



November 2020

INDIAN HEALTH SERVICE

Actions Needed to Improve Oversight of Federal Facilities' Decision-Making About the Use of Funds

Why GAO Did This Study

IHS, an agency of the Department of Health and Human Services, provides care to AI/AN populations through a system of federally operated and tribally operated health care facilities. AI/AN have experienced long standing problems accessing needed health care services. GAO has previously reported that IHS has not been able to pay for all eligible health care services; however, the resources available to federally operated facilities have recently grown.

This report assesses IHS oversight of federal health care facilities' decision-making about the use of funds. GAO reviewed IHS policies and documents; and interviewed IHS officials from headquarters, nine area offices, and three federally operated facilities (two hospitals and one health clinic).

What GAO Recommends

GAO recommends that IHS develop processes to guide area offices in (1) systematically assessing how federally operated facilities will effectively meet the needs of their patient populations, and (2) reviewing federal facilities' spending proposals. HHS concurred with these recommendations.

INDIAN HEALTH SERVICE

Actions Needed to Improve Oversight of Federal Facilities' Decision-Making About the Use of Funds

What GAO Found

The Indian Health Service's (IHS) oversight of federally operated health care facilities' decision-making process about the use of funds has been limited and inconsistent. Funds include those from appropriations, as well as payments from federal programs, such as Medicaid and from private insurance, for care provided by IHS to American Indians and Alaska Natives (AI/AN). While some oversight functions are performed at IHS headquarters, the agency has delegated primary responsibility for the oversight of health care facilities' decision-making about the use of funds to its area offices. Area office officials said the oversight they provide has generally included (1) reviewing facilities' scope of services, and (2) reviewing facilities' proposed expenditures. However, GAO's review found that this oversight was limited and inconsistent across IHS area offices, in part, due to a lack of consistent agency-wide processes.

- While IHS officials from all nine area offices GAO interviewed said they reviewed facilities' scope of services and coordinated with tribes when doing so, none reported systematically reviewing the extent to which their facilities' services were meeting local health needs, such as by incorporating the results of community health assessments. Such assessments can involve the collection and assessment of data, as well as the input of local community members and leaders to identify and prioritize community needs. These assessments can be used by facilities to assess their resources and identify priorities for facility investment. While IHS has identified such assessments as a priority, the agency does not require federally operated facilities to conduct such assessments or require the area offices to use them as they review facilities' scope of services.
- To ensure that facilities are effectively managing their resources, IHS has a process to guide its review of facilities' proposed construction projects that cost at least \$25,000. However, IHS does not have a similar process to guide its oversight of other key proposed expenditures, such as those involving the purchase of major medical equipment, the hiring of providers, or the expansion of services. Specifically, GAO found limitations and inconsistencies with respect to requiring a documented justification for proposed expenditures; documenting the review and approval of decisions; and conducting an impact assessment on patient access, cost, and quality of care.

The limitations and inconsistencies that GAO found in IHS's oversight are driven by the lack of consistent oversight processes across the area offices. Without establishing a systematic oversight process to compare federally operated facilities' current services to population needs, and to guide the review of facilities' proposed expenditures, IHS cannot ensure that its facilities are identifying and investing in projects to meet the greatest community needs, and therefore that federal resources are being maximized to best serve the AI/AN population.

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Abbreviations

AI/AN	American Indian and Alaska Native
HHS	Department of Health and Human Services
IHS	Indian Health Service

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November 12, 2020

The Honorable John Hoeven
Chairman
The Honorable Tom Udall
Vice Chairman
Committee on Indian Affairs
United States Senate

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), provides health care for over 2 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 November 2019, IHS, tribes, and tribal organizations operated 47 hospitals and 362 health centers, as well as a range of other types of health care facilities. Of these facilities, 24 hospitals and 49 health centers were federally operated IHS facilities. These federally operated facilities reported nearly 5 million outpatient visits in fiscal year 2018, providing mostly primary and emergency care, and are located in 10 of IHS's 12 geographic areas.³

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 January 30, 2020, there were 574 federally recognized tribes. See 85 Fed. Reg. 5462 (Jan. 30, 2020).

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. §§ 5301-5332, 5381-5399. In fiscal year 2020, IHS allocated over 60 percent of its appropriations to tribes and tribal organizations to operate part or all of the 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.

³The 12 IHS areas are Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

AI/AN have experienced long-standing problems accessing needed health care services. They also have historically had poorer health outcomes than the general U.S. population, as evidenced by shorter average life spans and higher incidence of certain medical conditions—many of which can be mitigated, at least in part, through access to effective preventive primary care services. In prior reports we have noted that IHS has not been able to pay for all covered health care services, leading to an unmet need for health care among AI/AN.⁴ In 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. In addition, IHS is authorized to collect and retain reimbursements, referred to as third-party collections, from Medicaid (the federal-state health insurance program for certain low-income and medically needy individuals), Medicare (the federal health insurance program for persons aged 65 and over, and certain others), the Department of Veterans Affairs (which provides health care services for veterans), and private insurance for services provided at IHS facilities.⁶ Beginning in 2014, the Patient Protection and Affordable Care Act provided opportunities to expand coverage of AI/AN through Medicaid and private health insurance.⁷ In September 2019, we reported that the

⁴See GAO, *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).

⁶42 U.S.C. §§ 1396j, 1395qq; 25 U.S.C. §§ 1621e(a), 1621f(a).

⁷Specifically, the Patient Protection and Affordable Care Act 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 (2010).

resources available to both federally operated and tribally operated facilities had grown in recent years, and that facilities were increasingly relying on third-party collections to maintain their facilities' operations and expand services.⁸ Federally operated and tribally operated IHS facilities may use their funds in a variety of ways, and IHS is responsible for overseeing the decisions of federally operated facilities' decisions regarding their use of funds.

We prepared this report under the authority of the Comptroller General to assist Congress in its oversight responsibilities. This report assesses IHS oversight of federally operated facilities' decision-making process about the use of federal and other funds.

To assess IHS oversight, we reviewed IHS policies and procedures that outline the agency's process for overseeing federal facilities' decision-making about the use of federal and other funds.⁹ We interviewed IHS officials from headquarters and all nine of the agency's area offices that oversee two or more federally operated facilities to gather information about the steps that IHS headquarters and area office officials take to conduct this oversight.¹⁰ We also interviewed officials from three federally operated facilities (two hospitals and one health center) to obtain illustrative examples on how IHS reviewed federally operated facilities' recent decisions about the use of federal and other funds. The selected facilities reflected a geographically dispersed mix of hospitals and health centers that experienced a range of increases in third-party collections compared to the average rate across all federally operated facilities from

⁸See GAO, *Indian Health Service: Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections*, [GAO-19-612](#) (Washington, D.C.: Sept. 3, 2019).

⁹After decisions are made on how to spend funds, IHS engages in a separate oversight process to ensure that funds are available and that the procurement of such goods and services is in adherence with the Federal Acquisition Regulation, among other things. We did not review the procurement process.

IHS does not oversee tribally operated facilities' decision-making about the use of funds and therefore tribally operated facilities are not included in the scope of this review.

¹⁰As of fiscal year 2020, nine of the agency's 12 areas had two or more federally operated IHS facilities. These areas are: Albuquerque, Bemidji, Billings, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, and Portland. The California area had one federally operated IHS facility and the Alaska and Tucson areas had no federally operated IHS facilities.

fiscal year 2013 through 2018.¹¹ Our findings from our interviews with facility officials cannot be generalized to all federally operated facilities.

