



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

December 10, 2018

The Honorable Ken Calvert
Chairman
The Honorable Betty McCollum
Ranking Member
Subcommittee on Interior, Environment, and Related Agencies
Committee on Appropriations
House of Representatives

Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs

The Indian Health Service's (IHS) mission is to provide health care services to American Indian and Alaska Native (AI/AN) people who are members or descendants of federally recognized tribes, consistent with federal law.¹ Congress has declared that it is federal policy, in fulfillment of special trust responsibilities and legal obligations to Indians, to ensure the highest possible health status for AI/AN people.² IHS, within the Department of Health and Human Services (HHS), provides health care to approximately 1.6 million AI/AN people annually.³

Advocates for AI/AN people have longstanding concerns about whether IHS has sufficient funding to provide eligible individuals with all needed services, noting IHS's lower funding relative to federal health programs for other populations (some of which include AI/AN people). These other federal health programs include:

- The Veterans Health Administration (VHA), which is part of the Department of Veterans Affairs (VA), which provides health care services for approximately 7 million veterans and non-veterans;⁴
- Medicare, which is overseen by HHS's Centers for Medicare & Medicaid Services (CMS), which pays for health care services for around 58 million persons aged 65 years and older (among others); and
- Medicaid, which is jointly administered and financed by CMS and state governments, which pays for health care services for about 74 million low-income individuals.

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 July 23, 2018, there were 573 federally recognized tribes. See 83 Fed. Reg. 34863 (July 23, 2018).

²25 U.S.C. § 1602.

³The 1.6 million represents IHS's user population, that is, those individuals who accessed a federally or tribally operated facility at least once over the past 3 years. The user population is a subset of the total service population of 2.2 million, which is IHS's estimate of the number of AI/AN users that could access its services.

⁴There are approximately 20 million veterans in total, of which 9 million are enrolled in VHA, with approximately 7 million receiving care. The 7 million receiving care are defined by VHA as "unique patients"—uniquely identified individuals treated by VHA, or whose treatment is paid for by VHA. The unique patient population includes about 700,000 non-veterans (e.g., family members, active duty military and reservists, employees receiving preventive occupational immunizations).

You asked us to compare IHS program characteristics, including spending levels, to those of other federal health care programs. In this report, we present information on the spending levels and program characteristics for IHS, VHA, Medicare, and Medicaid from 2013 through 2017.

To address this objective, we analyzed budget and program documents from the four programs for the years 2013 through 2017, such as agency budgets and Congressional budget justifications, and reports produced by the Medicare Trustees, the Medicaid and CHIP Payment and Access Commission, and CMS. For each program, we examined total annual spending levels and spending on a per capita basis.⁵ To do so, for IHS and VHA, we analyzed total obligations per fiscal year. For IHS, we then calculated the per capita spending amount by dividing the total obligations by the number of individuals served.⁶ For VHA, we used data that are presented in VHA's annual congressional budget submission on obligations per unique patient. For Medicare and Medicaid, we analyzed expenditure data and relied on per capita spending data publicly available in the sources noted above.⁷ For each program, we refer to these amounts as spending or spending on a per capita basis because they represent the agencies' use of funds for the provision of health care services. One inherent limitation to our analysis is that the per capita spending amount for each program does not directly account for spending for beneficiaries who are eligible for multiple federal programs. To supplement our analysis, we interviewed knowledgeable agency officials, and, to obtain the perspective of tribal communities, we also interviewed representatives from the National Indian Health Board and attended a meeting of its National Tribal Budget Formulation Work Group, which makes recommendations to IHS on tribal budget priorities.

We conducted this performance audit from December 2017 to November 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

IHS, VHA, Medicare, and Medicaid are diverse programs through which the federal government is either a direct provider of health care services or pays for services as a public insurer. Specifically, IHS and VHA provide health care services directly to eligible beneficiaries. Both programs provide care through agency-administered hospitals and other health care facilities,

⁵The programs have differing definitions of their user populations. Therefore, we use the term "individuals served" to encompass IHS users (individuals receiving care from a federally or tribally operated facility within the last 3 years); VHA unique patients (uniquely identified individuals treated by VHA or whose treatment is paid for by VHA); and Medicare beneficiaries and Medicaid enrollees (individuals enrolled in either program in a specific year).

⁶An "obligation" is a definite commitment that creates a legal liability of government for the payment of goods and services ordered or received.

⁷An "expenditure" is the actual spending of money or an outlay. We calculated Medicare and Medicaid spending using expenditures because, in contrast to IHS and VHA, Medicare and Medicaid act as public insurers, reimbursing for services provided. Because of the differences in the four programs' operations and structures, the data we obtained and report on the Medicare program are on a calendar year basis, and the data we obtained and report on the IHS, VHA, and Medicaid programs are on a fiscal year basis. Medicaid per capita spending data for fiscal year 2017 were not publicly available at the time of this report, so for that year, we calculated spending using estimates published by CMS's Office of the Actuary.

though IHS funds also pay for care provided by tribally operated facilities.⁸ These programs also contract with health care providers outside of agency-funded facilities to provide care for users under certain circumstances—IHS's Purchased/Referred Care (PRC) program and VHA's community care programs.⁹ In contrast, Medicare and Medicaid act as public insurers for their beneficiaries by reimbursing health care providers for covered health care services or contracting with managed care plans to pay providers for services delivered to program enrollees.

In addition, the programs' administrative structures and eligibility requirements differ markedly, and they are intended to serve different populations. (See table 1 for additional information on the programs' administrative structures and eligibility requirements.)

⁸Under 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 for Indians previously administered by IHS on their behalf. See generally 25 U.S.C. §§ 5301-5423. In 2017, IHS transferred approximately 54 percent of its total budget 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.

⁹VHA also has the option to purchase care from community providers through a number of community care programs, in circumstances when a health care service is not offered at a VA medical center or cannot be provided in a timely manner.

Table 1: Structure of and Eligibility for Four Federal Health Care Programs—Indian Health Service (IHS), Veterans Health Administration (VHA), Medicare, and Medicaid

Program Item	IHS	VHA	Medicare	Medicaid
Administrative structure	<i>Direct provider.</i> <ul style="list-style-type: none"> • Within the Department of Health and Human Services (HHS) • Provides health care services through a network of federally or tribally operated hospitals, clinics, and health stations. • Pays for health care services unavailable at these facilities through its Purchased/Referred Care program. 	<i>Direct provider.</i> <ul style="list-style-type: none"> • Within the Department of Veterans Affairs • Provides services through VHA-administered hospitals and other health care facilities. • Pays for certain care outside the VHA health care system through its community care programs. 	<i>Public insurer.</i> <ul style="list-style-type: none"> • Federal program administered by the Centers for Medicare & Medicaid Services (CMS) within HHS. • Pays health care providers for covered health care services. • Pays insurers for health care services delivered through managed care plans.^a 	<i>Public insurer.</i> <ul style="list-style-type: none"> • A joint federal-state program—administered by the states, with CMS oversight. • Pays health care providers for covered health care services. • Pays insurers for health care services delivered through managed care plans.^a
Who is eligible	<ul style="list-style-type: none"> • Members of a federally recognized Indian tribe, or those who meet certain other requirements (e.g., actively participating in tribal affairs). 	<ul style="list-style-type: none"> • Veterans, as determined by a number of service-related factors, such as the period of active service, discharge status, and the presence of service connected disabilities. • Certain non-veterans, such as veterans' spouses, dependents, and survivors. 	<ul style="list-style-type: none"> • Persons aged 65 and older, certain individuals with disabilities, and individuals with certain conditions, such as end-stage renal disease. 	<ul style="list-style-type: none"> • Certain low-income individuals, such as pregnant women, children, the disabled, and persons aged 65 and older.^b

Source: GAO analysis of program information. | GAO-19-74R

Notes: Individuals may be eligible for more than one program. For individuals eligible for IHS services, the IHS or tribally operated facility may be reimbursed by VHA, Medicare, and Medicaid for care provided. When approving funding for services through IHS's Purchased/Referred Care program, IHS is the payer of last resort—that is, IHS will only pay for a service if the individual is not eligible to have it covered by another program.

