



December 2013

INDIAN HEALTH SERVICE

Opportunities May Exist to Improve the Contract Health Services Program

GAO Highlights

Highlights of [GAO-14-57](#), a report to congressional addressees

Why GAO Did This Study

IHS provides health care to American Indians and Alaska Natives. When services are unavailable from IHS, IHS's CHS program may pay for care from external providers. GAO previously reported on challenges regarding the timeliness of CHS payments and the number of American Indians and Alaska Natives who may gain new health care coverage as a result of PPACA. PPACA mandated GAO to review the CHS program. This report examines (1) the length of time it takes external providers to receive payment from IHS after delivering CHS services; (2) the performance measures IHS has established for processing CHS provider payments; (3) the factors that affect the length of time it takes IHS to pay CHS providers; and (4) how new PPACA health care coverage options could affect the program. To conduct this work, GAO analyzed fiscal year 2011 CHS claims data, interviewed IHS officials, including officials in four IHS areas, and reviewed agency documents and statutes.

What GAO Recommends

GAO recommends that IHS revise an agency measure of the timeliness with which purchase orders are issued, use available funds as appropriate to improve the alignment between CHS staffing levels and workloads, and proactively develop potential options to streamline CHS eligibility requirements. The agency concurred with two recommendations, but did not concur with the recommendation to use available funds to improve CHS staffing levels. GAO believes the recommendation is valid as discussed in the report.

View [GAO-14-57](#). For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

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What GAO Found

For Indian Health Service (IHS) contract health services (CHS) delivered in fiscal year 2011, a majority of claims were paid within 6 months of the service delivery date, but some took much longer. Specifically, about 73 percent of claims were paid within 6 months of service delivery, while about 8 percent took more than 1 year. The CHS payment process consists of three main steps: (1) the local CHS program issues a purchase order to the provider authorizing payment (either before service delivery, or after, such as in emergency situations), (2) the provider submits a claim for payment, and (3) IHS pays the provider. GAO found that the first step took the longest—often taking more than 2 months.

IHS uses three measures to assess the time it takes to approve and then process payments to CHS providers. Two of the measures concern the first step in the payment process (purchase order issuance) and the third concerns the final step (making the payment). One of the measures IHS uses to assess the timeliness of the first step is the average time it takes to issue a purchase order after a service has been delivered; IHS's current target for this measure is 74 days. However, the measure does not provide a clear picture of timeliness for this activity as it combines data for two different types of CHS services—those for which payment eligibility was determined prior to service delivery and those for which eligibility was determined after service delivery. IHS officials told GAO that when eligibility is determined prior to service delivery, it may take only one day from the date of service to issue the purchase order. Including this type of service in the calculation, therefore, lowers the overall average.

The complexity of the CHS program affects the timeliness of provider payments. IHS program officials make decisions on what care will be funded on a case-by-case basis, evaluating each case against a number of eligibility requirements involving multiple steps. This process can lead to payment delays. Officials noted that delays also can occur when processing payments and that staffing shortages can affect the timeliness of payments. Some program officials noted that their staffing levels were below standards established by IHS.

New coverage options in the Patient Protection and Affordable Care Act (PPACA) may provide an opportunity to simplify CHS eligibility requirements. PPACA made significant changes to the Medicaid program and included new health care coverage options that may benefit many American Indians and Alaska Natives beginning in 2014. IHS officials reported the agency developed the current CHS program eligibility requirements to manage CHS program funding constraints. In particular, some of the complexities of the program were designed to allow the program to operate within the constrained levels of program funding. With the availability of new coverage options under PPACA, some constraints on CHS program funds could be alleviated, providing IHS an opportunity to streamline service eligibility requirements and expand the range of services it pays for with CHS funds.

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Abbreviations

CHS	contract health services
CHSDA	contract health service delivery area
FI	fiscal intermediary
GPRA	Government Performance Results Act
HHS	Department of Health and Human Services
IHS	Indian Health Service
PPACA	Patient Protection and Affordable Care Act of 2010

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December 11, 2013

Congressional Addressees

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), is charged with providing health care services to the approximately 2.1 million American Indians and Alaska Natives who are members or descendants of federally recognized tribes.¹ These services are provided at federally or tribally operated health care facilities,² which receive IHS funding and are located in 12 federally designated geographic areas overseen by IHS area offices.³ These facilities vary in the services they are able to provide; for example, some facilities offer comprehensive hospital services, while others offer only primary care services. When services are not available at these facilities, the facilities may use IHS's contract health services (CHS) program funds to obtain care for eligible patients from external health care providers, including hospitals and office-based physicians.

At the local level, the CHS program is administered by individual CHS programs generally affiliated with IHS-funded facilities. IHS has oversight authority over local CHS programs that are affiliated with IHS-operated

¹IHS defines an Indian tribe as any Indian tribe, band, nation, group, Pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the programs and services provided by the United States to Indians because of their status as Indians. 42 C.F.R. § 136.21(g)(2012).

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 Secretary of Health and Human Services to take over the administration of IHS programs for Indians previously administered by IHS on their behalf. Self-governance compacts allow tribes to consolidate and assume administration of all programs, services, activities, and competitive grants administered throughout IHS, or portions thereof, that are carried out for the benefit of Indians because of their status as Indians. In contrast, self-determination contracts allow tribes to assume administration of a program, programs, or portions thereof. See 25 U.S.C. §§ 450f(a) (self-determination contracts) and 458aaa-4(b)(1) (self-governance compacts).

³IHS's 12 areas are: Aberdeen, Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson. All areas but Alaska and California include IHS-operated facilities.

facilities.⁴ The local CHS programs determine whether to pay for services from external providers based on requirements that are unique to CHS.

This report is one in a series of reports we have conducted in the last 3 years that have examined the CHS program.⁵ In our previous reports, we identified challenges cited by providers with the CHS program payment process.⁶ We found, for example, that according to providers, sometimes it took months or years to receive payment after providing a service, which added to the burden of both patients and providers.⁷ In addition, we reported on the number of American Indians and Alaska Natives who may gain new health care coverage beginning in 2014⁸ as a result of provisions in the Patient Protection and Affordable Care Act (PPACA) of 2010.⁹

PPACA mandated GAO to examine the administration of the CHS program.¹⁰ This report focuses on the timeliness of CHS payments to providers and how changes in PPACA could affect the CHS program. Specifically, this report examines:

⁴Of the 243 local CHS programs, 66 are affiliated with IHS-operated facilities. The remaining 177 CHS programs are affiliated with tribally operated facilities.