We also examined area office documentation showing federally operated facilities' proposed expenditures and related agency oversight, including governing board meeting minutes, project summary and justification documents, and facility budgets. We reviewed the agency's website and examined linked documents including resources related to the development of community health assessments, as well as the agency's process for overseeing federally operated facilities' proposed expenditures.¹² We obtained the input of tribal representatives on IHS oversight and outreach to tribes through an interview organized by the Self-Governance Communication & Education Tribal Consortium.¹³

We assessed IHS oversight in the context of the agency's strategic objectives to improve communication with tribes and others, and to secure and effectively manage its assets and resources.¹⁴ We also determined that federal internal control standards were significant to our objective.¹⁵

We conducted this performance audit from August 2019 through November 2020 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

¹¹Specifically, we interviewed officials from Cass Lake Indian Hospital in the Bemidji area, El Reno Indian Health Center in the Oklahoma area, and Whiteriver Indian Hospital in the Phoenix area. We were unable to complete additional planned interviews with officials from federally operated facilities because of impacts to government operations related to Coronavirus Disease 2019.

¹²Specifically, IHS posts information related to community health assessments at <https://www.ihs.gov/hpdp/communityhealth/>, last accessed September 1, 2020; and information related to its process for reviewing facilities' planning for proposed expenditures at <https://www.ihs.gov/oehe/handbook/>, last accessed September 1, 2020.

¹³The Self-Governance Communication & Education Tribal Consortium is comprised of tribal representatives from areas served by tribally operated facilities. The organization provides technical assistance to IHS related self-governance and the related administration of tribally operated facilities.

¹⁴Indian Health Service, *Strategic Plan FY 2019-2023* (Rockville, Md.: July 9, 2019).

¹⁵See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014).

believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

IHS Services and Organization

IHS was established within the Public Health Service in 1955 to provide health services to members of federally recognized AI/AN tribes primarily in rural areas on or near reservations. IHS provides services directly through a network of hospitals, clinics, and health stations operated by IHS, and also funds services provided at tribally operated facilities.¹⁶ When services are unavailable at federally operated or tribally operated facilities, IHS may pay for services provided through private providers through its Purchased/Referred Care program. As of November 2019, there were 109 federally operated facilities, including hospitals and health centers, and 667 facilities operated by tribes. The types of services offered by these facilities vary, but most commonly include primary care and emergency care, as well as some ancillary and specialty services.¹⁷ (See table 1.)

¹⁶IHS also provides funding to nonprofit, urban Indian organizations through the Urban Indian Health program to provide health care services to AI/AN people living in urban areas. See 25 U.S.C. § 1653.

Based on the needs of their communities, tribes and tribal organizations can choose to receive health care administered and operated by IHS, or assume responsibility for providing all or some health care services formerly administered and operated by IHS. Under the Indian Self-Determination and Education Assistance Act, as amended, federally recognized Indian tribes can enter into self-determination contracts or self-governance compacts with the Director of IHS to take over administration of IHS programs for Indians previously administered by IHS on their behalf. See generally 25 U.S.C. §§ 1661, 5301-5332, 5381-5399.

¹⁷For example, federally operated IHS hospitals range in size from four 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 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.

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

Facility type	Federal	Tribal	Total
Hospitals	24	23	47
Health centers	49	313	362
Other facilities ^a	36	331	367
Total	109	667	776

Source: GAO presentation of Indian Health Service data. | GAO-21-20.

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

IHS’s headquarters is responsible for setting the agency’s national health care policy, ensuring the delivery of quality comprehensive health services, and advocating for the health needs and concerns of AI/AN people. Its area offices are responsible for monitoring federally operated IHS facilities’ operations and finances, and providing guidance and technical assistance.¹⁸ Each federally operated facility also has a governing board that includes leadership from the area office and the facility. The governing board is responsible for each facility’s compliance with all federal and state laws and accreditation standards; the development, approval, and monitoring of each facility’s annual financial spending plan and operating budget; and oversees each facility’s quality of care and access to care, as well as its management and operations. IHS oversight of federally operated facilities’ decision-making about the use of funds occurs either through the area office or the facility’s governing board.

IHS Funding

IHS’s annual appropriations and third-party collections are the main sources of funding available to federally operated and tribally operated IHS facilities. In addition, facilities may apply for and receive grants or other resources.

Annual Appropriations

IHS uses annual appropriations to fund all of its operations, including federally operated and tribally operated IHS facilities throughout the

¹⁸As of fiscal year 2020, nine of IHS’s 12 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 2020, the California area had one federally operated IHS facility, the Desert Sage Youth Wellness Center. The Alaska and Tucson areas had no federally operated IHS facilities.

country. In fiscal year 2019, IHS received a total of \$5.95 billion in budget authority from annual appropriations.¹⁹ Of this amount,

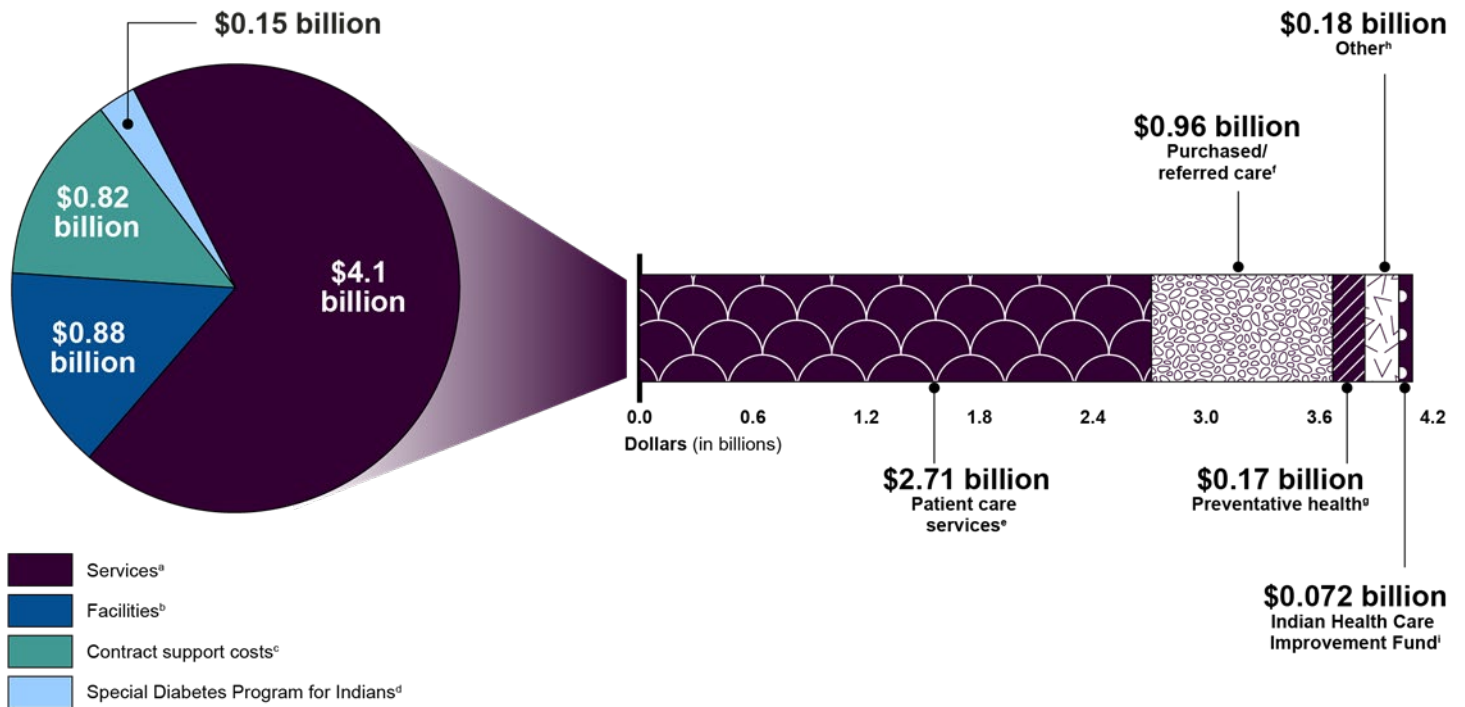
- \$4.1 billion (69 percent) supported the agency’s services. The majority of these funds (\$2.7 billion) were used to fund patient care services provided at federally operated and tribally operated IHS facilities, including clinical health services, dental health, mental health, and alcohol and substance abuse services.²⁰ The remainder of IHS’s services funding supported Purchase/Referred Care, which pays for care from private providers when patients meet certain criteria and funding is available; preventive health programs, which include patient education and immunization programs; other programs and services; and the Indian Health Care Improvement Fund, which was created to eliminate resource deficiencies at federally operated and tribally operated facilities and may be used by selected facilities in a variety of ways.
- \$879 million (15 percent) supported facilities—including the construction of new facilities, the purchase of equipment, the repair and improvement of existing facilities, and sanitation projects involving water and sewer systems.
- \$822 million (14 percent) supported tribes’ contract support costs associated with administering tribal contracts and compacts at tribally operated facilities.