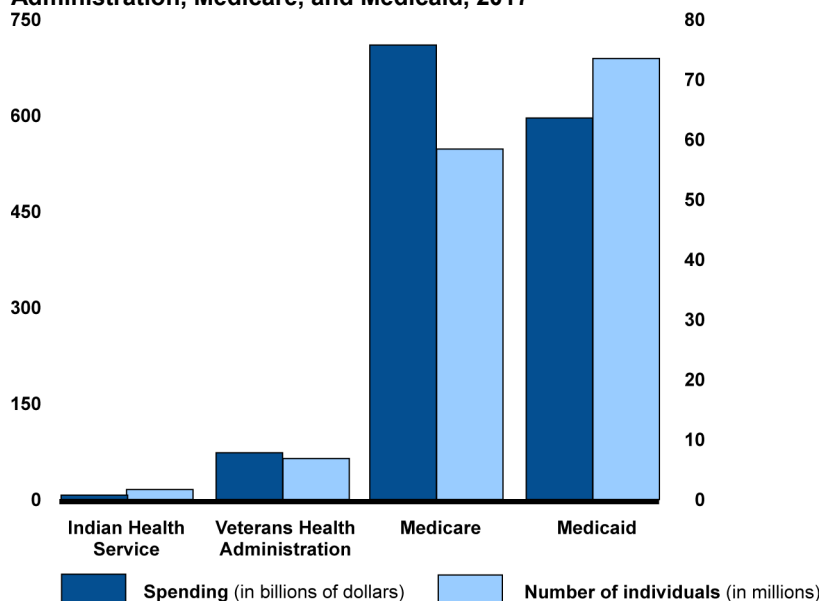
^aIn managed care for Medicare and Medicaid, the federal government or states respectively contract with managed care plans to provide a specific set of covered services to beneficiaries and pay them a set amount, typically per beneficiary per month, to provide those services.

^bStates are required to cover certain mandatory populations, such as low-income children and pregnant women, but have the option to cover other populations, such as low-income, childless adults. As of June 2018, 33 states (including the District of Columbia) have chosen to expand Medicaid to cover certain childless adults with incomes at or below 133 percent of the federal poverty level.

IHS's Spending Levels and Program Characteristics Vary from Those of VHA, Medicare, and Medicaid

IHS is significantly smaller than VHA, Medicare, and Medicaid in terms of annual spending levels and the number of individuals served. For example, in 2017, IHS's total spending of \$6.68 billion was less than 10 percent of VHA's and about 1 percent of both Medicare's and Medicaid's spending. In this same year, IHS served about 1.6 million individuals, about 25 percent of the number served by VHA and less than 3 percent of the number served by Medicare and Medicaid (see fig. 1). Although spending and service levels varied over time, these differences among the programs were also present in prior years. (See enclosures I through IV for additional spending information about each of these four programs for 2013 through 2017.)

Figure 1: Spending Levels and Number of Individuals Served by Indian Health Service, Veterans Health Administration, Medicare, and Medicaid, 2017



Source: GAO analysis of 2017 data from: Indian Health Service; Veterans Health Administration; the Medicare Board of Trustees; and the Centers for Medicare & Medicaid (CMS). | GAO-19-74R

Notes: Spending levels for Indian Health Service (IHS) and Veterans Health Administration (VHA) are reported using total obligations. IHS individuals served are those users who have accessed a federally or tribally operated facility at least once over the past 3 years. For VHA, individuals served are “unique patients”—those uniquely identified individuals treated by VHA or whose treatment is paid for by VHA. For Medicare and Medicaid, we report expenditures (including those by states for Medicaid), and individuals served are beneficiaries and enrollees, respectively. Spending for Medicare represents total expenditures from the Medicare trust funds and does not include beneficiary cost-sharing spending. The data for IHS, VHA, and Medicaid are for fiscal year 2017, and the Medicare data are for calendar year 2017. Medicaid data are based on projections published by CMS’s Office of the Actuary, as actual data were not yet available at the time of this report.

Our analysis showed that IHS’s per capita spending levels were likewise lower than those of the other three programs.¹⁰ For example, in 2017, IHS per capita spending was \$4,078, as compared to \$8,109 for Medicaid, \$10,692 for VHA, and \$13,185 for Medicare.¹¹ In each of the

¹⁰As discussed earlier, we calculated per capita spending as total obligations divided by the number of individuals served for IHS and VHA, and total expenditures per individual beneficiary or enrollee for Medicare and Medicaid, respectively. In the case of Medicaid, expenditures include spending by states.

¹¹We calculated IHS per capita spending using the agency’s 3-year reported user population for 2017—about 1.6 million. IHS also collects data on the number of users who accessed a facility each year—an average of about 1.3

four programs, the per capita spending was relatively stable from 2013 through 2017, increasing slightly for each program over the time period. While the per capita spending represents the average amount of program spending per individual served, the amount does not necessarily represent the total health spending for its beneficiaries since eligibility for one program does not preclude eligibility for others. Therefore some individuals may receive or have services covered through more than one program. For example, an AI/AN veteran may be eligible to receive care from an IHS facility but may also be enrolled and eligible for care from VHA for service-connected injuries, as well as enrolled in Medicare.¹² That individual may use the IHS facility for primary health care and use VHA facilities or Medicare coverage for other specialty care. Total health care spending for that individual would be captured across each of the three programs.

While examining per capita spending is one way to compare these programs, the vast differences between IHS, VHA, Medicare, and Medicaid programs limit the applicability of such comparisons. The programs differ in design and structure, funding, population needs, and the services provided, for example. These fundamental differences limit the extent to which comparisons of federal funding for each program can be used to make a determination about the sufficiency of program funding:

- **Program Design and Structure.** Because IHS and VHA are direct health care providers, they operate health care facilities and manage health care professionals as employees.¹³ Medicare and Medicaid act as public insurers for their beneficiaries by reimbursing health care providers for covered health care services. In addition, the four programs differ in how funding is used for services beyond direct clinical care. For example, in addition to using funding to partner with other federal agencies to build water sanitation systems, IHS provides scholarships and loan repayment awards to recruit health professionals to serve in areas with high provider vacancies. In the case of Medicare, a portion of the amount that it reimburses certain facilities for care provided to patients is also intended to provide support for physician graduate medical education at those facilities.
- **Funding Mechanism.** IHS and VHA funding is largely determined through the annual appropriation process, with specific limits on the amounts that can be spent to deliver health care services.¹⁴ Thus, any increases in the number of people served in these two programs absent increased funding could result in reductions in per capita spending. In contrast, Medicare and Medicaid are entitlement programs—that is, the federal government is required to pay for covered services for any person meeting eligibility criteria. In terms of funding, Medicare is financed through payroll taxes, general revenues, and beneficiary

million, from fiscal years 2013 through 2017. Using this 1-year user population count, IHS's per capita spending is \$5,173.

¹²According to IHS data, in fiscal year 2017, approximately 75 percent of IHS individuals reported that they had at least one other means of health care coverage. This estimate of the proportion of IHS users with additional coverage is not an estimate of the extent to which they obtain services through additional coverage.

¹³IHS and VHA also purchase some care from external providers.

¹⁴Discretionary appropriations refer to those budgetary resources that are provided in appropriation acts, other than those that fund mandatory programs. While IHS and VHA receive most of their funding from these appropriations, they also receive mandatory spending authority for specific purposes. Mandatory spending refers to budget authority that is provided in laws other than appropriation acts and includes entitlement authority. VA also receives advance appropriation authority—an appropriation of new budget authority that becomes available one or more fiscal years after the fiscal year for which the appropriation providing it is enacted. See 38 U.S.C § 117. Legislation has been introduced in the House to provide IHS with advance appropriation authority, and we recently reported on the issue. See GAO, *Indian Health Service: Considerations Related to Providing Advance Appropriation Authority*, [GAO-18-652](#) (Washington, D.C.: Sept. 13, 2018).

contributions.¹⁵ Medicaid is financed through a combination of federal and state funding.¹⁶ As entitlement programs, Medicare and Medicaid have no annual spending caps. Instead, spending for Medicare and Medicaid is controlled by Congress through a modification of benefits or changes to the way providers are paid.

- *Service Availability.* While each of the programs can pay for a wide variety of services, there are differences in the actual availability of certain services. Medicare and Medicaid pay for primary and specialty services in a variety of hospital and other settings in all parts of the country. In contrast, IHS and VHA facilities vary in the extent to which services are available. For example, VHA medical centers offer a variety of inpatient and outpatient services, ranging from routine examinations to complex surgical procedures. VHA's system also includes facilities such as community-based outpatient clinics. In the case of IHS, most of its facilities are smaller and may offer mostly primary and emergency care services. These IHS facilities also tend to be located primarily in rural areas where patients and providers must travel long distances, and where other health care providers are not available.¹⁷ While IHS is able to use its PRC program to pay for care not available at these facilities, the agency has reported that PRC funds are not sufficient to pay for all necessary care and, therefore, generally pay for only the highest priority costs, such as emergency care and transportation to that care. (See enclosure V for more information about the PRC program.)
- *Population Needs and Services Provided.* The four programs serve populations with different health needs and issues and therefore provide or pay for a wide variety of services with varying costs. For example, while IHS has a younger population overall, its users have higher rates of diabetes, alcoholism, and accidental deaths than the general population. Medicare enrollees, on the other hand, tend to be older and need more in-patient care—in addition, a subset are eligible for Medicare coverage because they have end-stage renal disease and require ongoing kidney dialysis, a long-term and costly treatment. In each of these programs, the needs of the population impacts the services needed, and the services provided will impact the per capita costs.