⁵GAO, *Indian Health Service: Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment*, [GAO-13-553](#) (Washington, D.C.: Sept. 5, 2013); *Indian Health Service: Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services*, [GAO-13-272](#) (Washington, D.C.: Apr. 11, 2013); *Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program*, [GAO-12-446](#) (Washington, D.C.: Jun. 15, 2012); and *Indian Health Service: Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need*, [GAO-11-767](#) (Washington, D.C.: Sept. 23, 2011).

⁶[GAO-11-767](#) and [GAO-13-272](#).

⁷[GAO-11-767](#).

⁸[GAO-13-553](#).

⁹Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. For the purposes of this report, references to PPACA include the amendments made by the Health Care and Education Reconciliation Act of 2010.

¹⁰See Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935 (2010) (enacting S. 1790, as reported by the Committee on Indian Affairs in the Senate in December 2009, into law with amendments); S. 1790, 111th Cong. §§ 137, 199 (2009).

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1. the length of time it takes external providers to receive payment from IHS after delivering CHS services;
 2. the performance measures that IHS has established for the amount of time it takes to process CHS provider payments;
 3. the factors that affect the length of time it takes IHS to pay CHS providers; and
 4. how new health care coverage options included in PPACA could affect the CHS program.

To determine the length of time after service delivery that payments are made, we obtained IHS data on paid CHS claims for health care services delivered in fiscal year 2011 that were authorized by IHS-operated CHS programs in 10 areas and that were paid as of February 2013; a total of approximately 398,000 claims.¹¹ Claims data from fiscal year 2011 were the most recent sufficiently complete data available for our analysis. We assessed the reliability of IHS's federal CHS program claims data by reviewing documentation and discussing the data with knowledgeable officials. We also performed data reliability checks, such as examining the data for missing values and obvious errors, to test the internal consistency and reliability of the data. We determined that the data were sufficiently reliable for our purposes.

To examine IHS's performance measures for the amount of time it takes IHS-operated CHS programs to process provider payments, we reviewed relevant statutes, agency documentation, and interviewed officials from IHS headquarters, areas, and CHS programs.

To determine the factors that affect the length of time to pay providers, we interviewed IHS officials in selected areas and CHS programs. We conducted interviews in four areas: Albuquerque, Billings, Navajo, and Oklahoma; and within each of these areas, at three local IHS-operated CHS programs. We selected these 4 areas and 12 programs to reflect a range in the length of time for paying CHS claims based on previous claims data. In our interviews, we asked officials about their procedures for processing CHS referrals and the factors they believed affected the

¹¹We did not obtain data on CHS claims that were authorized by tribally operated facilities, which account for approximately 54 percent of total CHS program payments. This review focused entirely on data and activities of CHS programs affiliated with IHS-operated facilities. These programs are located in 10 of the 12 IHS areas.

length of time to pay providers. In addition, we interviewed IHS's fiscal intermediary, who is responsible for the final processing of payments to providers. We also reviewed relevant statutes and agency regulations and documentation.

To determine the effect that new coverage options available in PPACA might have on the CHS program, we reviewed relevant statutes and our recent report on eligibility among American Indian and Alaska Natives for new coverage options available in PPACA.¹²

We conducted this performance audit from November 2012 to November 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CHS Program Organization

IHS facilities and their associated CHS programs are located in 12 geographic areas, each overseen by an IHS area office led by an Area Director. Ten of the 12 areas include at least some IHS-operated facilities; these 10 areas oversee local CHS programs in 33 states. IHS headquarters sets CHS program policies and oversees the areas. Each IHS area contains multiple local CHS programs. The areas distribute funds to the local CHS programs in their areas, monitor the programs, and establish procedures and provide guidance and technical assistance to the programs.

CHS Program Funding and Service Eligibility Requirements

The CHS program is funded through annual appropriations and must operate within the limits of available appropriated funds.¹³ Based on the regulations that IHS has established for the CHS program, a number of requirements must be met in order for a service to be eligible for CHS

¹²[GAO-13-553](#).

¹³IHS received about \$800 million for the CHS program for fiscal year 2013.

payment.¹⁴ Based on the requirements, before approving a service for payment, local CHS programs must consider the following:

- **Is the patient a member or descendent of a federally recognized tribe or someone with close ties to the tribe?** To be eligible for CHS payment, the service must be for a patient who is a member or descendent of a federally recognized tribe or someone who maintains close economic and social ties with the tribe.
- **Does the patient reside within the Tribal Contract Health Service Delivery Area (CHSDA)?** For a service to be paid for with CHS funds, it must be for a patient who resides in the Tribal CHSDA. Unless otherwise established, the CHSDA encompasses the reservation, the counties that border the reservation, and other specified lands.¹⁵ Exceptions exist for students who are temporarily absent from their CHSDA during full-time study and individuals who are temporarily absent from the CHSDA for less than 180 days due to travel or employment.
- **Are alternate health care resources available to the patient?** Many users of IHS services are also eligible for other sources of payment for care, including Medicaid, Medicare, and private insurance.¹⁶ The CHS program is typically the payer of last resort.¹⁷ Therefore, before a service is approved for CHS payment, the patient must apply for and use all alternate resources that are available and accessible. Services from an IHS facility are also considered a

¹⁴Eligibility requirements for CHS are in addition to meeting the requirements for direct care services.

¹⁵Tribal groups or IHS may submit requests to re-designate a CHSDA. These requests are reviewed by IHS and are subject to public comment.

¹⁶Medicaid is a jointly funded federal-state health care program that covers certain low-income individuals and families. Medicare is the federal government's health care insurance program for individuals aged 65 and older and for individuals with certain disabilities or end-stage renal disease.

¹⁷See 25 U.S.C. §§ 1621e, 1623; 42 C.F.R. § 136.61 (2012). There are certain exemptions to the CHS program's designation as a payer of last resort. For example, certain tribally funded health insurance plans are not considered alternate resources and the CHS program must pay for care before billing the tribally funded insurance plan. The CHS program must also pay for care provided to eligible American Indians and Alaska Natives before the crime victim compensation program, a federal program that provides compensation to victims of criminal violence.

resource, so CHS funds cannot be used for services reasonably accessible and available at IHS facilities.