¹⁹Budget authority is the authority provided by federal law to enter into financial obligations that will result in immediate or future outlays involving federal government funds. Although third-party collections are also a part of IHS’s budget authority, for this report, we use the term budget authority to refer to amounts derived from annual appropriations. We use the term third-party collections to refer to funds collected from public and private insurance providers. See GAO, *A Glossary of Terms Used in the Federal Budget Process*, [GAO-05-734SP](#) (Washington, D.C.: Sept. 1, 2005). Accordingly, for this report, total budget authority includes funding from all three IHS appropriation accounts—Indian Health Services, Indian Health Facilities, and Contract Support Costs—but not collections or grants. We obtained the budget authority amounts from IHS’s congressional budget justifications, which noted that the amount of budget authority for fiscal year 2019 reflects reprogramming adjustments and may continue to be adjusted during the period of availability, which concludes on September 30, 2020. Department of Health and Human Services, Indian Health Service, *Justification for Estimates for Appropriations Committees, Fiscal Year 2021* (Rockville, Md.: Feb. 5, 2020), CJ-9.

²⁰For the purpose of this report, we use the term “patient care services” to refer to funding for medical services provided to patients exclusively onsite at federally operated and tribally operated facilities. IHS does not use this term or otherwise distinguish between medical services provided at the facility or by private providers through its Purchased/Referred Care program, or to distinguish between medical or other services, such as health promotion and education.

- \$150 million (3 percent) supported the Special Diabetes Program for Indians, a grant program aimed at reducing the incidence of diabetes among AI/AN. (See fig. 1.)

Figure 1: Indian Health Service Fiscal Year 2019 Federal Budget Authority



Source: GAO presentation of IHS data. | GAO-21-20

Notes: Budget authority is the authority provided by federal law to enter into financial obligations that will result in immediate or future outlays involving federal government funds. Although third-party collections are also a part of the Indian Health Service's (IHS) budget authority, for this report, we use the term budget authority to refer to amounts derived from annual appropriations. We use the term third-party collections to refer to funds collected from public and private insurance providers. We obtained IHS budget authority data from IHS's Justification for Estimates for Appropriations Committees, Fiscal Year 2021, reflecting fiscal year 2019 data. The fiscal year 2019 budget authority amounts reflect reprogramming adjustments and may continue to be adjusted during the period of availability, which concludes on September 30, 2020. Data do not sum to totals due to rounding.

^aServices includes funds for patient care services provided at federally operated and tribally operated IHS facilities, including clinical health services, dental health, mental health, and alcohol and substance abuse services, as well as services provided by private providers through Purchased/Referred Care. It also includes funding for preventative health programs, the Indian Health Care Improvement Fund, and other programs and services.

^bFacilities includes funds for the construction of new facilities, the purchase of equipment, the maintenance and improvement of existing facilities, and sanitation projects involving water and sewer systems.

^cContract Support Costs funds are provided to tribes to support the costs associated with administering tribal contracts and compacts at tribally operated facilities.

^dThe Special Diabetes Program for Indians includes funds for a grant program aimed at reducing the incidence of diabetes among American Indians and Alaska Natives.

^ePatient care services includes funds for services provided onsite at federally operated and tribally operated IHS facilities, including clinical health services, dental health, mental health, and alcohol and substance abuse services.

^fPurchased/Referred Care includes funds for patient care provided from private providers if patients meet certain requirements and funding is available.

^gPreventative health includes funds for public health nursing, health education, and immunization programs.

^hOther includes funds for the Urban Indian Health Program, health professions scholarship and loan repayment programs, direct operations, tribal management grants, and self-governance.

ⁱThe Indian Health Care Improvement Fund includes funds to enhance services and facilities at selected federally operated and tribally operated services as a way to reduce disparities across facilities.

IHS reported that in fiscal year 2019, tribally operated facilities and programs managed 63 percent of IHS's total budget authority, and federally operated facilities and programs managed 37 percent.²¹

Appendix I provides information on how IHS annual appropriations are allocated to facilities.

Third-Party Collections

Federally operated and tribally operated IHS facilities also collect payments, referred to as third-party collections, from patients' health insurance programs, such as Medicaid, Medicare, the Department of Veterans Affairs, and private insurance companies. By statute, 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.²² In fiscal year 2019, federally operated IHS facilities collected \$1.1 billion in third-party collections, according to IHS data.²³ As we have previously reported, third-party collections have increased in recent years for federally and tribally operated facilities, and facilities are increasingly relying on third-party collections to maintain their operations and expand

²¹The amounts allocated to federally operated and tribally operated facilities are not split evenly across the categories. For example, tribally operated facilities receive 100 percent of budget authority for contract support costs every year, as these costs are not relevant to federally operated facilities.

²²25 U.S.C. § 1623(b).

²³The total amount collected by tribally operated facilities is unknown, as they are not required to report this information to IHS.

services.²⁴ Third-party collections are available to facilities until expended.²⁵

Grants and Other Resources

Federally operated and tribally operated IHS facilities may apply for certain grants at their discretion—although this is relatively rare—and tribally operated facilities may receive funding from other sources such as their local tribe. According to IHS, in fiscal year 2019, federally operated facilities received four grants—one from HHS and three from state health departments—totaling nearly \$62,000 to support activities including hospital preparedness, data systems, and cancer screening and prevention. IHS facilities may also enter interagency agreements to carry out work on behalf of other agencies on a reimbursable basis. According to IHS, federally operated facilities commonly receive funding through interagency agreements with the Environmental Protection Agency to carry out sanitation projects to bring essential water supply, sewage disposal, and solid waste disposal facilities to AI/AN homes and communities.²⁶

Tribally operated facilities may also receive grants and other resources from a variety of entities, such as federal agencies, state and local governments, universities, and private foundations, as well as additional resources from their local tribe.²⁷ For example, in fiscal year 2019, the Health Resources and Services Administration provided 32 tribes with Health Center Program awards to provide health care at their tribally operated facilities to individuals who are members of the health center's target population or to all individuals located in the health center's service area, regardless of their ability to pay.²⁸ Health Center Program awards accounted for between 3 percent and 83 percent of each grantee's total

²⁴See [GAO-19-612](#).

²⁵Federally operated and tribally operated facilities are allowed to retain third-party collections without an offset to their annual appropriations. 25 U.S.C. § 1621(b).

²⁶In addition to providing direct care to patients, IHS administers a sanitation facilities construction program that provides technical and financial assistance to American Indian tribes and Alaska Native villages for the cooperative development and construction of safe drinking water supply, sewage, and solid waste disposal facilities, and related support facilities.