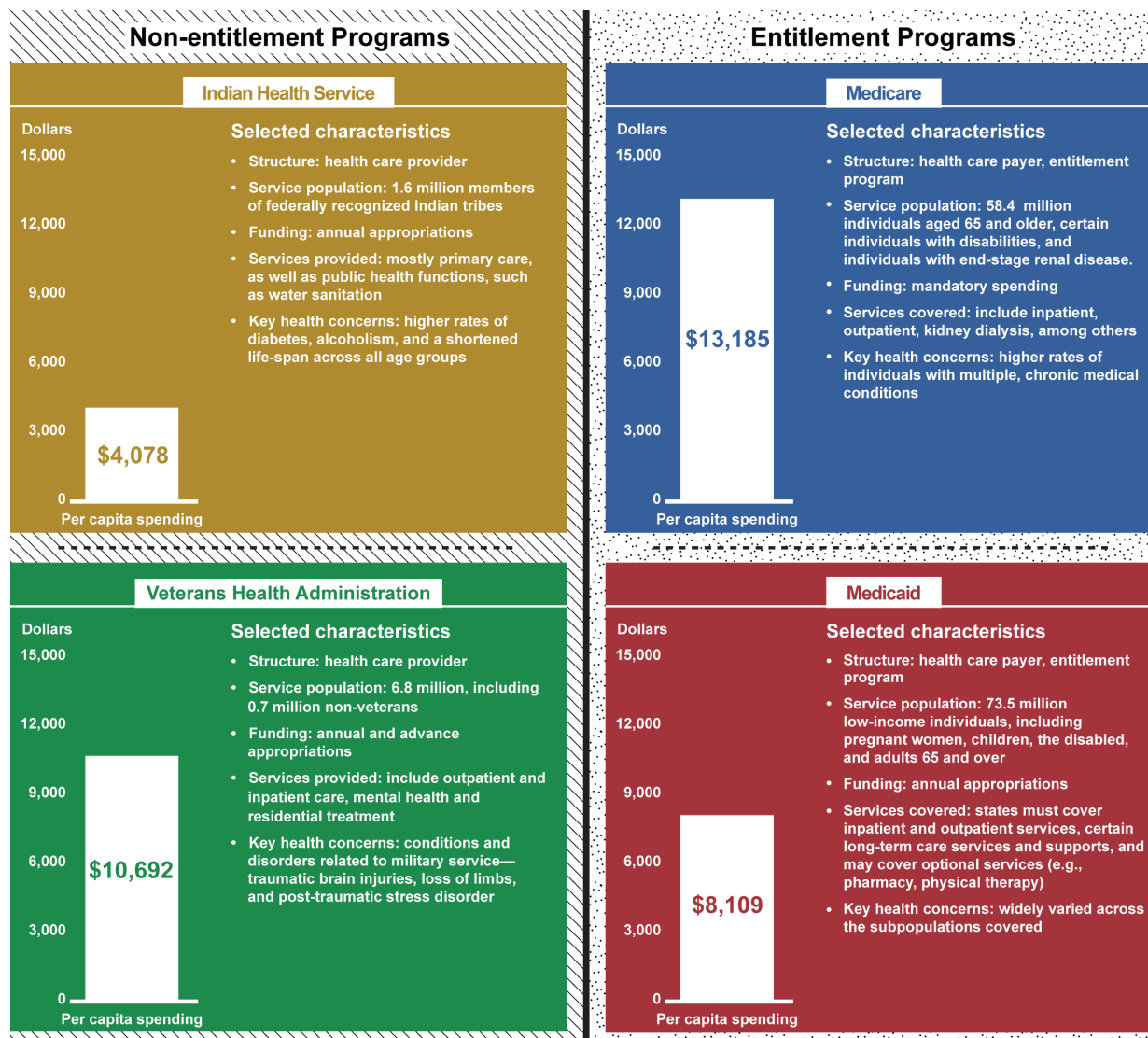
(See fig. 2 for 2017 per capita spending levels and selected program characteristics for each of the four federal health programs.)

¹⁵Funds from beneficiary contributions are deposited into the Medicare trust funds that are overseen by the Medicare Board of Trustees.

¹⁶State Medicaid expenditures are matched by the federal government on the basis of a statutory formula. Medicaid is considered an appropriated entitlement because, although it is an entitlement program, its funding is provided in annual appropriation acts. CMS estimates Medicaid expenditures for the fiscal year and Congress appropriates that amount. For the final quarter of the fiscal year, Congress also appropriates such sums as may be necessary for any unanticipated costs.

¹⁷We recently reported that IHS officials told us that the agency provides services almost exclusively in locations designated by HHS's Health Resources and Services Administration as Health Professional Shortage Areas, or extreme shortage areas, meaning they lack sufficient number of primary care physicians. See GAO, *Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies*, [GAO-18-580](#) (Washington, D.C.: Aug. 15, 2018).

Figure 2: 2017 Per Capita Spending Levels and Selected Program Characteristics for Four Federal Health Programs: Indian Health Service, Veterans Health Administration, Medicaid, and Medicare



Source: GAO analysis of 2017 data from: Indian Health Service (IHS); Veterans Health Administration (VHA); the Medicare Board of Trustees; and the Centers for Medicare & Medicaid Services (CMS). | GAO-19-74R

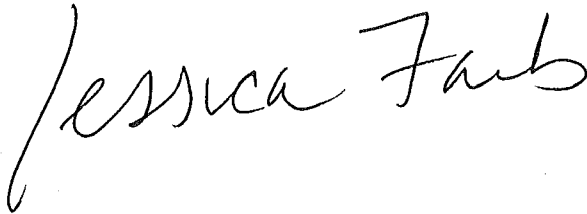
Notes: Some individuals may receive or have services covered through more than one program; however, the reported per capita spending amounts do not account for spending across multiple programs. While IHS and VHA receive most of their funding from annual appropriations, they also received mandatory amounts for specific purposes. For IHS we calculated per capita spending as total obligations divided by the number of individuals served. IHS defines individuals served as those who have accessed a federally or tribally operated facility at least once over the past 3 years. For VHA, the per capita spending represents obligations per unique patient (uniquely identified individuals treated by VHA or whose treatment is paid for by VHA). For Medicare and Medicaid, we report on expenditures (including those by states for Medicaid) by the number of individuals served. Spending for Medicare represents total expenditures from the Medicare trust funds and does not include beneficiary cost-sharing spending. The data for IHS, VHA, and Medicaid are for fiscal year 2017, and the Medicare data are for calendar year 2017. The Medicaid data are based on estimates published by CMS's Office of the Actuary, as actual data were not yet available at the time of this report.

Agency Comments

We provided a draft of this report to HHS and VA. Both departments provided us with technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, Secretary of Veterans Affairs, 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 staffs have any questions about this information, 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 were William D. Hadley, Assistant Director; Kristeen McLain, Analyst-in-Charge; Manuel Buentello; and Keith Haddock. Also contributing were Muriel Brown, Jackie Hamilton, Laurie Pachter, and Vikki Porter.

A handwritten signature in black ink that reads "Jessica Farb". The signature is written in a cursive, flowing style.

Jessica Farb
Director, Health Care



Program Overview

The Indian Health Service (IHS) was established within the Public Health Service in 1955 to provide health services to American Indian and Alaska Native (AI/AN) people. IHS provides services directly through a network of 26 hospitals, 53 health centers, and 30 health stations in 37 U.S. states, primarily in rural areas on or near reservations. IHS also awards contracts and grants to non-profit urban Indian organizations that provide health care and referral services to urban Indians. IHS also funds services provided at tribally operated facilities. In fiscal year 2017, about 54 percent of IHS funds went to tribal organizations. In certain circumstances, IHS pays for services provided by external providers through its Purchased/Referred Care program. In addition to the provision of health care, IHS performs several public health functions, including public health nursing and water sanitation facility construction.

