansion states. For example, officials from one tribally operated facility told us that they anticipated that their third-party collections for 2018 would be more than twice the amount they collected for 2013.²⁸ Similar to federally operated IHS facilities, officials we interviewed from some tribally operated facilities noted that their facilities had enhanced collections by making improvements to their billing processes and taking steps to increase patient volume. For example, officials at one tribally operated facility said they recently began allowing non-tribal members to receive care at their facility—an option available to tribally operated facilities but not to federally operated IHS facilities—as a way to increase third-party collections and bolster the facility's long-term sustainability.²⁹

Some officials also noted that not all tribally operated facilities experienced increases in collections, in part because of decreases or limitations in the number of providers, patients, or business office staff that process billing and collections. Similar to federally operated IHS

²⁸Final 2018 collections amounts for this facility were unavailable at the time of our interview.

²⁹Federally operated IHS facilities generally provide services to eligible AI/AN and certain non-Indians, such as children of eligible AI/AN. See 25 U.S.C. § 1680c; 42 C.F.R. §§ 136.12, 136.14 (2018). Tribally operated facilities, however, have in some cases chosen to provide services to a broader patient population.

facilities, officials from tribally operated facilities noted that the enrollment of patients in Medicaid managed care plans also reduced their ability to collect payment for covered services because these plans often identify the facilities as out-of-network providers and therefore do not pay for covered services provided onsite.

Increases in Coverage and Collections Reportedly Helped Selected Federally Operated and Tribally Operated Facilities to Continue Operations and Expand Services

Continued Operations

Officials we interviewed from selected federally operated and tribally operated facilities stated that increases in coverage and third-party collections helped them to (1) continue their facilities' operations, (2) expand the services they offer onsite at their facilities, and (3) expand the services they cover offsite through IHS's PRC program.

Officials we interviewed from all 17 selected federally operated and tribally operated facilities noted that they used increased third-party collections to fund their continued operations. Even as officials we interviewed from nearly all of the 11 selected federally operated IHS facilities reported that their facilities' third-party collections had grown from fiscal years 2013 to 2018, officials from most of these facilities also said they relied more heavily on these collections to support their continued operations. Officials we interviewed from all of the IHS area offices told us that third-party collections provide a vital source of funding for federally operated IHS facilities in their area. These collections allowed them to maintain a level of operations that would otherwise be challenging, for reasons such as increasing costs of payroll and of maintaining an aging infrastructure. In addition, officials we interviewed from most of the selected federally operated IHS facilities reported using third-party collections to fund a substantial and increasing portion of their payroll costs. Officials at many of the IHS area offices and most of the selected federally operated IHS facilities we interviewed also reported using third-party collections to ensure that their facility met all required standards, including those required for ongoing accreditation, or to undertake any needed maintenance such as by repairing roofs and heating systems. Some of these officials also reported using third-party

collections to repair or replace medical equipment that was broken or had exceeded its intended lifespan. Table 2 displays examples of how selected federally operated and tribally operated facilities reported using third-party collections.

Table 2: Examples of How Selected Federally Operated and Tribally Operated Facilities Used Third-Party Collections to Continue Operations or Expand Services, Fiscal Years 2013 through 2018

Category	Examples
Providers	<ul style="list-style-type: none"> Hiring or contracting to offer increased onsite services through primary care physicians, nurse practitioners, behavioral health specialists, cardiologists, dentists, podiatrists, and others. Offering more competitive wages to assist with recruiting providers. Offering recruitment, relocation, and retention bonuses for providers. Funding efforts to construct and make available government housing for providers near facilities. Developing a training program for local tribal members to become health care providers.
Medical equipment	<ul style="list-style-type: none"> Repairing, purchasing, or contracting to provide enhanced access to diagnostic medical equipment including ultrasound, x-ray, computed tomography scan, and magnetic resonance imaging machines. Purchasing hospital beds and stretchers, dental equipment and chairs, surgical devices, electrocardiogram machines, and patient monitoring systems.
Health promotion and education activities	<ul style="list-style-type: none"> Continuing to provide intensive diabetes case management interventions to reduce cardiovascular disease after expiration of IHS's Healthy Hearts grant funding. Establishing or continuing diabetes education and nutrition programs. Providing a free anticoagulation clinic. Establishing targeted interventions to reduce the number of patients with uncontrolled high blood pressure.
Expanding and renovating facilities	<ul style="list-style-type: none"> Repairing facility infrastructure, including roofs and heating systems. Renovating existing space, such as operating rooms, emergency rooms, and patient care areas to improve patient flow and meet industry standards. Expanding a facility by adding exam rooms within the current facility or constructing a new building to be part of an existing facility. Purchasing modular buildings or leasing space to increase capacity. Enhancing existing information technology infrastructure, including by implementing an electronic health records system and replacing wiring and servers.
Purchased/Referred Care (PRC) ^a	<ul style="list-style-type: none"> Supplementing appropriated funds for PRC to enhance access to offsite services.