²⁷The total amount and type of grant funding received by tribally operated facilities is unknown, because it is not required to be reported to IHS.

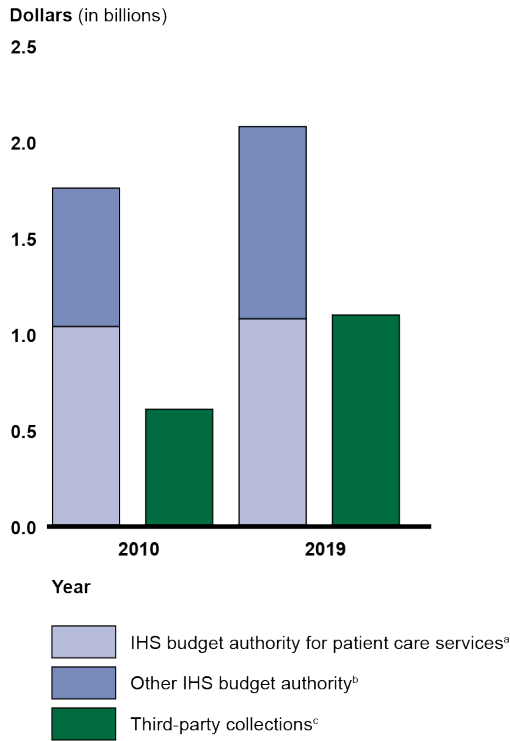
²⁸The Health Resources and Services Administration, an agency within HHS, is the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable.

revenue in calendar year 2018 (the latest year of data available), according to their reports to the Health Resources and Services Administration. In addition, some tribally operated facilities receive grants from other federal agencies, such as the Environmental Protection Agency, U.S. Department of Agriculture, and Department of Housing and Urban Development to support sanitation projects.

Changes in Federally Operated IHS Facilities' Resources for Patient Care

From fiscal year 2010 through fiscal year 2019, federally operated facilities' third-party collections grew at a faster rate than their total budget authority from annual appropriations, as well as the portion of their budget authority slated for patient care services—leading collections to comprise a greater share of federally operated facilities' budgets for patient care. Specifically, third-party collections across all federally operated IHS facilities grew from \$614 million in fiscal year 2010 to \$1.1 billion in fiscal year 2019—an increase of 79 percent—while total budget authority for federal facilities increased 19 percent and budget authority for patient care services increased 4 percent. (See fig. 2.)

Figure 2: Funding Resources for Federally Operated Indian Health Service Facilities, Fiscal Years 2010 and 2019



Source: GAO presentation of IHS data. | GAO-21-20

Notes: Budget authority is the authority provided by federal law to enter into financial obligations that will result in immediate or future outlays involving federal government funds. Although third-party collections are also a part of the Indian Health Service’s (IHS) budget authority, for this report, we use the term budget authority to refer to amounts derived from annual appropriations. We use the term third-party collections to refer to funds collected from public and private insurance providers. Fiscal year 2010 budget authority data reflect enacted amounts published in IHS’s Fiscal Year 2012 Justification for Estimates for Appropriations Committees. Fiscal year 2019 budget authority data reflect estimated amounts published in IHS’s Fiscal Year 2020 Justification for Estimates for Appropriations Committees, include reprogramming adjustments, and may continue to be adjusted during the period of availability, which concludes on September 30, 2020. We obtained third-party collections data from IHS.

^aPatient care services reflects budget authority for clinical, dental, mental, and alcohol and substance abuse services provided onsite at federally operated facilities.

^bOther reflects budget authority for all other activities at federally operated facilities, including preventative health, Purchased/Referred Care for care provided by private providers, facilities, and the Special Diabetes Program for Indians.

^cThird-party collections are payments federally operated facilities collect from public programs—such as Medicaid and Medicare, the Department of Veterans Affairs, or from private insurers—for providing health care services to enrollees.

While third-party collections increased for federally operated facilities in the aggregate, we previously found significant variation in the growth of

these collections for individual facilities from fiscal years 2013 through 2018.²⁹ Specifically, we reported 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. We also reported that increases in collections over this period resulted from gains in health insurance coverage, as well as other factors such as increased facility efforts to enhance collections.

Despite recent increases in the resources available to many federally operated and tribally operated facilities, both IHS and tribal leaders have reported that the total amount of funding available to support the provision of health care to AI/AN has been insufficient. Specifically, IHS estimated that in fiscal year 2018, federally operated and tribally operated facilities were able to fund, on average, 49 percent of the need for health care that exists in the AI/AN population.³⁰ According to some tribal leaders, the funding of IHS is chronically inadequate and requires tribal nations to supplement program resources with those generated from tribal enterprises or partnerships.

IHS Oversight of Federally Operated Facilities' Funding Decisions Has Been Limited and Inconsistent

IHS oversight of federally operated health care facilities' decision-making about the use of federal and other funds has been limited and inconsistent. IHS has adopted a practice of delegating decisions to the lowest level possible, in order to help ensure that such decisions meet local needs, according to agency officials. Accordingly, while some oversight functions are performed at IHS headquarters, the agency has delegated primary responsibility for oversight to its area offices. According to area office officials we interviewed, their oversight of federally operated facilities' decision-making about the use of federal and other funds may occur through the functions of the area office or through the facilities' governing boards.³¹ IHS area office officials told us the oversight they provide has generally included (1) reviewing facilities' scope of services and (2) reviewing facilities' proposed expenditures.

²⁹See [GAO-19-612](#), p.16-17.

³⁰Indian Health Service, *Table 4B: Indian Health Care Improvement Fund Allocations by Area*, accessed August 14, 2020, https://www.ihs.gov/sites/ihsif/themes/responsive2017/display_objects/documents/2018/IH_CIF_4B%20Table_Area%20Rollup%20Allocations.pdf.

³¹Each facility has a governing board that is chaired by the area office director and includes both area office staff and facility executives.

Review of Scope of Services

Officials at all nine of the IHS area offices that oversee two or more federally operated facilities told us that they periodically review facilities' scope of services to determine whether the facilities' current level of services can be maintained with current resources, or if changes are needed to either the services offered or the resources supporting them. According to area office officials, the frequency of these reviews varied widely, ranging from monthly to every 3 years. Additionally, we found that officials from these area offices used a variety of approaches to conduct these reviews. For example, officials from some area offices told us they asked facilities to conduct and present a variety of assessments related to the needs of the facility with respect to continuing current services. Officials from other area offices reported conducting these reviews more informally using data that is otherwise available to them, such as patient utilization, staff workload, patient satisfaction scores, and the results of accreditation surveys.³² Officials from one area office told us that they recently began assisting their local facilities in engaging in a master planning process with the goal of identifying, prioritizing, and sequencing a future capital investment of \$10 million to \$20 million over the next 10 years. This process, at the time of our review, had been completed for one facility. Our review of related documents showed that local IHS and tribal health program leaders compared the facility's current scope of services to agency estimates on the amount of services that their population would need and support.³³ The documents also incorporated the feedback of facility health care providers and staff, as well as local tribal health officials as they worked to develop a long term prioritized investment plan for the facility. According to IHS officials, this flexibility in the timing and approach to the review of the scope of services is important given the wide variation in the sizes and types of facilities, and the areas and populations served.

When reviewing facilities' scope of services, IHS officials told us that they assess community needs and incorporate this information into their review of facilities' services. Specifically, IHS officials from headquarters

³²IHS has implemented processes to more systematically assess and document its needs for facility maintenance and improvement. For example, each federally operated facility is required to annually submit to their area office a facilities engineering program plan, which provides an assessment of facility maintenance needs and assists areas in planning maintenance and improvement projects at its facilities. In addition, IHS submits a facilities' needs assessment to Congress every 5 years, which describes the comprehensive national ranked list of all health care facility needs for the IHS system.