How Funded

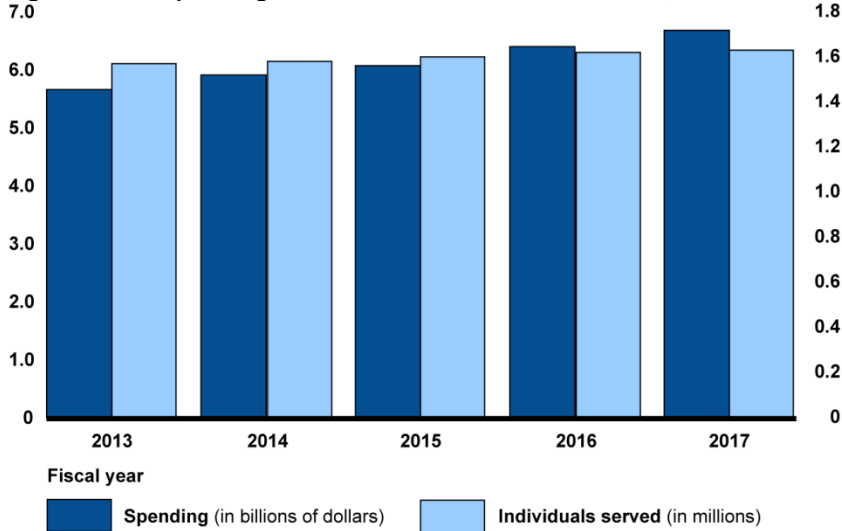
IHS is largely funded through discretionary appropriations, but also receives some funding through reimbursements from other federal programs such as Medicaid, Medicare, and the Veterans Health Administration, as well as private insurance. IHS also receives mandatory spending authority (around \$150 million annually) to support Special Diabetes Programs for Indians.

Indian Health Service

Annual Spending and Numbers Served

According to our analysis, from fiscal years 2013 through 2017, IHS’s annual spending increased from \$5.66 billion to \$6.68 billion (18 percent), while the annual population served remained around 1.6 million.

Figure 3: IHS Spending and Number of Individuals Served, Fiscal Years 2013-2017

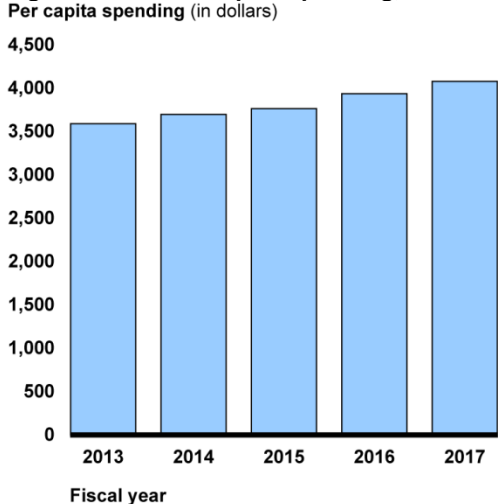


Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-74R
Notes: Spending is in total obligations. Individuals served are referred to as “users” by IHS, and are defined as a person who has accessed IHS at least once over the past 3 years.

Per Capita Spending

Over the past five fiscal years, IHS’s per capita spending increased from \$3,591 to \$4,078 (14 percent).

Figure 4: IHS Per Capita Spending, Fiscal Years 2013-2017



Source: GAO analysis of Indian Health Services (IHS) data. | GAO-19-74R
Notes: To calculate per capita spending, we analyzed IHS’s total obligations. We then divided the spending amount by the number of individuals served, which are defined by IHS as a person who has accessed services at least once over the past 3 years.

Indian Health Service (con't.)

Eligibility

IHS users generally must be a member or descendant of one of the 573 currently federally recognized Indian tribes belonging to the Indian community, as evidenced by such factors as membership, residence on tax-exempt land, active participation in tribal affairs, or other relevant factors. IHS services are provided free to eligible IHS users and there are no cost-sharing requirements.

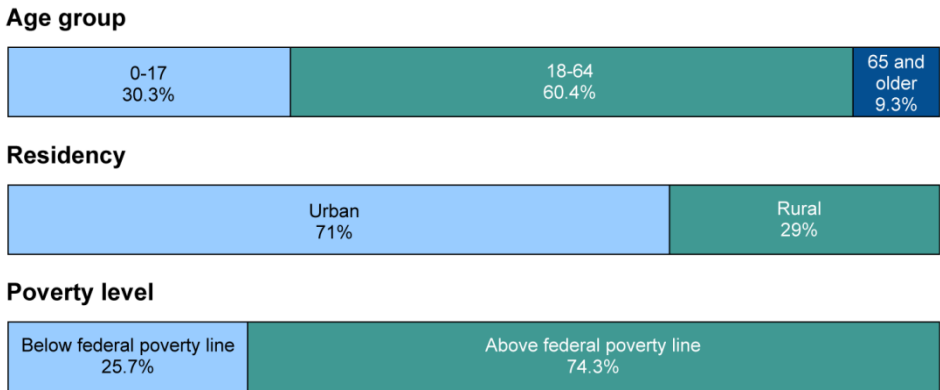
Health Issues

According to IHS, AI/AN people die at higher rates in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault or homicide, intentional self-harm or suicide, and chronic lower respiratory diseases.

IHS provides a number of health services that target common health conditions among beneficiaries, such as diabetes prevention and treatment, and behavioral health services including suicide prevention and methamphetamine treatment.

User Characteristics

Figure 5: Selected Characteristics of IHS Users

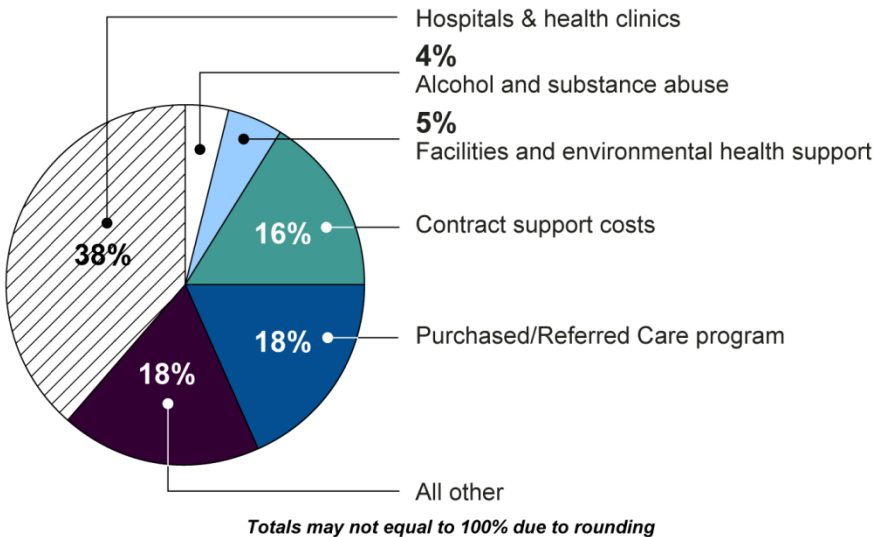


Source: GAO analysis of Indian Health Service (IHS) and Department of Health and Human Services data. | GAO-19-74R
Notes: Age group data are fiscal year 2017, residency data are calendar year 2010, and poverty data are calendar year 2000.

Services

According to our analysis, in fiscal year 2017, just over one-third of IHS's budget was allocated to hospitals and health clinic services. IHS also funded several service categories outside direct health care. For example, 16 percent of funds were allocated to contract support costs—supporting required activities that ensure tribes' compliance with their self-governance agreements.

Figure 6: IHS Services Provided by Percentage of Funding, Fiscal Year 2017



Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-74R
Notes: Funding for services is measured in budget authority. IHS's Purchased/Referred Care program pays for care when those services are not available at federally operated or tribally operated IHS facilities. Contract support costs cover required activities to ensure compliance with their self-determination contracts and self-governance compacts.



Program Overview

The Veterans Health Administration (VHA), part of the Department of Veterans Affairs (VA), established a network of facilities to provide health care to veterans, in particular to help them recover from illnesses and injuries sustained in service to the country. In addition to providing services through agency-administered facilities—hospitals, outpatient clinics, and nursing homes—VHA can also pay for services outside its health care system for eligible veterans through its community care programs when care is not readily available at its medical facilities.