- **Did the CHS program receive timely notification of services provided from a non-IHS facility?** In non-emergency cases, the local CHS program should be notified and the service approved for payment prior to the patient receiving care. In cases where the patient was not referred for care by an IHS provider, such as with emergency room services, the CHS program must be notified within 72 hours of when the service was delivered. Notification may be made by the individual, provider, hospital, or someone on behalf of the individual in order for the service to be eligible for CHS payment. The notification time is extended to 30 days for the elderly and disabled.
- **Are the services considered medically necessary and listed as one of the established area medical or dental priorities?** To be eligible for payment under the CHS program, the service must be considered medically necessary and listed as one of the established IHS area's medical or dental priorities. A program committee that is part of the local CHS program evaluates the medical necessity of the service, for example, at a weekly meeting. IHS has established four broad medical priority levels of health care services eligible for payment and a fifth for excluded services that cannot be paid for with CHS program funds. Each area is required to establish priorities that are consistent with IHS's medical priority levels and are adapted to the specific needs of the CHS programs in its area. CHS programs that are affiliated with IHS-operated facilities must assign a priority level to services based on the priority system established by their area offices. Funds permitting, these CHS programs first pay for the highest priority services and then for all or some of the lower priority services they fund.¹⁸ Our prior work has found that available CHS program funds have not been sufficient to pay for all eligible services.¹⁹ At some IHS facilities, the amount of CHS funding available was only sufficient to cover cases with the highest medical priority—Priority 1—emergent or acutely urgent care services that are necessary to prevent immediate death or serious impairment of

¹⁸Tribal CHS programs must use medical priorities when making funding decisions but, unlike CHS programs affiliated with IHS-operated facilities, tribal programs may develop systems that differ from the set of priorities established by IHS.

¹⁹GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, [GAO-05-789](#) (Washington, D.C.: Aug. 31, 2005); and [GAO-11-767](#).

health. (See table 1 for a description of the medical priority levels and related services.)

Table 1: IHS Medical Priority Levels for Contract Health Services

Medical priority level	Services included in priority level
Level I	Emergent/acutely urgent care services, such as trauma care, acute/chronic renal replacement therapy, obstetrical delivery and neonatal care.
Level II	Preventive care services, such as preventive ambulatory care, routine prenatal care, and screening mammograms.
Level III	Primary and secondary care services, such as scheduled ambulatory services for nonemergent conditions, elective surgeries, and specialty consultations.
Level IV	Chronic tertiary and extended care services, such as rehabilitation care, skilled nursing facility care, and organ transplants.
Level V	Excluded services, such as cosmetic plastic surgery and experimental procedures that programs may not pay for with CHS program funds.

Source: GAO analysis of IHS documents.

After considering these questions, local CHS programs review each case based on the availability of funding and may defer or deny requests to pay for services when program funds are not available. If the CHS program determines that a service can be funded, it issues a purchase order for the service.

CHS Payment Process

In general, three entities are involved in the CHS payment process: (1) the local CHS program, (2) the provider, and (3) IHS's fiscal intermediary (FI). The timing of the CHS program's and the provider's involvement depends on whether the service was prompted by a referral from an IHS provider prior to the date of service—called IHS referrals, or prompted by the patient seeking care without first obtaining a referral from an IHS provider—these are typically emergency services and called self-referrals.

IHS Referrals

IHS referrals are cases in which an IHS-funded provider refers a patient for care to an external provider. The local CHS program receives the referral and evaluates it against the eligibility requirements. Once the CHS program receives the needed information to make its determination, it will:

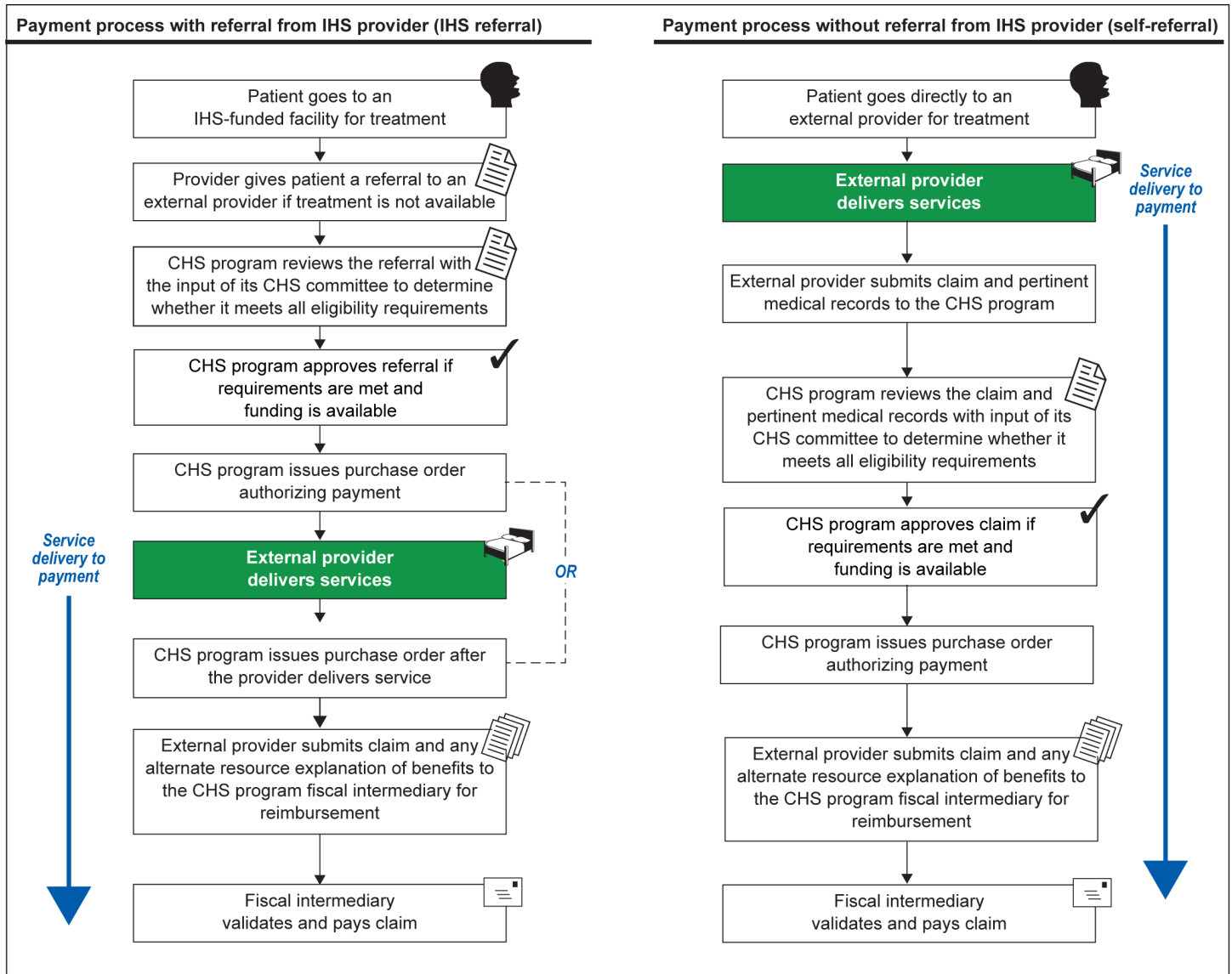
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- approve the service for payment and issue a purchase order to obligate the funds and send copies of the purchase order to the provider and to the FI;
 - defer funding if it meets all the eligibility criteria, but funds are not available; or
 - deny the service.