³³According to IHS officials, IHS develops these estimates based on agency data on the number of patients living in a particular area, their demographics, and the number of patient visits to each facility, among other things.

told us that the agency plays a vital role in understanding the health needs of a community, noting that its strategic plan includes a goal to ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people. To reach this goal, IHS officials told us they developed various objectives and strategies, including to collaborate with tribes on the development of community-based health programs, develop a community feedback system where community members can provide suggestions regarding services, and work with community partners to develop new programs responsive to local needs.

IHS officials from headquarters told us that facilities' consultation with tribes is the primary mechanism that the agency uses to assess the needs of their communities. Officials from all area offices we interviewed reported that they or their facilities coordinated with tribal leaders while reviewing facilities' scope of services. According to IHS policy, IHS officials must consult with tribal leaders when there is a critical event that may impact tribes, as new or revised policies or programs are proposed, and during the development of the annual budget and performance plan.³⁴ Separately, IHS officials told us that as they plan for a facility replacement or expansion, they prepare and review projections of the number of services that the population would support and need, based on the number of patients living in the area and the number of patient visits to the facility. Despite these efforts, tribal leaders we interviewed told us that they would like to be able to provide more input on local needs as federally operated facilities establish priorities for investment.

Although officials from all of the area offices we interviewed reported reviewing facilities' scope of services, none of these officials reported systematically reviewing the extent to which their facility's services were meeting local health needs. For example, none of the area office officials we interviewed reported incorporating the results of community health assessments into their scope of service reviews, even though such assessments were available in some areas. Community health assessments can involve the systematic collection and analysis of data, as well as the input of local community members and leaders to

- identify key health needs and issues,

³⁴See Indian Health Service, "*Tribal Consultation Policy*", Indian Health Service Circular No. 2006-01 (Rockville, Md.: Jan. 18, 2006).

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- help facilities determine whether current services meet local needs,
 - assess their resources to address and prioritize those needs, and
 - serve as a baseline to evaluate progress toward meeting health improvement goals.

These community health assessments are commonly performed by health care facilities and health departments throughout the U.S. health care system.³⁵ In some areas, state, local, and tribal health departments also perform community health assessments.³⁶ While the scope of these assessments can vary, agency officials acknowledge that they may require a considerable amount of time, leadership, and resources.³⁷

Although IHS has identified community health assessments as a priority on its website, IHS officials told us that the agency does not require federally operated facilities to conduct such assessments or area offices to use them to identify the medical needs of their patient populations—including existing patients, as well as those who live in the community but do not currently access care at these facilities. However, the agency has funded the development of a toolkit for tribes to use in assessing the

³⁵For example, all nonprofit hospitals, as a condition of their tax-exempt status, are required to conduct community health assessments every 3 years and adopt an implementation strategy to meet the needs identified in their assessment. See 26 U.S.C. § 501(r).

³⁶For example, the Navajo County Public Health Services District, which governs an area that includes six federally operated facilities, has periodically conducted community health assessments. The department's most recent assessment and resulting community health improvement plan—which identifies goals resources and outcomes to address key public health concerns, including health disparities experienced by AI/AN communities—were both published in 2018. See Navajo County, "2018 Navajo County Community Health Assessment" (Navajo County, Ariz.: 2018), and Navajo County, "2018 Navajo County Community Health Improvement Plan" (Navajo County, Ariz.: October 2018).

Separately, the Blackfeet Tribal Health Department conducted a community health assessment in 2017 in an area that includes two federally operated facilities. In 2018, the health department issued a related community health improvement plan that lists the two IHS facilities as among the community health resources tribal members could access. See Blackfeet Tribal Health Department, "Blackfeet Reservation Community Health Assessment 2017" (Browning, Mont.: February 2017), and Blackfeet Tribal Health Department, "Community Health Improvement Plan" (Browning, Mont.: August 2018).

³⁷See Indian Health Service, "Community Health Assessment," accessed June 11, 2020, <https://www.ihs.gov/hpdp/communityhealth/>.

health needs of their members, and included links on its website to this and additional tools that other organizations have developed to aid in planning for and conducting an assessment.³⁸

Although some community health assessments are available in areas that include federally operated facilities, IHS officials told us that the agency has not established a process to ensure that area offices use these community health assessments to help identify and prioritize facilities' future investments, or to otherwise ensure that a current and systematic assessment of community health needs is incorporated into their review of facilities' scope of services. Officials from two area offices described challenges they faced in identifying the highest priority and best investments for local facilities given the large volume of needs in their areas. These challenges could be averted by conducting or using systematic assessments of community health needs, which aim to provide needed information to decision makers. In addition, officials from one IHS facility we interviewed explained how helpful a local organization's community health assessment was for them in identifying services that they could add to their facility in order to better meet local community needs.

The limitations and inconsistencies we found in IHS's oversight of federally operated facilities' scope of services are driven by the lack of a consistent process to guide IHS area offices in conducting these reviews. IHS officials told us they have adopted a practice of delegating decision-making and review to the lowest level possible in order to allow for variation in local circumstances and to ensure that decisions meet local needs. However, the lack of any process to ensure that a systematic assessment of community health needs is incorporated into their review of a facility's scope of services is inconsistent with the IHS Strategic Plan for fiscal years 2019-2023. The plan states that in order to strengthen IHS program management and operations, IHS should work to better understand health-specific program needs, modify programs as needed,

³⁸See Angus L, Stehr-Green P, Robertson LD, Lutz T., *Indian Community Health Profile Project Toolkit*. (Portland, Ore., June 2005), and IHS, "Community Health Tools," accessed June 11, 2020, <https://www.ihs.gov/hdpd/communityhealth/tools/>.

IHS's Health Promotion/Disease Prevention program notes that it is working to increase access to an online clearinghouse that contains best and promising practices and local efforts, resources, training tools, and community assessment tools for health promotion and disease prevention, as part of its mission to improve the health status of the AI/AN population.

and monitor the effectiveness of programs. Consequently, the agency cannot reasonably ensure that its facilities are identifying and providing services and allocating resources to meet the greatest community needs.

Review of Proposed Expenditures

Under IHS procedures, the agency reviews proposed construction projects costing at least \$25,000, but does not consistently review other proposed expenditures of any amount, including those related to the purchase of major medical equipment and the hiring of providers to offer an increased amount or type of services.³⁹

To guide its review of any projects involving the construction, renovation, or addition of space costing at least \$25,000, IHS requires facilities to prepare a short written summary and justification, and area office officials must approve such expenditures. For construction projects of \$1 million or more, IHS requires facilities to develop a more extensive summary and justification, including estimates of the type and amount of services that should be provided given agency data on the number of patients obtaining services at the facility and their demographics. IHS headquarters must review and approve all such projects. IHS also requires that a final review be conducted for all construction projects, which includes an examination of what went right and wrong during the construction process. IHS officials told us that the agency developed this process to implement governmentwide capital investment project review and documentation requirements, as directed by the Office of Management and Budget and HHS.⁴⁰

For proposed expenditures not related to construction—including any expenditures above \$25,000, such as those related to the purchase of major medical equipment and the hiring of providers—we found IHS oversight to be limited and inconsistent across the areas, especially with

³⁹IHS's review of construction projects may include some information about changes unrelated to construction, such as plans for additional providers or services, to the extent that they are related to the construction.

The scope of our review only included the decision-making process related to how funds were to be used. According to area office officials we interviewed, after making a decision to expend funds, the area offices engage in a separate procurement review to examine additional factors, including the availability of funds and conformance to the Federal Acquisition Regulation.