How Funded

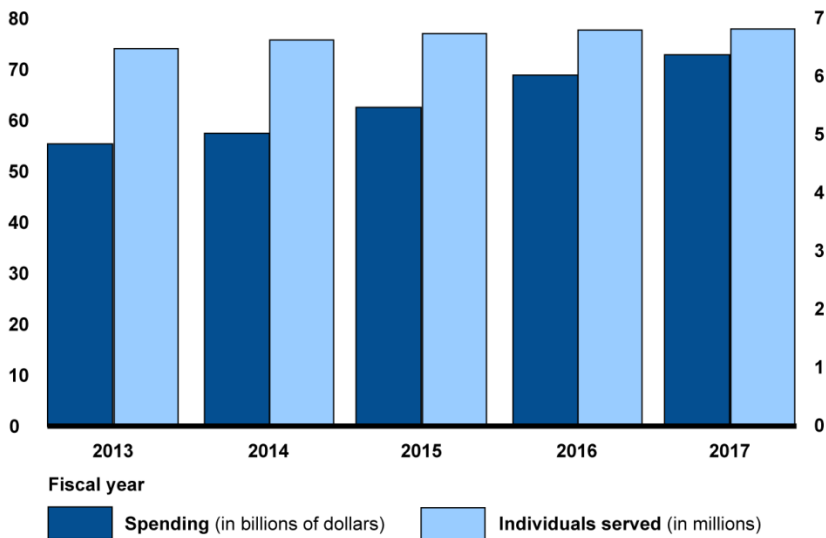
The VHA program is largely funded through discretionary appropriations. VA (which oversees VHA) also receives advance appropriations—an appropriation of new budget authority that becomes available one or more fiscal years after the fiscal year for which the appropriation providing it is enacted—for specified medical care accounts. In addition, VHA can be reimbursed by private insurance for services that are not service-connected. While VHA users do not pay premiums, some users may have to pay copayments for certain medical services.

Veterans Health Administration

Annual Spending and Numbers Served

According to our analysis, from fiscal years 2013 through 2017, VHA’s annual spending level increased from \$55 to \$73 billion (32 percent), while the number of individuals served increased from 6.5 million to 6.8 million (5 percent).

Figure 7: VHA Spending and Number of Individuals Served, Fiscal Years 2013-2017

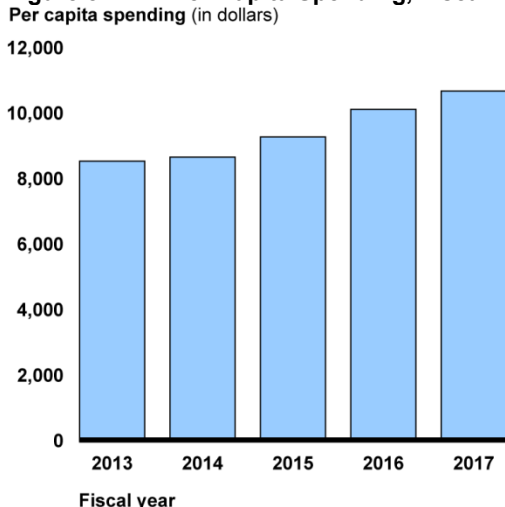


Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-19-74R
Note: Spending represents total obligations per fiscal year. Individuals served are “unique patients” and represent uniquely identified individuals treated by VHA or whose treatment is paid for by VHA expenditures.

Per Capita Spending

Over the past five fiscal years, per capita spending for VHA increased from \$8,551 to \$10,692 (25 percent).

Figure 8: VHA Per Capita Spending, Fiscal Years 2013-2017



Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-19-74R
Note: Spending per capita represents total obligations per unique patient—uniquely identified individuals treated by VHA or whose treatment is paid for by VHA expenditures.

Veterans Health Administration (con't.)

Eligibility

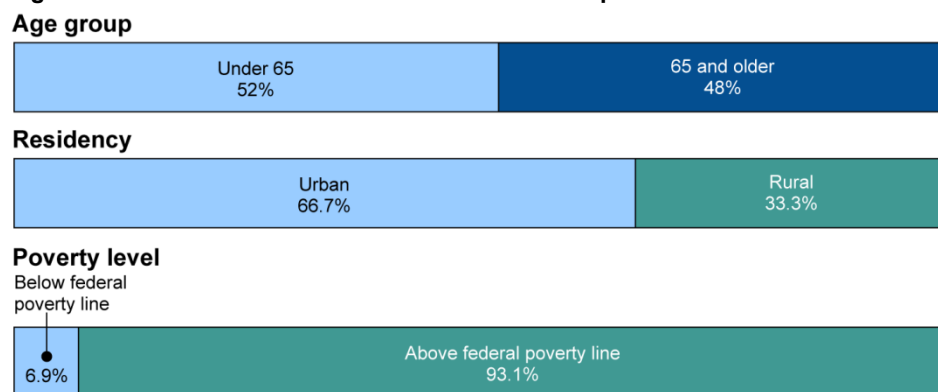
Eligibility for services provided through the VHA is based on several factors, including the veteran's period of active service, discharge status, and the presence of service connected disabilities. In addition, VHA categorizes eligible veterans into eight priority groups that determine the type of services the veteran can access, and that have implications for cost-sharing. Eligibility for VHA's community care programs vary.

Health Issues

VHA focuses on conditions and disorders related to military service and war, including traumatic brain injuries, post-traumatic stress disorder, mental health issues, such as suicide prevention, and loss of limbs.

User Characteristics

Figure 9: Selected Characteristics of the Veteran Population



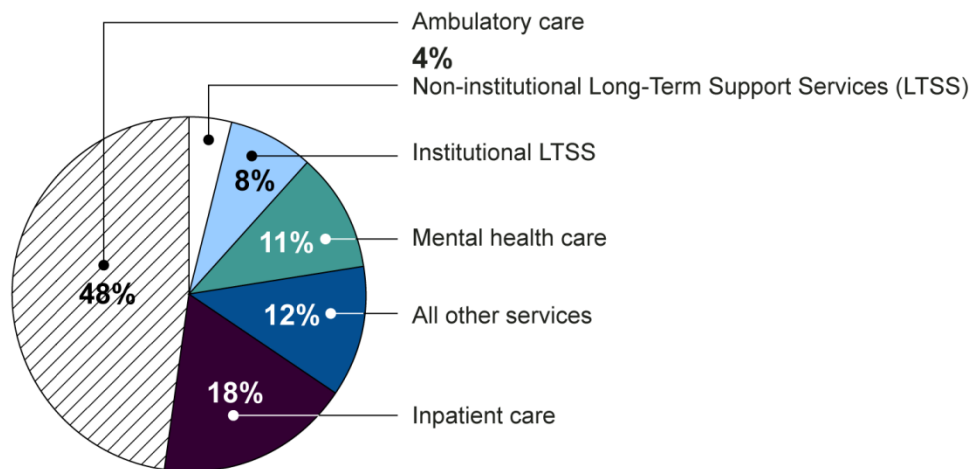
Source: GAO analysis of Department of Veterans Affairs (VA) and Veterans Health Administration (VHA) data. | GAO-19-74R

Note: The age group and residency data represent VHA's unique patient populations for fiscal year 2017 and fiscal year 2015, respectively. The poverty data represent the total veterans population, and are based on a 3-year period estimate, 2010 through 2012.

Services

VHA's health care system provides enrolled veterans with a full range of services including primary care, mental health, inpatient care, and residential treatment. In fiscal year 2017, close to half of the expenditures for services provided by VHA were for ambulatory (outpatient) care, according to our analysis.

Figure 10: VHA Services Provided by Expenditures, Fiscal Year 2017



Totals may not equal to 100% due to rounding

Source: GAO analysis of Veterans Health Administration (VHA) data. | GAO-19-74R



Program Overview

The Medicare program, established under Title XVIII of the Social Security Act in 1965, pays for health services for individuals 65 and older and individuals with certain disabilities and conditions. The program is administered by the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services. Medicare consists of four distinct parts (A through D). Part A covers inpatient hospital services, skilled nursing care, hospice care, and some home health services. Part B covers physician services, outpatient services, and some home health and preventive services. Part C (Medicare Advantage) is a private plan option for beneficiaries, and covers all Parts A and B services except hospice. Lastly, Part D covers outpatient prescription drug benefits.