If the service is approved, the local CHS program typically works with an external provider to set up an appointment for the patient to receive the service and issues the purchase order to the provider—either before the service is provided or shortly after the service is provided. After performing the service, the external provider submits the purchase order along with the claim for payment to the FI. Once the FI receives the claim and purchase order from the external provider, it verifies the purchase order and patient data, evaluates whether alternate resources are available, and, if appropriate, makes the required payment. If there are any issues with the claim, such as missing information from the CHS program or provider, the FI will put the claim in a hold status until the issues are resolved.

Self-referrals

Self-referrals are typically emergency situations where the patient receives services from external providers without first obtaining a referral from an IHS-funded provider. After the services are delivered, the provider seeks approval from the CHS program for payment for the services. With self-referrals, the steps taken by the CHS program to evaluate the referral against the program's eligibility requirements to determine whether the service is eligible for CHS payment do not begin until after the service is provided. In these cases, the local CHS program may have to communicate with the external provider, for example, requesting information about the services provided. Similar to IHS referrals, once the CHS program receives the needed information to make an eligibility determination, it will approve the service for payment and issue a purchase order to obligate the funds; defer funding the service; or deny the service. For approved self-referral services, once the FI receives the claim and purchase order from the external provider, it follows the same procedures for processing the payment as for IHS referrals. (See fig. 1 for an overview of the approval and payment processes for IHS referrals and self-referrals.)

Figure 1: Two Paths for Patient Care to Be Funded by Contract Health Services (CHS) Program



Source: GAO interviews with IHS officials and analysis of IHS documents.

For services that are ultimately paid for under the CHS program, whether they are IHS or self-referrals, the CHS payment process consists of three main steps that encompass the time from the date a service is delivered to the date the provider is paid.

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1. **Local CHS program issues the purchase order.** The time for this step can be measured by the length of time between when a service is provided and when the local CHS program issues the purchase order. (Sometimes the purchase order is issued before the service is provided, such as for some IHS referrals; in these cases this step has no effect on the time it takes to pay the provider.)
 2. **External provider submits a claim to IHS's FI.** The time for this step can be measured by the length of time between when the CHS program issues the purchase order and when the FI receives the claim.
 3. **The FI pays the claim.** The time for this step can be measured by the length of time between when the FI receives a claim from an external provider and when the payment is made.

Health Care Coverage Options in PPACA Affecting American Indians and Alaska Natives

PPACA made significant changes to the Medicaid program and included new health care coverage options that may benefit American Indians and Alaska Natives. In 2014, Medicaid eligibility will expand in states opting to participate, such that all individuals with incomes at or below 138 percent of the federal poverty level will be eligible for the program, including previously ineligible categories of individuals, such as childless adults.²⁰ Also in 2014, health insurance exchanges will be available—health insurance marketplaces in which individuals and small businesses can compare, select, and purchase health coverage from participating carriers.²¹ For individuals obtaining insurance through the exchanges, PPACA provides premium tax credits for those meeting certain income requirements and cost-sharing exemptions for qualifying American

²⁰PPACA established 133 percent of the federal poverty level as the income limit for expanded Medicaid eligibility; however, it also specifies that an individual's income be reduced by an amount equivalent to 5 percent of federal poverty level when determining Medicaid eligibility, which effectively raises the eligibility limit for newly eligible Medicaid recipients to 138 percent of the federal poverty level. See Pub. L. No. 111-148, §§ 2001(a)(1), 2002, 124 Stat., 271, 279; Pub. L. No. 111-152, § 1004(e), 124 Stat. 1036 (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) and 42 U.S.C. § 1396a(e)(14)(B)(I)).

²¹PPACA directed states to establish state-based exchanges by January 1, 2014. In states electing not to establish and operate such an exchange, PPACA requires the federal government to establish and operate such an exchange in the state. Pub. L. No. 111-148 §§ 1311(b)(1), 1321(c), 124 Stat., 173, 186 (codified at 42 U.S.C. §§ 18031(b) and 18041(c)).