⁴⁰See Office of Management and Budget, *Capital Programming Guide — Supplement to Office of Management and Budget Circular No. A11: Planning Budgeting and Acquisition of Capital Assets* (Washington, D.C.: 2020); and Department of Health and Human Services, *HHS Facilities Program Manual, Volume I* (Washington, D.C.: May 19, 2006).

respect to requiring a written justification for proposed expenditures; reviewing proposed expenditures; documenting review and approval of proposed expenditures; and assessing the impact on patient access, cost, and quality of care.

Requiring a written justification for proposed expenditures. IHS area offices varied with respect to the extent to which they required each facility to provide data and a written justification for other proposed decisions, such as the purchase of major medical equipment and the hiring of providers. Specifically, officials from three area offices told us that they required facilities to provide some analysis or documentation for all proposed expenditures—in the form of a written summary, justification, or plan—and officials from four area offices told us that they required analysis or documentation only in certain cases. Officials from these seven area offices told us that the level of detail and analyses that facilities needed to provide was generally not specified and varied by project. For example, officials from one area office stated that if a facility proposed the addition of a new service, the area office would expect to see data on patient referrals and a list of benefits related to adding the service instead of using Purchased/Referred Care funding.⁴¹ However, officials from two of the nine area offices told us that they did not require facilities to provide any written analyses or materials in support of such proposed expenditures.

Reviewing proposed expenditures. Officials from all area offices told us that they generally discussed facilities' proposed expenditures with facility executives. However, the area office officials also reported taking different approaches to review facilities' proposed expenditures, including using a wide range of available data and criteria to evaluate the proposals. According to the area office officials we interviewed, these data and criteria included

- the expected effect on patient access to care;
- staff utilization, showing how many patients providers cared for;
- use of Purchased/Referred Care, showing how many patients were being referred to private providers for services not available onsite;
- patient satisfaction scores and complaints, showing patient feedback about available services and needed changes;

⁴¹Purchased/Referred Care enables patients to obtain needed care from private providers, if the patients meet certain requirements and funding is available.

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- the facility's ability to maintain changes over time; for example, with available financial and staffing resources;
 - whether sufficient physical space was available;
 - the facility's readiness to implement change;
 - alignment with IHS's mission; and
 - tribal input.

Officials from one of the area offices we interviewed told us that when reviewing facilities' proposed expenditures, their main focus was ensuring that funding was available. Specifically, officials from this area office told us that as long as the facility had identified funding for the investment, they would approve the expenditure.

Documenting the review and approval of proposed expenditures.

Additionally, we found that area offices did not consistently document their review of decisions related to facilities' proposed expenditures. Area office officials told us that any changes that affect a facility's annual budget or staffing are generally discussed with area office officials, including at governing board meetings, and final decisions are documented in various ways, including in approved facility budgets and organizational charts. However, officials from all area offices we interviewed told us that there is no specific record of the area office's review and approval of decisions underlying these documents. Our examination of area office-approved facility budgets confirmed that while specific line items may include increases from prior years, these documents generally do not specify changes or convey related considerations from the area office's review, including any tradeoffs. Further, our review of governing board minutes from one area, for example, showed that these documents did not include a detailed discussion of the area office's review of proposed expenditures.

Assessing the impact of decisions. We also found inconsistency in the area offices' review of the impact of decisions on patient access, cost, and quality of care. Specifically, officials from seven area offices told us that they conducted some type of informal review of the impact of decisions on their patient population after they were implemented, for example, by reviewing available data on patient utilization and wait times for an appointment, staff workload, and patient or tribal comments. Officials from two area offices reported not routinely conducting assessments of the impact of decisions on their patient population. Officials from one of these offices explained that they did not review the impact of some decisions, because they had confidence that the steps

they took to review facilities' proposed decision-making was thorough enough to ensure positive impacts.

The limitations and inconsistencies we found in IHS's oversight of federally operated facilities' decision-making about proposed expenditures are driven by the lack of a consistent process to guide IHS area offices' review of federally operated health care facilities' spending proposals, both before approval and after they are implemented. IHS officials told us that they have adopted a practice of delegating decision-making and review to the lowest level possible in order to allow for variation in local circumstances and to ensure that decisions meet local needs. However, the lack of any process to review decision-making is inconsistent with the IHS Strategic Plan for fiscal year 2019-2023, which states that in order to effectively manage its assets, IHS should develop policies, use tools, and apply models that ensure the efficient use of assets, and it should strengthen management operations through effective oversight. Without a process to guide area office reviews, IHS cannot reasonably ensure that its facilities are identifying and investing in projects that meet the greatest community needs and agency priorities.

Conclusions

The resources available to IHS's federally operated facilities have increased in recent years, giving them a new ability to invest in their operations and expand services. However, we found that IHS's oversight of federally operated facilities' decision-making process about these facilities' use of funds has been limited and inconsistent.

IHS has designated community health assessments as a priority, but the agency has not developed a consistent process to help ensure that its area offices are systematically incorporating assessments of community needs into their facilities' planning, as a way to help identify the highest priority investments. In addition, while IHS has implemented a process for a standardized review of construction projects costing at least \$25,000, it has no such process for facilities to justify and for the agency to review other types of key investment decisions. As a result of these weaknesses, the agency cannot ensure that it is maximizing its use of resources to provide services that address the patient population's greatest needs.

Recommendations for Executive Action

We are making the following two recommendations to IHS:

The Director of IHS should develop a process to ensure that IHS area offices systematically assess how the scope of services provided by federally operated health care facilities will effectively meet the current and future needs of their patient populations, which could include the

incorporation of a current community health needs assessment.
(Recommendation 1)

The Director of IHS should develop a process to guide IHS area offices' review of federally operated health care facilities' spending proposals, both before approval and after they are implemented, and ensure this process is followed. (Recommendation 2)

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS provided written comments, which are reprinted in appendix II. HHS concurred with both of our recommendations.

In its comments, HHS elaborated on steps IHS would take to implement the first recommendation, including determining best practices in assessing patient population needs, identifying key elements for area offices to include when assessing facilities' scope of services, and adapting current processes to ensure there is consistent monitoring and reporting that encompasses areas and federal facilities' needs and resources. HHS also noted that IHS is committed to strengthening oversight and accountability across its federally operated facilities.

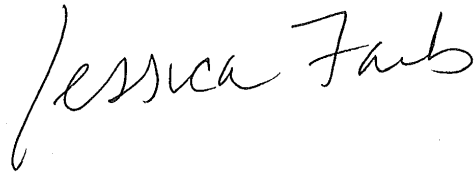
Regarding our second recommendation, HHS stated that IHS will identify best practices and use this input to develop and implement an enhanced process to create increased consistency in area office reviews of health care facilities' spending proposals before approval and after implementation, and will ensure regular IHS headquarters' review of area office implementation of this process. HHS also stated that IHS must rigorously manage and oversee their limited resources to ensure they best meet the needs of AI/AN population.

HHS also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of HHS, appropriate congressional committees, 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 III.

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

Jessica Farb
Director, Health Care

Appendix I: Allocation of Indian Health Service Annual Appropriations

The Indian Health Service (IHS) receives annual appropriations for services, facilities, contract support costs, and the Special Diabetes Program for Indians.

Most of IHS's annual appropriations fund its services, and the agency allocates nearly all of these funds to federally operated and tribally operated facilities through three primary methods: base funding, annual adjustments, and program increases.¹ IHS uses these methods sequentially.