Source: Indian Health Service. | GAO-19-612

Note: Table reflects information gathered through interviews with officials from 12 Indian Health Service area offices and 17 selected federally operated and tribally operated facilities.

^aPRC programs enable patients to obtain health care services from private providers if the patients meet certain requirements and funding is available.

Expanded Services Onsite

Officials we interviewed from most of the 17 selected federally operated and tribally operated facilities told us they used increased third-party collections to expand the volume or scope of services they offered onsite as a way to better meet patients' medical needs.³⁰ With respect to increasing the volume of services provided, officials at most of these facilities said they added providers and medical equipment to provide patients with more timely access to services. In one example, officials from a federally operated IHS hospital said they added about 30 additional nurses from 2013 to 2018 as a result of increased third-party collections. As a result of increases in the number of providers at their facilities, officials we interviewed from several federally operated IHS facilities said they were able to schedule appointments for patients more quickly, which reduced wait times for an appointment—including two facilities that reported being able to newly offer same-day appointments.³¹ Officials from facilities that expanded the scope of services provided said they did so by adding new specialties, such as behavioral health and dentistry, purchasing new medical equipment such as hospital beds, dental chairs, and magnetic resonance imaging machines, and funding health promotion and education activities such as those related to diabetes education. (See fig. 6.)

³⁰While officials from most of the selected facilities reported adding services that could be reimbursed through third-party collections to help keep those services sustainable, officials from a few federally operated IHS facilities also noted they added services such as acupuncture and chiropractor services that are not traditionally reimbursed through insurance as a way to further meet the needs of their patient populations.

³¹We previously reported that a lack of primary care providers, as well as aging infrastructure and equipment, were significant obstacles to IHS in ensuring that patients receive timely care. See GAO, *Indian Health Service: Actions Needed to Ensure Patients' Access to Timely Care*, GAO-16-333 (Washington, D.C.: Mar. 29, 2016).

Figure 6: Example of Equipment Purchased with Third-Party Collections at a Federally Operated Indian Health Service (IHS) Facility



This dental chair with x-ray capability allows dentists to view x-rays while performing oral surgery.

Source: GAO. | GAO-19-612

To support efforts to expand services and bolster their sustainability, officials from most of the 17 federally operated and tribally operated facilities said they used third-party collections to offer more competitive salaries and bonuses for providers. In addition, officials from a few of the 12 IHS area offices told us that federally operated facilities in their area used third-party collections to fund projects to construct nearby housing for providers.³² In another example, officials from a national tribal organization noted that the use of third-party collections to enhance provider salaries at one facility led to a decrease in provider turnover from about 40 percent prior to 2014 to 14 percent in 2018. In addition, officials

³²In 2018, we reported that the overall vacancy rate for IHS providers was 25 percent, and we identified challenges the agency faces with respect to recruiting and retaining providers, including difficulties matching local market salaries. See GAO, *Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies*, GAO-18-580 (Washington, D.C.: Aug.15, 2018).

from many of the IHS area offices told us that some federally operated facilities in their area reported using third-party collections accumulated over multiple years to make investments in expanding their facilities to provide the space necessary to support these additional services. For example, according to IHS officials,

- one federally operated IHS facility reported using \$7 million in third-party collections to fund an over 11,000 square foot expansion to house an expanded emergency room and a new urgent care clinic;
- two federally operated IHS facilities reported using third-party collections to purchase modular buildings to provide medical services such as audiology, behavioral health, and dental services; and
- one federally operated IHS facility reported saving third-party collections for six years to fund the construction of a new 23,000 square foot building to provide additional space for an increased volume of services, including dental, optometry and physical therapy services, and to pay for the new medical equipment to support these services (see fig. 7).

Figure 7: Example of a Federally Operated Indian Health Service (IHS) Facility Expansion Funded With Third-Party Collections



An IHS hospital used third-party collections saved over a 6-year period to finance the construction of new space that served to expand an existing facility by increasing the space available for existing programs and services, including dental, optometry, and physical therapy services.