Indians and Alaska Natives.²² Finally, in 2015, states may implement the new Basic Health Program option, under which the federal government will give states 95 percent of the premium tax credits and cost-sharing subsidies that would have been provided if the individuals had enrolled in the exchanges, to allow states to provide coverage for individuals with incomes between 138 and 200 percent of the federal poverty level.²³

In previous work, we found that, after these changes are implemented many American Indians and Alaska Natives may gain new health care coverage options. For example, we estimated that more than half of American Indians and Alaska Natives may be eligible either for cost-sharing exemptions and premium tax credits for insurance obtained through the exchanges, or eligible for health care coverage through the new Basic Health Program or Medicaid, including those who are currently eligible for Medicaid but not enrolled, and those who will be newly eligible under 2014 eligibility rules. A significant proportion of American Indians and Alaska Natives reflected in this potential new enrollment live in IHS service areas.²⁴

²²PPACA provides for a federal premium tax credit for eligible individuals obtaining insurance through an exchange with incomes equal to or exceeding 100 and up to 400 percent of the federal poverty level, and who do not have access to public insurance, such as Medicaid. See Pub. L. No. 111-148, §§ 1401, 10105(a) – (c), 10108(h), 124 Stat. 213, 906, 914 ; Pub. L. No. 111-152, §§ 1001, 1004, 124 Stat. 1030, 1034(codified at 26 U.S.C. § 36B); 26 C.F.R. § 1.36B-2(a)(2013). In addition, American Indians and Alaska Natives who obtain insurance through an exchange are eligible for exemptions from cost-sharing, such as deductibles and copays, if they are members of federally recognized tribes and have a household income of not more than 300 percent of the federal poverty level or if the services are provided by Indian Health providers, regardless of the enrollee's income. See Pub. L. No. 111-148, § 1402(d), 124 Stat. 222 (codified at 42 U.S.C. § 18071(d)).

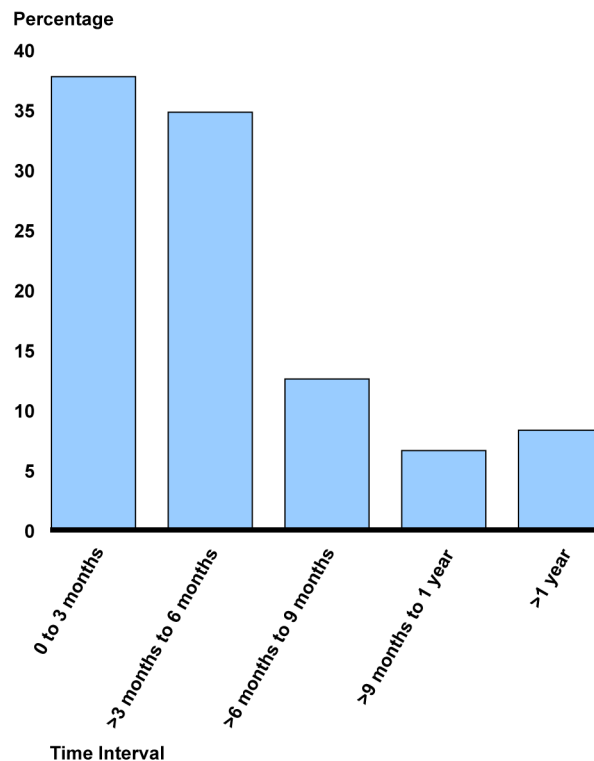
²³Pub. L. No. 111-148, §§ 1331, 10104(o), 124 Stat. 199, 902 (codified at 42 U.S.C. § 18051).

²⁴[GAO-13-553](#).

More than Two-Thirds of CHS Claims Were Paid within 6 Months but Some Took Much Longer to Pay

For CHS services delivered in fiscal year 2011, a majority of providers' claims were paid within 6 months of the service delivery date, but some took much longer. More than one-third (38 percent) of claims processed by IHS-operated CHS programs were paid within 3 months after services were delivered. Another 35 percent were paid between 3 and 6 months of service delivery. The percentage of claims paid more than 6 months after service delivery was much smaller, with 19 percent of claims being paid between 6 months and 1 year after services were delivered, and about 8 percent paid more than 1 year after services were delivered. (See fig. 2.)

Figure 2: Percentage of Contract Health Services (CHS) Claims Paid within Certain Time Intervals, for Services Delivered in Fiscal Year 2011



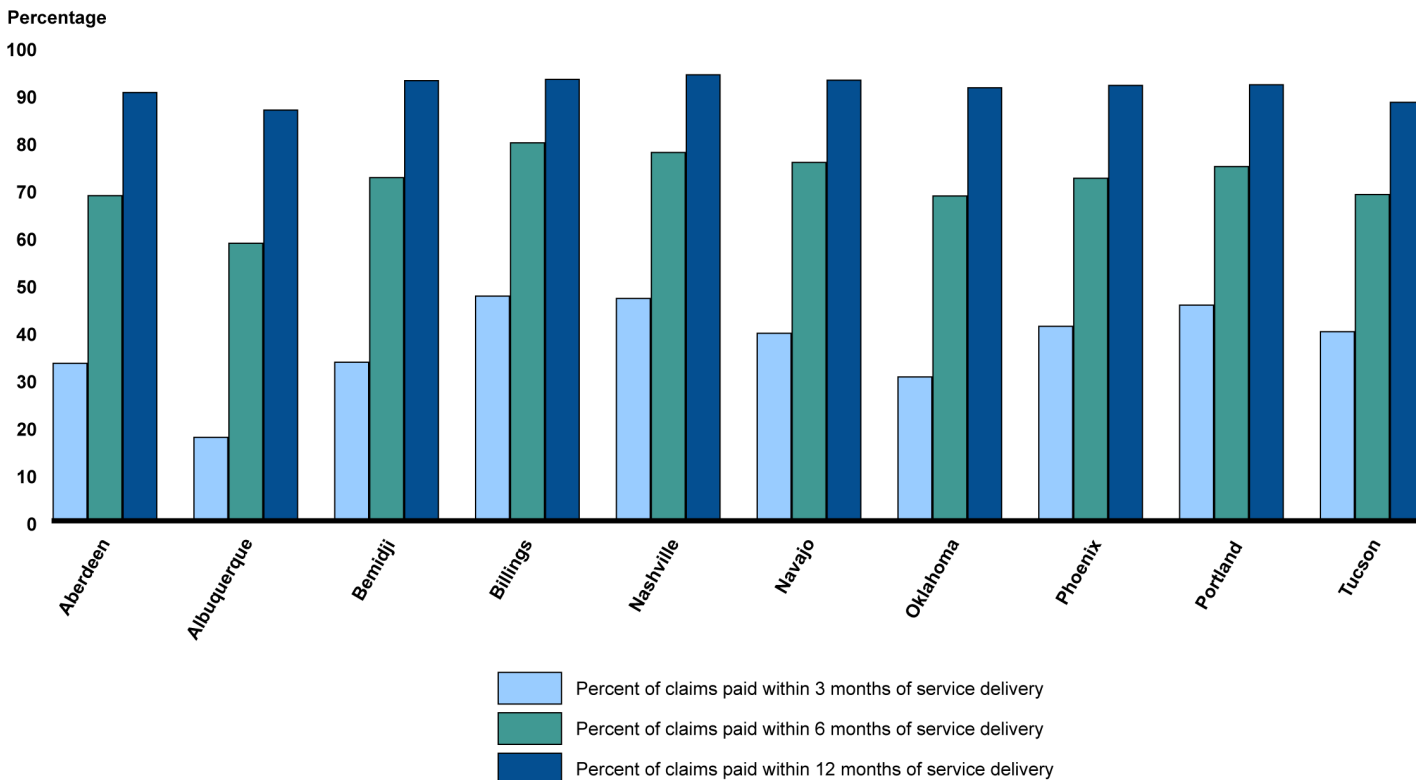
Source: GAO analysis of IHS claims data.