1. Base funding is the total amount of all IHS funds from annual appropriations that each area office and facility received in the prior fiscal year. IHS allocates the same level of base funding, also referred to as recurring funding, to each area office and facility as it had allocated during the prior year unless the agency receives a decrease or an increase in its congressional appropriations, as described below.
2. Annual adjustments, when appropriated, are provided to area offices and facilities to account for increases in pay costs, inflation, or population growth. These adjustments are not funded every year; in fiscal year 2020, IHS officials told us that they received appropriations sufficient to allocate funds for all three adjustments. Prior to that, though, agency officials told us they last received sufficient appropriations to fund pay cost increases in 2018, inflation increases in 2018, and population growth increases in 2011.² According to IHS officials, IHS distributes increases for pay costs—increases for federal and tribal employees' compensation—to facilities based on prior year federal obligations (for federally operated facilities) or recurring base funding amounts established by tribal contracts and compacts (for tribally operated facilities). IHS officials told us that they distribute

¹IHS may also receive appropriations for the Indian Health Care Improvement Fund, which was established to, among other things, eliminate resource deficiencies among federally operated and tribally operated IHS facilities. When provided with such appropriations, the agency allocates funds to facilities it identifies as having the highest need and lowest levels of funding based on its analysis of the size and health status of a facility's user population and the amount of resources—including annual appropriations and third-party collections—available to each facility. The formula IHS uses in its analyses was last updated in 2018 through tribal consultation. Since 2010, the Indian Health Care Improvement Fund has received appropriations in fiscal years 2012, 2018, 2019, and 2020.

²According to IHS officials, the increase that IHS would have used for a population growth adjustment in 2011 was subsequently offset by a rescission. IHS requested but did not receive increases to fund population growth adjustments for fiscal years 2012, 2016, and 2017 and 2020.

inflation increases proportionately across the agency according to the base funding of an area. For example, if an area office comprises 9 percent of the total base budget, they receive 9 percent of the inflation increase. IHS officials said that they allocate population growth increases proportionately based on birth and death data published by the National Center for Health Statistics. All adjustments for pay costs, inflation, and population growth carry forward and become part of the facilities' base funding for the following year.

3. Program increases reflect additional funds appropriated for new or existing programs. For example, in fiscal year 2019, IHS allocated \$10 million of the increase it received to aid its response to the opioid crisis. According to IHS officials, the agency has rarely received program increases without requesting them for specific purposes. IHS allocates program increases as directed by Congress, if specified, according to the allocation method specified in the President's annual budget request, if specified, or through a tribal consultation process. According to IHS officials, the agency engages in a tribal consultation process to obtain the input of tribes on an allocation method for such increases either prior to or after funds have been appropriated. In future years, program increases may become part of a facility's base funding.

According to IHS officials, the agency's use of the base funding approach to allocate its services appropriation was established by the agency after tribal consultation in the 1990s.³ This approach—which results in facilities being allocated the same amount of funding as they were allocated for the prior year, unless the agency receives an increase or decrease in its appropriations—does not take into account current or projected patient demographics and health care needs, or facilities' other sources of revenue. As a result, annual appropriations allocated to individual

³For more information about the methods determined to establish tribal shares and the base funding allocation, see Joint Allocation Methodology Workgroup, *IHS/Tribal Joint Allocation Methodology Workgroup on IHS Headquarters Tribal Shares Distribution* (Rockville, Md.: January 26, 1995); and Indian Health Service, *Special General Memorandum 95-02* (Rockville, Md.: April 19, 1995). See also GAO, *Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program*, [GAO-12-446](#) (Washington, D.C.: June 15, 2012), 12–13 and Congressional Research Service, *Advance Appropriations for the Indian Health Service: Issues and Options for Congress*, R46265 (Washington, D.C.: March 11, 2020). The allocation methods for the Indian Health Care Improvement Fund and the Purchased/Referred Care program have been reviewed more recently.

facilities vary little from year to year.⁴ IHS officials said this approach is intended to provide a level of predictable funding for all facilities and maintain existing levels of patient care services in all areas. Funds made available through appropriations acts must be obligated during the period of availability for which they were appropriated. Once these appropriations are apportioned to IHS, headquarters allocates funds to the area offices, which in turn allocate them to individual facilities in their area.

The remainder of IHS's annual appropriations—including those for facilities, contract support costs, and the Special Diabetes Program for Indians—are allocated through other methods.

- **Facilities.** IHS primarily uses prioritized lists and formulas developed through tribal consultation to allocate annual appropriations to support federally operated and tribally operated facilities, such as construction and maintenance, equipment purchases, and sanitation projects. For example, by statute, facilities' construction funds are allocated based on an IHS-wide list of priorities for constructing new facilities, which dates back to 1993.⁵ The total estimated cost of the projects on the list exceeds annual appropriations, which has led to a backlog. When funds become available, IHS allocates them to the appropriate area office to carry out the construction. IHS allocates funds for routine maintenance to facilities using a formula based on square footage, facility usage, and other costs.⁶ Funds for the purchase of equipment

⁴IHS is also prohibited from reducing funds to any tribally operated IHS facility except in certain circumstances, such as a congressional directive, a decrease in appropriations, or a reduction agreed to by a tribe. Absent such circumstances, the Indian Self-Determination and Education Assistance Act prohibits IHS from reducing the amount of funding provided to tribally operated facilities. 25 U.S.C. §§ 5325 (relating to self-determination contracts) and 5388 (relating to self-governance contracts).

⁵IHS established a new priority system to comply with the Indian Health Care Improvement Act, Pub. L. No. 94-437, tit. III, § 301, 90 Stat. 1400 (1976). Once IHS has completed the 1993 list, the agency will begin implementing the new priority system. As of July 15, 2020, 10 projects remained, according to IHS officials.

⁶Indian Health Service, *Technical Handbook for Environmental Health and Engineering, Volume VI – Facilities Engineering, Part 70 – Administration and Management* (Rockville, Md.: Feb. 21, 2007).

are allocated using a formula that incorporates data on clinical workload and facility size.⁷

- Contract support costs. This funding supports certain costs tribes must incur for managing their compact or contract—agreements tribes sign with IHS to administer health care services as authorized by the Indian Self-Determination and Education Assistance Act.⁸ Costs may fall into one of three categories: (1) the indirect costs a tribe incurs for common services that benefit more than one program and are reasonable and necessary, such as financial management and accounting; (2) direct costs, which are reasonable costs that a tribe must incur to operate a specific health care program; and (3) pre-award and startup costs, which are the one-time reasonable and necessary costs of beginning a contract, including the use of consultants to start the program. However, to be eligible for contract support costs funding, a particular cost also must meet other requirements. For example, activities that are otherwise included in the tribe's program funding are not funded as contract support costs.⁹
- Special Diabetes Program for Indians. This funding provides competitive grants for diabetes treatment and prevention services to federally operated facilities, tribally operated facilities, and urban Indian organizations. IHS allocates this funding to each of its 12 areas based on a formula developed through national tribal consultation that incorporates data on each area's user population, tribal sizes, and prevalence of diabetes. To identify grantees, IHS reviews facilities' applications and identifies facilities whose applications have scored above a predetermined threshold. Each area office works with its grantees to agree upon a formula for distributing the area's share of funding to them.

⁷Indian Health Service, *Technical Handbook for Environmental Health and Engineering, Volume III – Health Care Facilities Design and Construction, Part 51-2-Equipment Funding Allocation Methodologies* (Rockville, Md.: Oct. 29, 2015).

⁸Pub. L. No. 93-638, 88 Stat. 2203 (1974), codified, as amended, at 25 U.S.C. §§ 5301-5332, 5381-5399.

⁹Indian Health Service, *Indian Health Manual, Part 6—Services to Tribes and Tribal Organizations, Chapter 3—Contract Support Costs* (Rockville, Md.: Aug. 6, 2019). For more information, see GAO, *Indian Self-Determination Act: Shortfalls in Indian Contract Support Costs Need to Be Addressed*, [GAO/RCED-99-150](#) (Washington, D.C.: June 30, 1999).