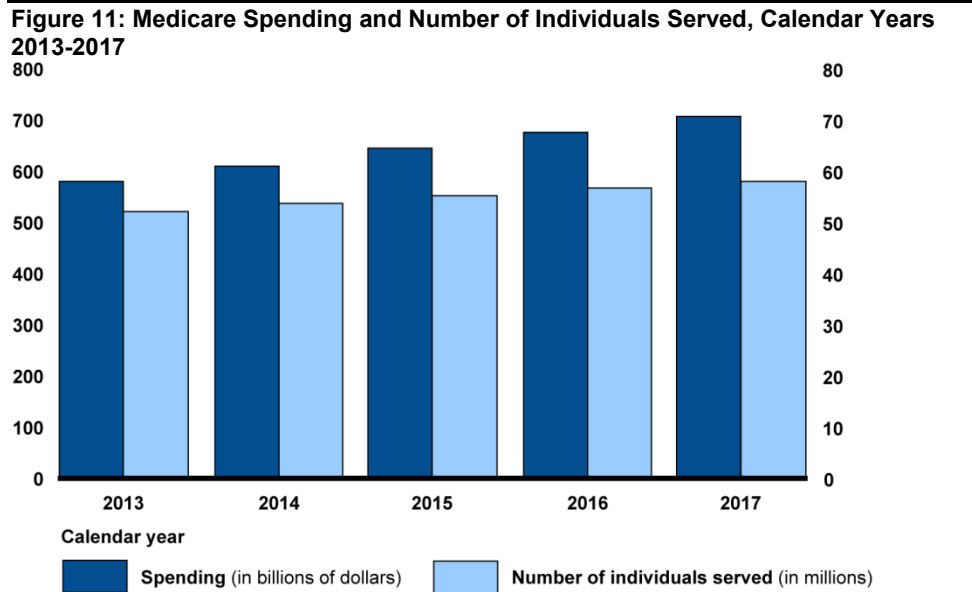
How Funded

Medicare is funded through payroll taxes paid by employees and employers, general revenues, and interest on the Medicare trust funds. Medicare is also funded through premiums paid by beneficiaries. Beneficiaries also are responsible for cost sharing—deductibles and co-payments—for covered services. Medicare is an entitlement program and required to pay for all covered services provided to eligible persons, so long as specific criteria are met. Thus, spending under the program (except for a portion of administrative costs) is considered mandatory and is not subject to spending caps in appropriation acts.

Medicare

Annual Spending and Numbers Served

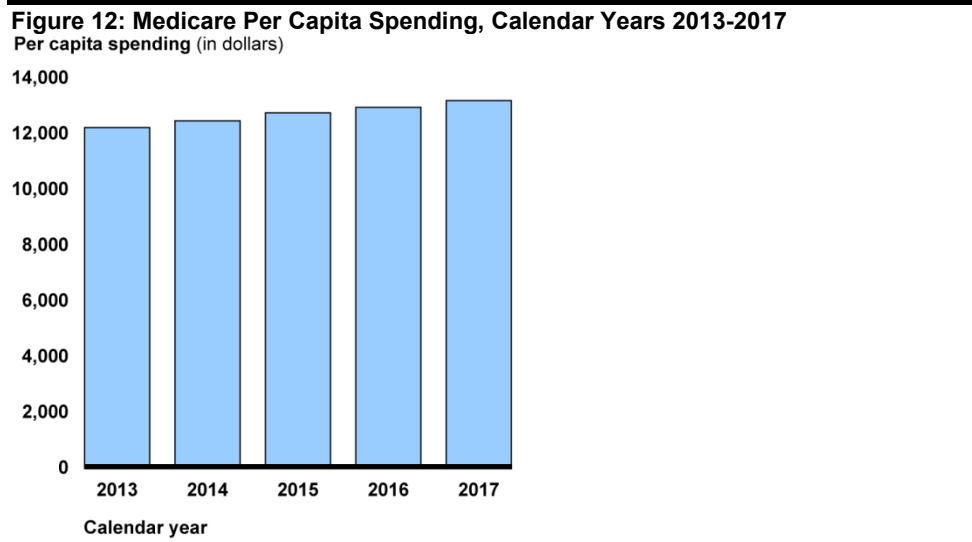
According to our analysis, from calendar years 2013 through 2017 Medicare spending increased by 22 percent, from \$583 billion to \$710 billion. During that same period, the number of individuals served grew about half as much, by 10 percent.



Source: GAO analysis of Medicare Board of Trustees data. | GAO-19-74R
Note: Spending represents total expenditures from the Medicare trust funds and does not include beneficiary cost-sharing spending. Individuals served are Medicare beneficiaries.

Per Capita Spending

Over the past five calendar years, Medicare per capita spending increased from \$12,218 to \$13,185 (8 percent).



Source: GAO analysis of Medicare Board of Trustees data. | GAO-19-74R
Note: Per capita spending represents average expenditures from the Medicare trust funds, and does not include beneficiary cost-sharing spending.

Medicare (con't.)

Eligibility

Generally, individuals are eligible for Medicare if they or their spouse worked for at least 40 quarters in Medicare-covered employment, are 65 years old, and are a citizen or permanent resident of the United States. Younger individuals who have been eligible for Social Security benefits for 24 months are also eligible, as are those who have end-stage renal disease (permanent kidney failure requiring dialysis or transplant), or have amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease).

Health Issues

Medicare serves approximately one in six Americans and virtually all of the population aged 65 and older. Leading causes of death among people 65 and over have remained the same over the past few decades, with heart disease and cancer remaining at the top followed by chronic respiratory issues and stroke. In addition, the Medicare population has high rates of individuals with multiple, chronic medical conditions.

User Characteristics

Figure 13: Selected Characteristics of Medicare Beneficiaries

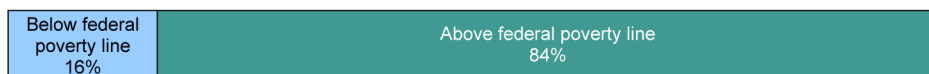
Age group



Residency



Poverty level



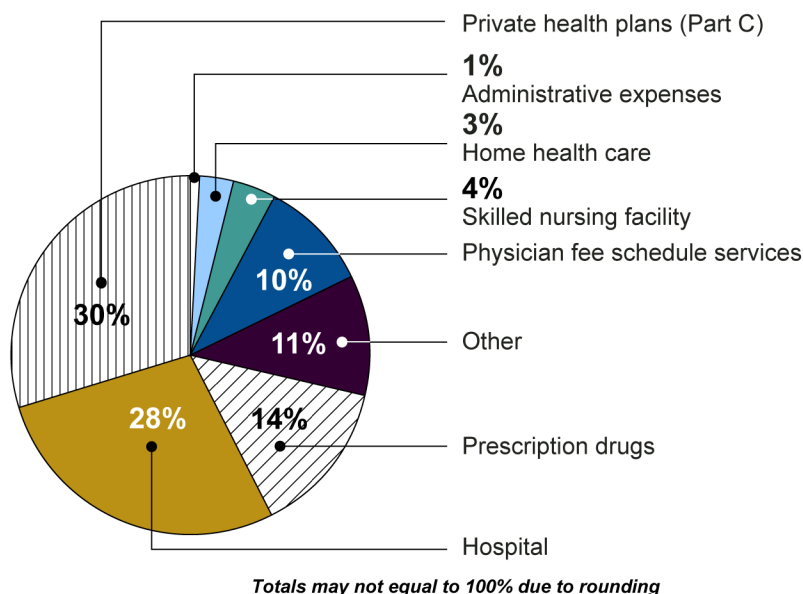
Source: GAO analysis of data from the Centers for Medicare & Medicaid Services and the Medicare Payment Advisory Commission. | GAO-19-74R

Notes: The age group and residency data represent the Medicare beneficiary population for calendar year 2015 and 2013, respectively. The poverty data represent calendar year 2013.

Services

The Medicare program covers a wide variety of services, including inpatient and outpatient care, some home health and preventive services, and prescription drug benefits. In calendar year 2017, our analysis showed that 30 percent of Medicare spending was for Part C (Medicare Advantage), followed by hospital care (28 percent) and prescription drugs (14 percent).

Figure 14: Medicare Services by Percentage of Expenditures, Calendar Year 2017



Source: Medicare Board of Trustees data. | GAO-19-74R

Note: These expenditures exclude cost-sharing spending by Medicare beneficiaries.



Program Overview

Medicaid—a joint federal-state health financing program for low-income and medically needy individuals—was authorized by Title XIX of the Social Security Act in 1965. The Centers for Medicare & Medicaid Services (CMS) oversees states' administration of Medicaid. States are allowed flexibility to design and implement their programs within broad federal parameters, resulting in variation in eligibility and services covered across the states.