Note: Analysis was limited to claims processed by IHS-operated CHS programs and included all claims for services delivered in fiscal year 2011 that were paid as of February 2013.

The amount of time it took to pay providers was not the same across all IHS areas. The areas varied in the amount of time between the date a service was provided and the date the claim was paid, particularly with

respect to the percentage of claims that were paid within 3 months and within 6 months of service delivery. For example, although more than one-third of claims IHS-wide were paid within 3 months or less of service delivery, across IHS areas this percentage ranged from 18 percent in Albuquerque to 48 percent in Billings. Similarly, the percentage of claims paid within 6 months or less of service delivery ranged from 59 percent to 80 percent, also in Albuquerque and Billings, respectively. There was less variation among IHS areas in the percentage of claims paid within 1 year or less of service delivery, ranging from 87 percent in Albuquerque to 94 percent in Nashville. For 8 of the 10 IHS areas we reviewed, 90 percent or more of their claims were paid within 1 year of service delivery. (See fig. 3.)

Figure 3: Percentage of Contract Health Services (CHS) Claims Paid within 3 Months, 6 Months, and 1 Year of Service Delivery, for Services Delivered in Fiscal Year 2011, by IHS Area

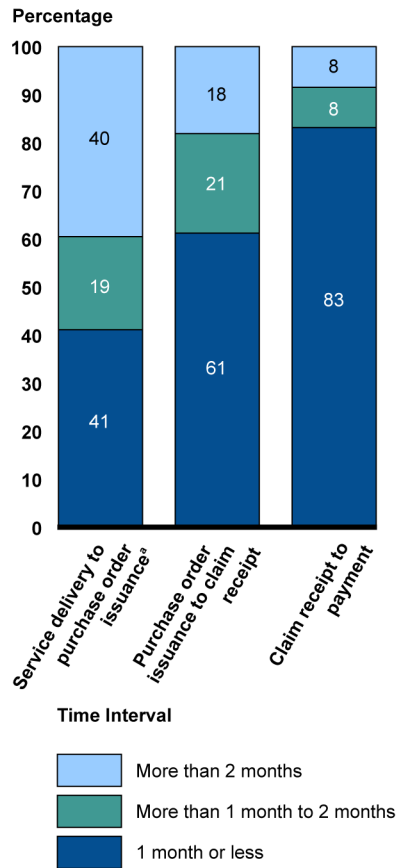


Source: GAO analysis of IHS claims data.

Note: Analysis was limited to claims processed by IHS-operated CHS programs and included all claims for services delivered in fiscal year 2011 that were paid as of February 2013.

Among the three main steps in the payment process, the step that most often took the longest in the payment process was the first step—the time from date of service to the issuance of the purchase order. For services delivered in fiscal year 2011, purchase orders were issued in 1 month or less after services were delivered for 41 percent of claims. For another 40 percent of claims, purchase orders were issued more than 2 months after services were delivered; and in about half of these cases, the purchase order was issued more than 4 months after the service was delivered. In comparison, the second step—the time from the date the purchase order was issued to the date the FI received the claim from the provider—took 1 month or less for 61 percent of the services, and the third step—the time from the date the FI received the claim to the date payment was made—took 1 month or less for 83 percent of the claims. (See fig. 4.)

Figure 4: Percentage of Claims Processed within Certain Time Intervals in Each Step of the Contract Health Services (CHS) Payment Process, for Services Delivered in Fiscal Year 2011



Source: GAO analysis of IHS claims data.

Notes: Analysis was limited to claims processed by IHS-operated CHS programs and included all claims for services delivered in fiscal year 2011 that were paid as of February 2013. Claims associated with purchase orders issued before the date of service were included in the analysis. Percentages may not add to 100 due to rounding.

^aFor claims associated with purchase orders issued before the date of service, the timeframe from service delivery to purchase order was considered to be 1 month or less.

IHS Has Three Timeliness Measures for Processing Provider Payments, but the Two Involving Purchase Order Issuance Do Not Provide a Clear Picture of Timeliness

IHS uses three measures to assess how long it takes to approve and then process payments to CHS providers. Two of these measures concern the first step in the payment process—the time it takes local CHS programs to approve payments to providers and issue purchase orders to them—but neither of these measures provides a clear or complete picture of the timeliness of these activities, which constitute the most time-consuming period within the provider payment process, according to our analyses. IHS also has a timeliness measure for the final step in the provider payment process—the time it takes IHS’s FI to make payment to providers once it receives claims from them.²⁵ Descriptions of the three timeliness measures follow.

Government Performance Results Act (GPRA) measure. The first of two measures that IHS uses to assess the timeliness of the first step in the provider payment process is the average time it takes for IHS to issue a purchase order after a service has been provided. IHS established this measure in fiscal year 2009 in response to GPRA, and has set annual targets for the measure since then. GPRA requires federal agencies to develop performance plans with annual goals and measures. (Hereafter, we refer to this as the GPRA measure.)

For fiscal years 2009 and 2010, IHS set the target for the GPRA measure at 82 days and 78 days, respectively. IHS missed the target by 28 days in 2009 and by 4 days in 2010. IHS kept the target at 78 days in fiscal year 2011, then lowered it to 74 days in 2012 and met these targets in both years. For fiscal year 2013, IHS kept the target at 74 days, and an IHS official said it would remain there for fiscal year 2014. According to IHS officials, the basis for the GPRA measure’s target was a health care industry consultant’s report showing average times that other health insurers, including private insurers and Medicaid, took to pay claims.