Appendix II: Comments from the Department of Health & Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

October 13, 2020

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

Dear Ms. Farb:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*INDIAN HEALTH SERVICE: Actions Needed to Improve Oversight of Federal Facilities' Decision Making About the Use of Funds*" (Job code 103741/ GAO-21-20).

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

Sincerely,

A handwritten signature in black ink, appearing to read "Sarah C. Arbes".

Sarah C. Arbes
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE OVERSIGHT OF FEDERAL FACILITIES' DECISION MAKING ABOUT THE USE OF FUNDS (GAO-21-20)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

Recommendation 1

The Director of IHS should develop a process to ensure that IHS area offices systematically assess how the scope of services provided by federally operated facilities will effectively meet the current and future needs of their patient populations, which could include the incorporation of a current community health needs assessment.

HHS Response

HHS concurs with GAO's recommendation.

In response to GAO's recommendation, to develop a process to ensure that the Indian Health Service (IHS) Area offices systematically assess how the scope of services provided by federal facilities will effectively meet the current and future needs of their patient populations, IHS will:

- Evaluate current administrative structures, processes, and available information to determine best practices in assessing patient population needs;
- Identify key elements for Area offices to include when assessing current and future scope of services; and
- Adapt current administrative processes, such as the Governing Board process, to ensure consistent monitoring and reporting that encompasses Area and federal facilities' needs and resources.

The IHS is committed to strengthening oversight and accountability across IHS's federally operated facilities. IHS has several administration and management processes (i.e. governing boards, Indian Health Manual, updated guidance, etc.) in place to facilitate Area oversight at federally operated facilities. Additionally, several areas also use data (i.e. performance measures, patient statistics, workload, etc.) and other information (i.e. Tribal Consultation, Urban Confer, monitoring of tribal needs, etc.) to inform service availability and delivery at federally operated facilities. Also, oversight of decision making about the use of federal and other funds may happen through the facilities' governing board process.

IHS works closely with Tribes, Urban Indian Organizations, and other partners to address the needs of the communities we serve. Although Governing Board members must be federal employees, due to the inherently federal functions Governing Boards perform, IHS seeks to include Tribal leaders and members in assessing community needs in a variety of ways, including Tribal Consultation and Urban Confer, community stakeholder engagement panels, and when planning, designing, and constructing health care facilities, to name a few.

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE OVERSIGHT OF FEDERAL FACILITIES' DECISION MAKING ABOUT THE USE OF FUNDS (GAO-21-20)

In the specific case of IHS Facilities Account funding decisions, each service unit and/or tribally owned and operated health care facility within an IHS Area is required to submit a Facilities Engineering Program Plan (FEPP) annually to their respective Area facilities office. The purpose of the FEPP is to ensure that IHS facilities are maintained at the highest level possible to ensure the delivery of comprehensive quality health care services. The FEPP is based on a local strategic process which assesses future needs in relation to a planning methodology, past experience, and available funding.¹

As required by the Indian Health Care Improvement Act, the IHS submits to Congress a health care facilities' needs assessment report every five years. The report shows assessed need, which is an estimate of need for planning level use. The report describes the comprehensive, national, ranked list of all health care facilities needs for the Indian health care system.² IHS plans to submit the next report to Congress in 2021.

Recommendation 2

The Director of IHS should develop a process to guide IHS area offices' review of federally operated health care facilities' spending proposals, both before approval and after they are implemented, and ensure this process is followed.

HHS Response

HHS concurs with GAO's recommendation.

In light of GAO's recommendation to develop a process to guide IHS Area Offices' review of federal operated health care facilities' spending proposals, the IHS will:

1. Convene appropriate Area Offices, Service Units, and other stakeholders to identify best practices and seek input,
2. Use this input for building on existing administrative structures to develop and implement an enhanced process that creates increased consistency in reviewing health care facilities' spending proposals before approval, and after implementation, and
3. Ensure regular IHS Headquarters review of Area Office's success in following this process.

The IHS is committed to strengthening program management and operations, as outlined in Goal 3 of the IHS Strategic Plan.³ A core element of this goal is Objective 3.2, securing and effectively managing its assets and resources.

¹ More information is available on the IHS website at: https://www.ihs.gov/sites/oehe/themes/responsive2017/display_objects/documents/handbook/07101.pdf.

² More information is available on the IHS website at: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf

³ IHS Strategic Plan FY 2019-2023, available at: <https://www.ihs.gov/strategicplan/>.

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO IMPROVE OVERSIGHT OF FEDERAL FACILITIES' DECISION MAKING ABOUT THE USE OF FUNDS (GAO-21-20)

As GAO points out, the IHS is only funded at approximately 49% of its level of need.⁴ This means that we must rigorously manage and oversee our limited resources to ensure they best meet the needs of American Indian and Alaska Natives to the maximum extent possible.

To that end, the IHS relies on its Area Offices, Service Units, Governing Boards, and Tribal Consultation and Urban Confer to determine the highest priorities for carrying out direct health care services, and allocate its resources accordingly. It is critical that these funding decisions are made as close to the local level as possible to ensure that the unique needs of each American Indian and Alaska Native community are addressed. It is also imperative that IHS Area Offices, Service Units, and Governing Boards have the flexibility they need to implement processes for reviewing funding decisions that are culturally appropriate for the population they serve.

Corporately, the IHS follows existing government-wide regulations and procedures pertaining to financial management, grants, and acquisitions. These regulations and procedures also allow for review of funding decisions for compliance with statute, regulations, policy, and other measures of appropriateness. In addition, IHS appropriations language and authorizing statutes lay out specific requirements for spending funds that IHS must follow for all funding decisions.

The Area Director and Area level staff are involved in the review and approval of decisions made related to construction projects, changes to services, purchasing of equipment, and other activities related to the operation and maintenance of the Service Unit. The Area Director and Area level staff oversee the federal Service Units at the local level and are central to the decision-making process at the Area and Service Unit levels.

The Area Director is responsible for:

- Overall administrative and financial management of the Area Office and the Area Service Units,
- Overseeing medical facilities, which meet quality of care requirements and Medicare quality standards, and
- Directing and supervising staff in planning, developing, and managing health programs.

Each federal Service Unit has a Governing Board, which is responsible for the care and services provided by each respective Service Unit. Each federal Governing Board has its own bylaws and is chaired by the Area Director, and a majority of the Governing Board members must represent the Area Office.

The Governing Board is responsible and accountable for ensuring the following:

- Compliance with all applicable Federal and State laws,
- Developing, approving, and monitoring of the annual financial spending plan and operating budget,

⁴ IHS table, Indian Health Care Improvement Fund Allocations by Area, available at: https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2018/IHCIF_4B%20Table_Area%20Rollup%20Allocations.pdf.

**Appendix II: Comments from the Department
of Health & Human Services**

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN
SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED: INDIAN HEALTH SERVICE: ACTIONS NEEDED TO
IMPROVE OVERSIGHT OF FEDERAL FACILITIES' DECISION MAKING ABOUT
THE USE OF FUNDS (GAO-21-20)**

- Services are provided in compliance with accreditation standards and according to acceptable standards of practice,
- Medical staff is organized in a manner approved by the Governing Board, and
- Monitoring, evaluating, and taking necessary corrective actions regarding risk management issues within the system.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Kristi Peterson (Assistant Director), Patricia Roy (Analyst-in-Charge), Shaunessye Curry, and Lauren Woodard made key contributions to this report. Also contributing were Jacquelyn Hamilton, Drew Long, and Vikki Porter.

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