Source: GAO. | GAO-19-612

Officials from some IHS area offices stated that the extent to which federally operated IHS facilities in their area invested in expanding onsite services largely depended on the level of facilities' third-party collections. Specifically, facilities experiencing larger increases in collections, such as larger facilities or those located in Medicaid expansion states, were able to invest more heavily in an expansion of onsite services compared to those that had lower increases in collections, according to these officials.

To identify their facilities' needs, officials from federally operated and tribally operated facilities reported using a variety of approaches. For example, officials from three IHS area offices and one tribally operated facility said they analyzed PRC data to identify the services that patients were obtaining through that program, and worked to bring those services onsite. Officials from two federally operated IHS facilities also noted that

they incorporated local tribal input as they identified local needs and projects to fund.³³ For example, these officials told us that their facilities were in the process of adding new specialty services onsite, including acupuncture, chiropractor, and eye clinic services, at the request of their local tribes.

The recent growth in third-party collections has made it possible for many federally operated IHS facilities to consider funding a range of projects, and IHS officials said they relied on established procedures to fund these projects. According to IHS officials, local facility officials draft annual spending proposals to identify the resources, including third-party collections, that they would like to use to address their facilities' needs. These proposals are provided to each facility's governing board for review; the governing board is comprised of area office and facility officials whose top priority is maintaining accreditation and ensuring patient safety at each facility, according to IHS officials. Once these basic needs are met, IHS officials told us that facilities may begin to identify and fund projects to expand access to health services.

Expanding Services Offsite

Officials from IHS, as well as some of the 17 selected federally operated and tribally operated facilities, told us that increased coverage and collections allowed for an expansion in the complexity of services provided offsite through the PRC program. Specifically, officials reported that an increase in the percent of patients with health insurance, coupled with facilities' enhanced onsite services, has led PRC programs to be able to expand the level of care that they can offer. For example, they stated that increases in the health insurance coverage of patients have led to a smaller percent of patients needing to access PRC, since patients may use their coverage to obtain needed services directly from other private providers. In addition, an expansion of available services onsite at

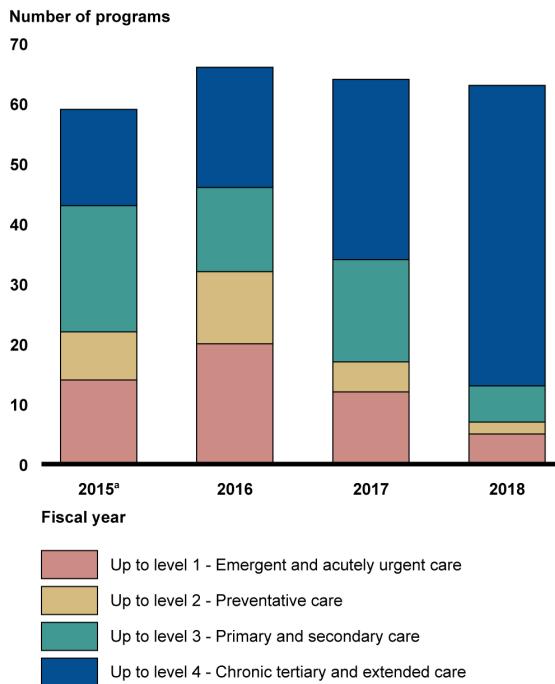
³³Federal agencies are required in certain circumstances to consult with tribes on infrastructure projects and other activities that may affect tribal natural and cultural resources. We recently examined key factors tribes and selected federal agencies identified that hinder effective consultation on infrastructure projects and steps agencies have taken to facilitate tribal consultation. See GAO, *Tribal Consultation: Additional Federal Actions Needed for Infrastructure Projects*, GAO-19-22 (Washington, D.C.: Mar. 20, 2019).

federally operated and tribally operated facilities resulting from increased collections reduced the need for some patients to use PRC.³⁴

From 2013 through 2018, most IHS-administered PRC programs moved from covering only the most acute and emergent cases to funding nearly all types of care covered through the PRC program, according to our analysis of IHS data and interviews with agency officials. Specifically, IHS officials we interviewed told us that prior to 2014, most PRC programs administered by the agency were only able to fund care for the most acute and emergent cases—referred to as priority level 1. Our analysis of IHS data showed that these PRC programs were increasingly able to fund additional medical priority levels of care each year from fiscal year 2015—the first year that such data were available—through fiscal year 2018, with most IHS-administered programs funding care through priority level 4 in fiscal year 2018. (See fig. 8.)