Although clear targets have been established for the GPRA measure, the way the measure is calculated does not result in a clear picture of whether the goal of the measure is being achieved. In our previous work, we found that successful performance metrics should demonstrate the

²⁵IHS does not have a performance measure for the second step of the payment process—the time between the date the purchase order is issued and the date IHS’s FI receives the claim from the provider seeking payment. IHS has little involvement in this step of the payment process. During this period, the provider submits the claim to the FI; IHS has not established a deadline for the provider to do this.

degree to which desired results are achieved.²⁶ According to IHS, the goal of the GPRA measure is to decrease the average number of days from the provision of services to purchase order issuance. However, the GPRA measure does not provide a clear picture of the timeliness of purchase order issuance because it combines self-referrals with some IHS referrals when calculating the average time it takes for IHS to issue a purchase order, even though the timing of when purchase orders are issued relative to service delivery can be very different for the two referral types. The GPRA measure calculates the average time it takes to issue purchase orders for services for which the purchase order was issued after the service was provided. This includes all self-referrals, where none of the work to determine whether the service is eligible for CHS payment can be started before the service is delivered because IHS does not know about it until after the service has been delivered. However, it also includes some IHS referrals—referrals for which all of the work to determine whether the service is eligible for CHS payment generally is completed before the service is delivered. Some local CHS programs said they wait to issue purchase orders for IHS referrals until shortly after they confirm that the services were actually delivered. Officials from one local CHS program told us that for these referrals, it may take only one day from the date of service to issue the purchase order. Including these IHS referrals in the calculation of the GPRA measure gives an unclear picture of performance because the inclusion of IHS referrals lowers the overall GPRA average. IHS officials agreed that the calculation of the GPRA measure mixes IHS referrals with self-referrals, and CHS officials at one area office said the measure would be more useful if IHS and self-referrals were analyzed separately. However, IHS officials told us that because the agency's claims data system does not include a data field that tracks referral type, it does not have a way to separate the two different types of referrals that would allow the agency to systematically determine the average time it takes to issue purchase orders by referral type.

IHS officials expressed varying opinions about the utility and quality of the GPRA measure. Some officials noted that before the measure was established, there was no timeliness performance measure for the CHS

²⁶GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act*, [GAO/GGD-96-118](#), (Washington D.C.: June 1996); and *Agencies' Strategic Plans Under GPRA: Key Questions to Facilitate Congressional Review*, [GAO/GGD-10.1.16](#) (Washington D.C.: May 1997).

program. These officials told us that the measure has helped to identify local CHS programs that have implemented practices that help improve timeliness of payments. But officials also criticized the GPRA measure, noting that many of the factors that help to determine whether an area or local CHS program meets the target are not within the area's or the program's control, such as how quickly a program receives information from providers.

The time it takes to make a decision about a claim. The other measure that IHS uses to assess the timeliness of the first step in the provider payment process is how long it takes from the time IHS is notified of a claim to when the agency makes a decision about it. Under a statutory provision, IHS must approve or deny the claim within 5 days of receiving "notification" of a provider's claim for a service or accept the claim as valid.²⁷ (Hereafter, we refer to this provision as the 5-day rule.) According to IHS officials, the agency has interpreted the rule's clock as beginning once a claim is "clean," or "completed," meaning that all information necessary to determine whether the claim should be approved, deferred, or denied has been obtained. IHS officials told us, however, that it is in obtaining this information—including medical records to determine medical priority and the availability of alternate resources—that delays most typically occur. Thus, the 5-day rule's clock does not begin until after completion of the part of the process in which IHS officials believe delays most typically occur. Although IHS officials said the agency's interpretation of the 5-day rule currently is not included in any official written guidance, they said the agency plans to include an explanation of its interpretation of the rule in revisions to the CHS chapter of the Indian Health Manual, which officials said is expected to be completed by early 2014.

The time it takes the FI to pay the claim. The third measure that IHS uses to assess the timeliness of the payment process focuses on the last step in the process—the length of time that the FI should take to process payments to providers once it receives claims from them. IHS's contract with its FI specifies that at least 97 percent of clean claims are to be paid within 30 days of receiving the claim from the provider. Similar to the 5-day rule, the FI defines clean claims as those containing all required information, including the purchase order; passing all IHS and FI agreed-

²⁷See 25 U.S.C. § 1621s.

upon internal checks; and not requiring additional investigation by the FI. The FI issues monthly reports to IHS documenting its compliance with this provision. According to these reports, this target was met every month from January 2012 through July 2013.²⁸

Complexity of the CHS Program, CHS Staffing and Funding Availability, and Variations in Program Practices Can Affect the Timeliness of Payments to Providers

The complex processes for determining whether a service is eligible for CHS funding can affect the timeliness of provider payments and result in delays. Even after a local CHS program determines that a service is eligible for CHS funding, complexities in the payment process managed by IHS's FI can result in delays. In addition, CHS officials reported that staffing shortages and limited funding contribute to delays in processing payments to providers. Local CHS programs also reported varying practices for assessing eligibility and approving CHS funding, which may contribute to variations in timeliness for provider payments.

Complex Processes for Determining Whether a Service Is Eligible for CHS Funding Can Affect the Timeliness of Provider Payments

IHS's process for determining whether services are eligible for CHS program funds is complex and different from processes used by other payers, which can affect the timeliness of provider payments. Unlike other payers that offer a defined set of benefits—including Medicare, Medicaid, and private insurers—the CHS program makes decisions about what care will be funded on a case-by-case basis, so that each time a referral for care is received by a local CHS program, it is evaluated against a number of eligibility requirements as well as against available funding. Evaluating a service against each of the service eligibility requirements involves multiple steps, some of which depend on the CHS program receiving information from providers, patients, and others, and delays can occur during the evaluation of some of these eligibility requirements, according to CHS officials. In some cases, making these eligibility determinations can be fairly involved, and can ultimately affect the amount of time it takes for a provider to receive payment after the service is delivered. The

²⁸Our analysis showed that 83 percent of claims were paid by the FI within 1 month of receiving the provider's claim. This difference between our analysis and the FI reports may be explained by the fact that our analysis included claims that were at one time not clean.

effects of this process on payment times is greater for self-referrals—situations in which the service was provided before it was approved for payment—because the entire process for determining whether the service was eligible for CHS payment does not begin until after the service was delivered. According to IHS officials, the agency developed the CHS program eligibility regulations in order to carefully manage and stretch limited CHS funding to provide the most critical services to the most patients.