How Funded

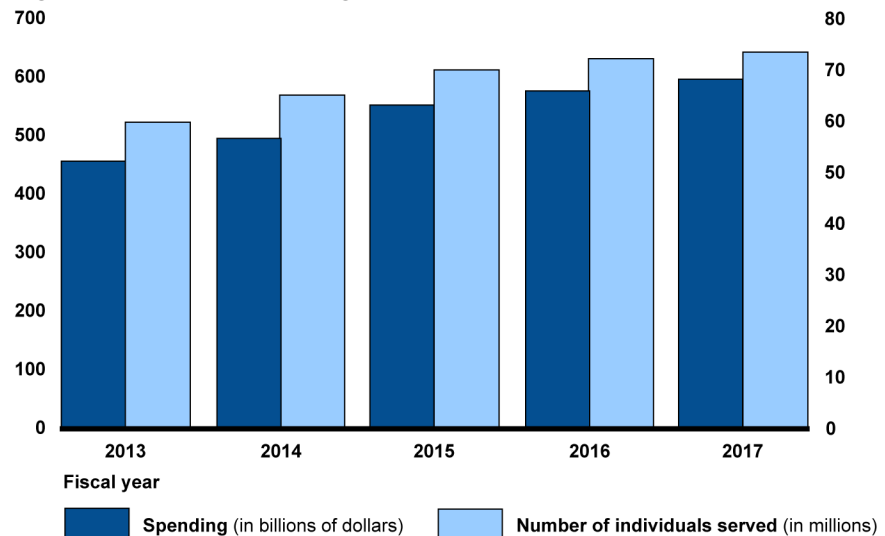
The federal government and states share in the financing of Medicaid expenditures, with the federal government matching most state expenditures for services on the basis of a statutory formula, known as the federal medical assistance percentage. The federal share of Medicaid expenditures typically ranges from 50 to 83 percent. Funding for Medicaid is provided in annual appropriations acts, but is not subject to specific dollar limits.

Medicaid

Annual Spending and Numbers Served

According to our analysis, from fiscal years 2013 through 2017, Medicaid spending increased from \$456 billion to \$596 billion (31 percent), while enrollment grew from 59.8 million to 73.5 million (23 percent).

Figure 15: Medicaid Spending and Number of Enrollees, Fiscal Years 2013-2017



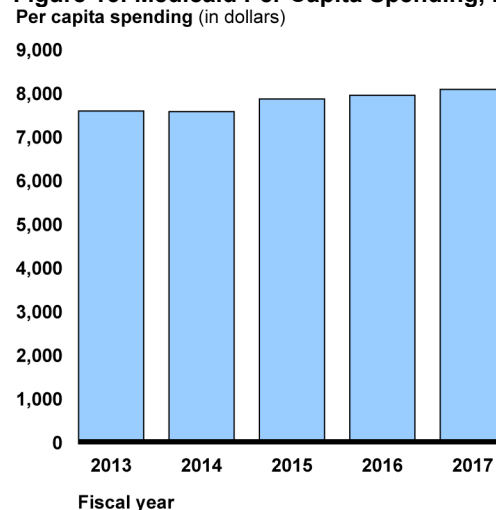
Source: GAO analysis of data from Medicaid and CHIP Payment and Access Commission (2013-2016) and Centers for Medicare & Medicaid Services (CMS) (2017). | GAO-19-74R

Notes: Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are full-year equivalents. Data for fiscal year 2017 are based on CMS estimates and were the most recent available.

Per Capita Spending

Over the past five fiscal years, Medicaid spending per capita increased from \$7,615 in to \$8,109 (6 percent).

Figure 16: Medicaid Per Capita Spending, Fiscal Years 2013-2017



Source: GAO analysis of data from Medicaid and CHIP Payment and Access Commission (2013-2016) and Centers for Medicare & Medicaid Services (CMS) (2017). | GAO-19-74R

Notes: Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are full-year equivalents. Data for fiscal year 2017 are based on CMS estimates and were the most recent available.

Medicaid (con't.)

Eligibility

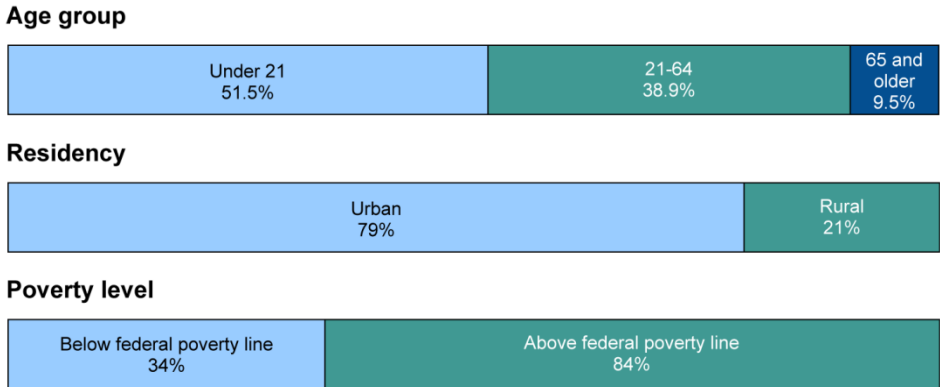
Eligibility for Medicaid varies across states. Federal law requires states to cover certain populations and gives them the flexibility to cover others. Mandatory populations include low-income children and families, pregnant women, and aged, blind and disabled individuals. States may also cover other populations. For example, under the Patient Protection and Affordable Care Act, states may expand their Medicaid programs to cover childless, non-elderly low-income adults. Medicaid enrollment is therefore expected to grow by as many as 13.2 million newly eligible adults by 2025.

Health Issues

Health concerns vary considerably among the different Medicaid populations. For example, the health concerns for children enrolled in Medicaid center on primary and preventive care, with a small proportion requiring medically complex care. In contrast, Medicaid beneficiaries who qualify on the basis of a disability may have conditions such as traumatic brain injuries, intellectual or developmental disabilities (such as cerebral palsy) or serious behavioral disorders or mental illness (such as schizophrenia), all of which require longer-term and high-cost care.

User Characteristics

Figure 17: Selected Characteristics of Medicaid Enrollees



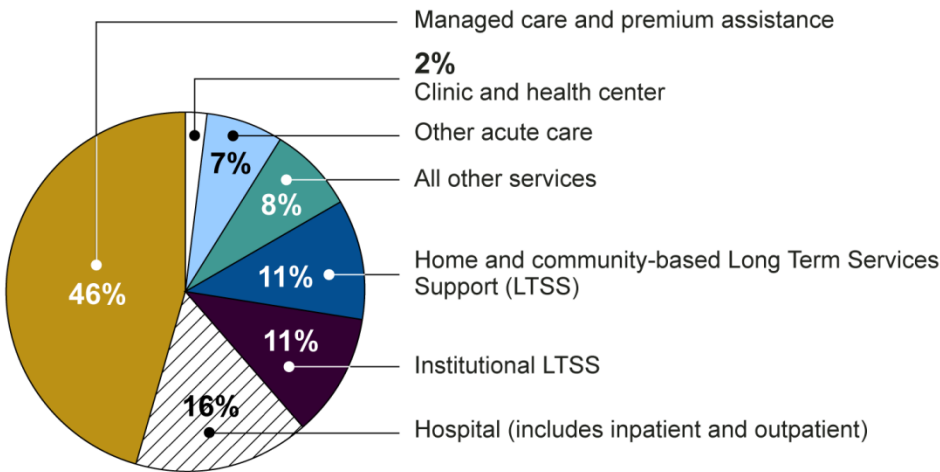
Source: GAO analysis of data from Department of Health and Human Services; the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission; and the Kaiser Family Foundation. | GAO-19-74R

Notes: The age group and residency data represent Medicaid enrollee population for fiscal year 2013 and calendar year 2013, respectfully. The residency data exclude nondisabled enrollees under age 65, and those ages 65 and older who did not have Medicare coverage. The poverty data represent Kaiser Family Foundation estimates based on Census Bureau data, 2014-2017.

Services

Medicaid provides a wide variety of services in order to provide care for its diverse enrollee population, that includes children, adults, the disabled, and the elderly. In fiscal year 2016, spending on managed care and premium assistance made up almost 50 percent of total Medicaid expenditures, followed by hospital services (both inpatient and outpatient) at 16 percent.

Figure 18: Medicaid Services, by Expenditures, Fiscal Year 2016



Totals may not equal to 100% due to rounding

Source: GAO analysis of Medicaid and CHIP Payment and Access Commission data. | GAO-19-74R

Enclosure V: Indian Health Service's Purchased/Referred Care Program

When an Indian Health Service (IHS) user needs health care services that are not available from providers at a federal or tribal facility, the IHS Purchased/Referred Care (PRC) program pays for services from external providers. Eligibility requirements for the PRC program are more restrictive than for services provided directly through a facility, and all PRC requests are categorized according to a medical priority system to help ensure that the program funds services for the most serious medical conditions.¹⁸ Therefore, not all requests for PRC program funding are approved.