³⁴Officials we interviewed also noted several other factors that affected their ability to expand services offsite. For example, IHS officials reported that beginning in 2016, they were able to use lower Medicare-like rates to pay for outpatient PRC services, which helped them to extend PRC resources. In addition, officials from a few IHS area offices told us that some federally operated IHS facilities in their area had supplemented their PRC funding with third-party collections, including at the request of a local tribe, in order to further enhance their ability to fund offsite patient services.

Figure 8: Medical Priority Levels Funded through Purchased/Referred Care (PRC) Programs Administered by IHS, Fiscal Years 2015 through 2018



Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-612

Notes: PRC programs enable patients to obtain health care services from private providers if the patients meet certain requirements and funding is available. IHS-administered PRC programs follow the agency's medical priority system for the use of funds. These programs first pay for all of the highest priority services—for example, priority 1, and then all or some of the lower priority services—depending on the availability of funds. Programs funding services at levels 2, 3, or 4 therefore must also fund all services at higher priority levels. IHS priority level 5 refers to services excluded from PRC, which include cosmetic and experimental procedures. Tribes may opt to administer PRC programs but are not required to use the IHS medical priority system. The number of IHS-administered PRC programs differs for each year because of changes in tribal administration of the programs. According to an IHS official, in fiscal year 2018, 39 percent of PRC appropriations were administered by IHS; the remaining 61 percent were administered by tribes.

^aTwo IHS-administered PRC programs did not provide data for 2015.

Officials we interviewed at some of the 17 selected federally operated and tribally operated facilities that had been able to both expand services onsite and offsite through PRC funds told us that these changes have made a large impact on patients' health and quality of life. For example, officials at some federally operated IHS facilities reported that having more providers onsite has allowed them to offer patients more rapid access to care, and officials from some tribally operated facilities reported that an expansion of onsite services has allowed them to serve more patients. Officials at some of the selected federally operated and tribally

operated facilities reported that an expansion of onsite services has also reduced the need for some patients to travel long distances to obtain diagnostic services and specialty care through the PRC program. In addition, officials from two IHS area offices noted that PRC has been able to pay for services such as patients' long-awaited knee and hip replacements, which have enabled patients to return to normal activities of life and reduce their need for pain management.

Agency Comments

We provided a draft of this report for review and comment to the Secretary of Health and Human Services. The Department did not have any comments on the draft report.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of the Department of Health and Human Services and other interested parties. In addition, the report will be 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 farbj@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 key contributions to this report are listed in appendix II.

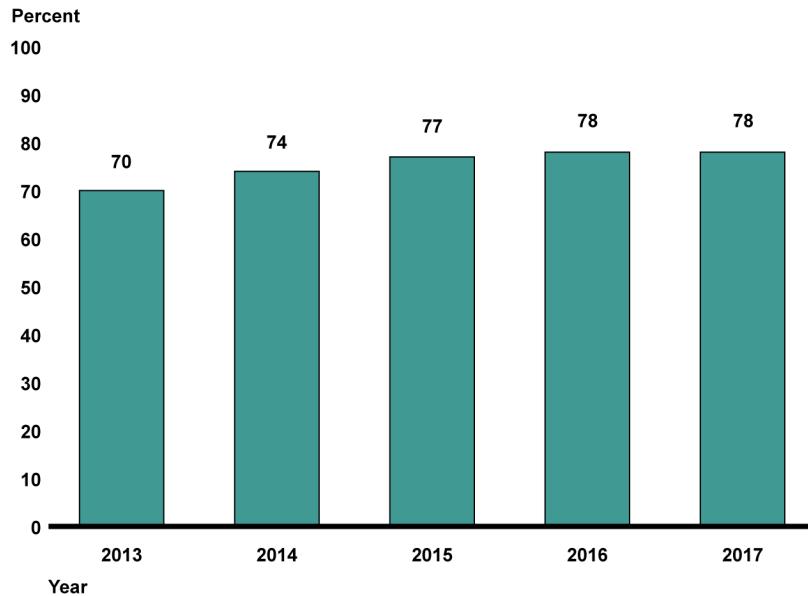


Jessica Farb
Director, Health Care

Appendix I: Estimated Health Insurance Coverage of the American Indian and Alaska Native Population, 2013 through 2017

In the years since the Patient Protection and Affordable Care Act (PPACA) authorized states to expand access to Medicaid and offer health insurance through the exchanges in 2014, the percent of American Indian and Alaska Native (AI/AN) in the general population with health insurance has increased. Specifically, according to an analysis of U.S. Census Bureau's American Community Survey data, the percent of nonelderly AI/ANs with health insurance coverage increased from 70 percent in 2013 to 78 percent in 2017.¹ (See fig. 9.)