We obtained and analyzed data from IHS on the PRC program for fiscal years 2013 through 2017, including the expenditures and type of services paid through federally administered facilities. We also analyzed the number of requests for payment that were not approved. These data represent federally operated facilities—which in fiscal year 2017 represented about 46 percent of all IHS expenditures—and some tribally operated facilities, which are encouraged, but not required, to report such data. We performed data reliability checks, such as checks for internal consistency on total services and comparison of service expenditures to the PRC program budgets, and determined the PRC program data were sufficiently reliable for our purposes.

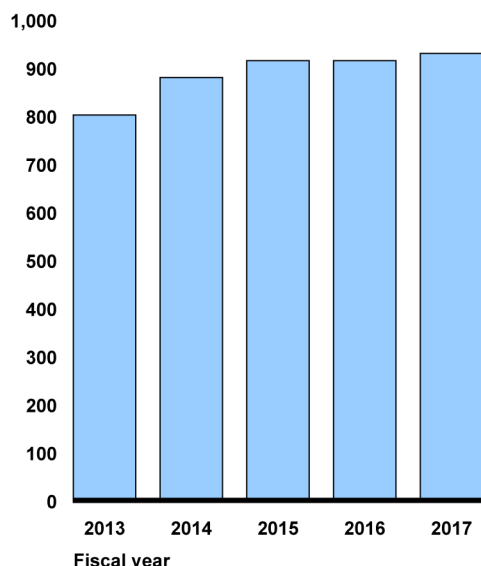
PRC Program Spending and Services

The PRC program is funded through the annual appropriations process, and available funds are distributed to federally and tribally operated facilities based on a formula.¹⁹ Spending for the PRC program grew from \$801 million in fiscal year 2013 to \$929 million in fiscal year 2017, an increase of 16 percent. (See fig. 19.)

¹⁸IHS's medical priority levels are: (1) Emergent or Acutely Urgent Care Services; (2) Preventive Care Services; (3) Primary and Secondary Care Services; (4) Chronic Tertiary Care Services; and (5) Excluded Services. IHS users who receive services paid through the PRC program must live within a specific geographic area for each facility; these areas are smaller than other IHS service areas. Furthermore, the IHS user must also demonstrate that other health care resources are not available to pay for the needed services.

¹⁹See GAO, *Indian Health Service: Action Needed to Ensure Equitable Allocation of the Resources for the Contract Health Service Program* [GAO-12-446](#) (Washington, D.C.: Jun. 15, 2012). "Contract Health Service Program" is the former name of the PRC program. In addition to receiving federal funding through IHS, the tribes may provide supplemental funds to the PRC programs they administer.

Figure 19: Indian Health Service Purchased/Referred Care Spending, Fiscal Years 2013-2017
Spending for purchased/referred care services (in millions of dollars)



Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-74R

Facilities can use PRC program funds to pay for a wide variety of services not available in the facility. Between fiscal years 2013 and 2017 PRC program expenditures associated with inpatient services ranged from 36 to 45 percent.²⁰ During that same period, outpatient services expenditures ranged from 43 to 51 percent and patient transportation expenditures were 10 to 11 percent of expenditures.²¹

Not All Requests for PRC Services Are Funded

Facilities do not approve all requests for services made through the PRC program. Requests may be denied because the user did not meet PRC eligibility requirements, or because the services were not within the medical priority for which funding is available. A facility may also defer requests to pay for services until funding becomes available.²²

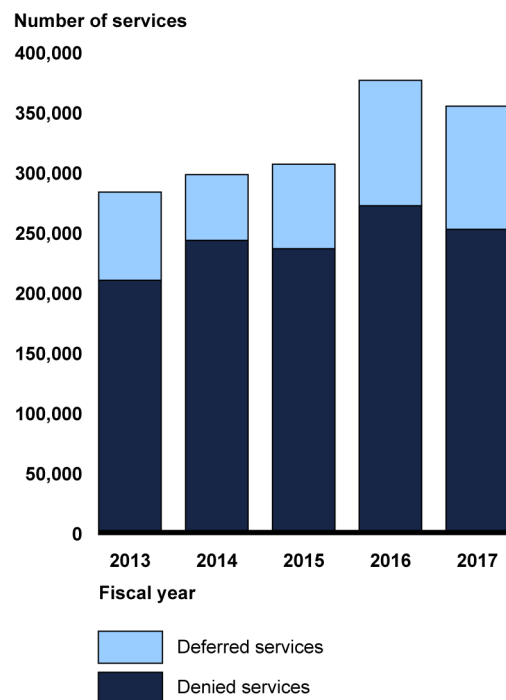
The number of deferred and denied services in federally and tribally operated facilities grew from 283,020 services overall in fiscal year 2013 to 354,446 services in fiscal year 2017, an increase of about 25 percent. (See fig. 20.) The majority of these services were categorized as denials.

²⁰As discussed earlier, available IHS data on PRC program expenditures are limited to those facilities that are federally operated, which in fiscal year 2017 represented about 46 percent of all IHS expenditures. The remaining facilities were tribally operated and are not required to report these data to IHS.

²¹According to IHS, IHS users living in rural areas often have to travel long distances for referral services.

²²IHS policy requires that deferred services be for elective care, rather than emergent or urgent care. Programs may not defer payment for services already rendered, only for services that have not been received.

Figure 20: Number of Denied and Deferred Purchased/Referred Care (PRC) Program Services (Federal and Tribal), Fiscal Years 2013-2017



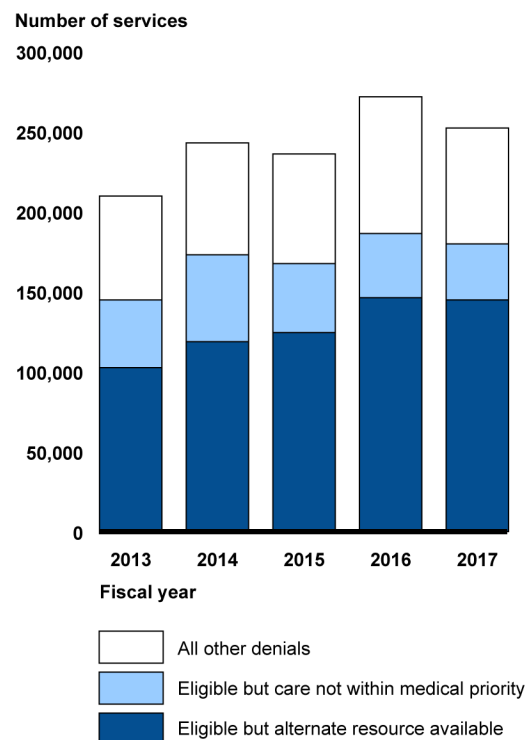
Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-74R

Note: Data represent PRC program requests from federally operated facilities—which in fiscal year 2017 represented about 46 percent of all IHS expenditures—and some tribally operated facilities, which are encouraged, but not required to report such data.

Federally and tribally operated facilities reported a variety of reasons for why services under the PRC program were denied. The most common reason for the denial from fiscal years 2013 through 2017 was that the user had an alternate source of coverage for the service—such as Medicaid or private insurance—to pay for the service, increasing from 102,409 denied requests in fiscal year 2013 to 144,655 denied requests in fiscal year 2017. (See fig. 21.) The second most common reason for denial under the PRC program was that the user’s needed health care services were not within the medical priorities for which the facility had funding, although the user was otherwise eligible.²³ Specifically, that reason accounted for 42,293 denials in fiscal year 2013 and decreased to 34,988 denials in fiscal year 2017. Those denied services included, among others, inpatient services, outpatient services, and transportation services.

²³We found that facilities have often been limited to paying for only those services within the first category of the medical priority system—emergency services to prevent the immediate death or serious impairment of the health of the individual. See [GAO-12-446](#). However, some facilities are able to pay for additional types of services.

Figure 21: Number of Denied Purchased/Referred Care (PRC) Program Services (Federal and Tribal) by Reason, Fiscal Years 2013-2017



Source: GAO analysis of Indian Health Service (IHS) data. | GAO-19-74R

Note: "All other denials" includes reasons such as emergency notification not provided within 72 hours and the patient residing outside the PRC service delivery area, among others. Data represent PRC program requests from federally operated facilities—which in fiscal year 2017 represented about 46 percent of all IHS expenditures—and some tribally operated facilities, which are encouraged, but not required to report such data.

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