Figure 9: Estimated Health Insurance Coverage of the Nonelderly American Indian and Alaska Native Population, 2013 through 2017



Source: Kaiser Family Foundation analysis of U.S. Census Bureau's American Community Survey data. | GAO-19-612

Note: Data include nonelderly individuals aged 0 to 64 who self-identified as non-Hispanic American Indians and Alaska Natives.

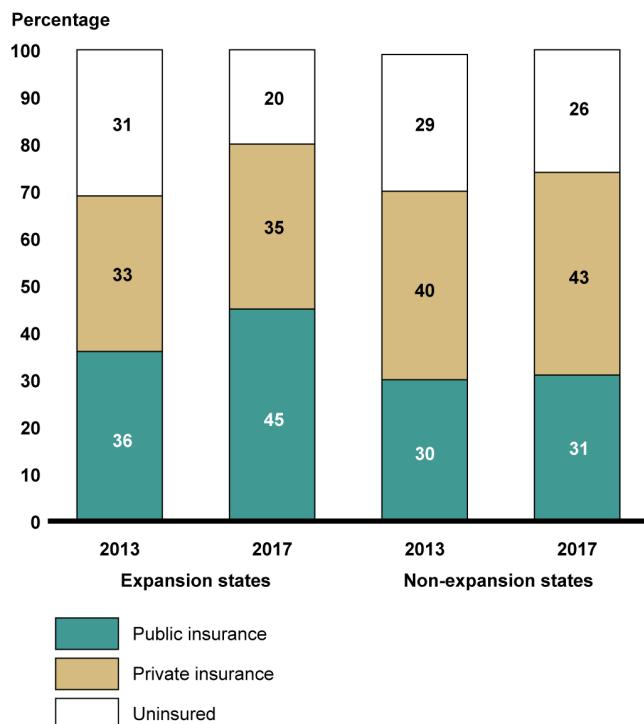
While the estimated percent of AI/AN nationwide reporting health insurance coverage increased from 2013 to 2017, these increases in coverage were not evenly distributed among the states, according to an

¹Kaiser Family Foundation, *Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017* (San Francisco, Calif.: Feb. 13, 2019).

Appendix I: Estimated Health Insurance Coverage of the American Indian and Alaska Native Population, 2013 through 2017

analysis of U.S. Census Bureau's American Community Survey data.² The estimated percent of AI/AN reporting health insurance increased more in states that expanded Medicaid compared to those that did not. (See fig. 10.)

Figure 10: Estimated Health Insurance Coverage Among Nonelderly American Indian and Alaska Natives, 2013 and 2017, by State Medicaid Expansion Status



Source: Kaiser Family Foundation analysis of U.S. Census Bureau's American Community Survey data. | GAO-19-612

Note: Data include nonelderly individuals aged 0 to 64 who self-identified as American Indians and Alaska Natives and excludes those identified as Hispanic or of mixed races.

²Kaiser Family Foundation, *Health and Health Care for American Indians and Alaskan Natives (AI/ANs) in the United States* (San Francisco, Calif.: May 10, 2019).

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Jessica Farb, (202) 512-7114 or farbj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kristi Peterson, Assistant Director; Patricia Roy, Analyst-in-Charge; Michelle Duren; and Lisa Rogers made key contributions to this report. Also contributing were Todd Anderson, Krister Friday, Ethiene Salgado-Rodriguez, and Emily Wilson Schwark.

Related GAO Products

Tribal Consultation: Additional Federal Actions Needed for Infrastructure Projects. [GAO-19-22](#). Washington, D.C.: March 20, 2019.

Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs. [GAO-19-74R](#). Washington, D.C.: December 10, 2018.

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High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others. [GAO-17-317](#). Washington, D.C.: February 15, 2017.

Indian Health Service: Actions Needed to Improve Oversight of Quality of Care. [GAO-17-181](#). Washington, D.C.: January 9, 2017.

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Indian Health Service: Opportunities May Exist to Improve the Contract Health Services Program. [GAO-14-57](#). Washington, D.C.: December 11, 2013.

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