Two aspects of the process for determining eligibility for CHS program funding were frequently reported as resulting in payment delays: (1) determining whether a service meets the area’s medical priorities and (2) identifying all available alternate resources. Officials from 8 of 12 local CHS programs we interviewed reported payment delays related to determining whether a service met the area’s medical priorities, and officials from 8 of 12 local CHS programs reported payment delays related to identifying all available alternate resources.

Determining medical priority can result in delays because local CHS programs must obtain from the provider medical records with sufficient detail to assess whether a service is medically necessary and falls within the established medical priorities. Officials reported that, while in some cases the necessary records have been provided relatively quickly (e.g., within a week) in other cases it has taken much longer. For example, some local CHS programs reported situations when it has taken weeks or months to obtain necessary medical documentation, and one program reported situations when it has taken as long as 1 to 2 years to receive this documentation. Program officials noted different reasons for these delays. For example, officials reported situations where providers have sent documentation to the wrong CHS program when the providers were unaware in which CHSDAs the patients resided. Another reason cited by local CHS program officials for delays in receipt of medical documentation included situations in which incomplete documentation was provided and the program needed to follow up with the provider.

Officials reported a number of situations in which determining whether the patient has alternate resources to pay for the service, has resulted in delays. For example, some local CHS program officials told us that when they believe a patient is eligible for alternate resources—such as Medicaid—they have the patient apply for those resources, and will hold off on approving a service for CHS funding until the determination is made on the application. Officials from one local CHS program said that Medicaid determinations in their state can sometimes take months. In

another example, officials from one local CHS program stated that for situations involving car accidents or a fall on private property, determining liability can take a long time, and availability of alternate resources cannot be determined until decisions on liability have been determined. In another example, officials from one CHS program said delays can occur when patients do not inform the CHS program of the alternate resources available to them, necessitating the CHS program doing the research itself.

Program officials also reported some delays related to the other three aspects of the process for determining eligibility for CHS payment. For example, officials from one CHS program said determining whether a patient is a member of a federally recognized tribe can result in a delay if they have never seen the patient before, and must obtain documentation of that patient's tribal affiliation. Similarly, officials from one CHS program said determining whether a patient resides in its CHSDA can result in a delay when the program needs to wait on documentation from patients confirming their addresses. Finally, one local CHS program reported that determining whether the program has been notified within required timeframes can result in a delay when an incorrect decision is made to deny the service, which is later overturned.

The complexity of determining whether services delivered to American Indians and Alaska Natives are eligible for CHS funding can also result in misunderstandings in which providers think payments have been delayed, when in fact the services provided were not eligible for payment. For example, IHS officials told us that sometimes patients do not understand CHS rules and seek emergency care from external providers, expecting the CHS program to cover it, when they are in fact not eligible for CHS. The officials also said that providers will send claims to the CHS program, assuming the patient and service are eligible, and expect to be paid. IHS does not issue eligibility cards to beneficiaries that would indicate to external providers their eligibility for CHS services or information about which local CHS program is responsible for payment. In a previous GAO review of the CHS program, several providers noted that, in the absence of a process they can use prior to providing service to determine patient eligibility for the CHS program, they submit claims for payment to the CHS program for all patients who self-identify as American Indian or Alaska Native or as eligible for the CHS program.²⁹ IHS officials said that

²⁹[GAO-11-767](#).

they believe situations such as these—in which the provider will never be paid because the patient or service was not eligible, as opposed to situations in which the service is eligible but the payment process is prolonged—accounted for the majority of provider complaints about the timeliness of CHS payments.

Local CHS program officials noted that providers' lack of understanding of the complex CHS approval process was due in part to provider staff turnover or was exacerbated when the provider's billing functions were located out of state, which could result in delays in providing information needed to determine eligibility. These officials noted that education of provider staff was an ongoing necessity for CHS programs. Some IHS officials also noted that providing such training took staff time away from processing referrals. Officials from a number of CHS programs noted that they meet regularly with some of their high-volume providers to reconcile specific outstanding cases, and that over time these meetings have helped improve providers' understanding of the unique rules and procedures of the CHS program. However, officials also mentioned that turnover among provider staff often necessitated starting the process of educating providers again.

Complexities Associated with the CHS Processes for Paying Providers Also Can Affect Timeliness

Even after a service has been approved for CHS funding and a purchase order has been issued, delays can occur because of complexities in the last step in the payment process, which is managed by IHS's FI. Officials said this can occur because the providers do not understand the CHS process used by the FI. For example, officials said some providers do not understand that after receiving a purchase order, they also need to submit the claim to the FI to be paid.

Officials from local CHS programs and from the FI also reported examples where delays occurred because claims submitted by providers to the FI could not be matched to a corresponding purchase order in the FI's system. According to FI officials, it will issue only one payment for each purchase order. However, some purchase orders are intended to cover multiple services, such as for a series of physical therapy treatments. FI officials reported that providers sometimes submit claims for services that pertain to only a portion of the services authorized on the purchase order. In these cases, the FI pays for those services and closes out the purchase order. When providers submit subsequent claims related to other services that were authorized on the original purchase order, the FI is unable to pay the provider because the purchase order was closed. The provider then must go back to the CHS program to

request a new purchase order and payment to the provider is delayed until the new purchase order is issued and submitted to the FI.

In addition to delays in payments to providers from issues matching claims and purchase orders, claims may be put on hold by the FI for other payment processing issues. One of the most common causes for claims being put on hold by the FI is when alternate resources have been confirmed, but the FI is waiting for information from the provider showing the amount paid by the other resources and the remaining amount that the provider is claiming from IHS.

CHS Staffing and Funding Availability Also Can Affect Timeliness of Payments to Providers

Local CHS program officials said insufficient CHS program staffing levels have affected their ability to issue timely purchase orders. IHS's staffing standards model established a staffing ratio based on the annual number of purchase orders authorized for health care services by a facility.³⁰ Some CHS program officials noted that their number of staff was below these standards. Further, local CHS program officials in programs that had a very small number of CHS staff (e.g., two or three) said that a vacancy or extended leave for even one staff person could affect the timeliness of issuing purchase orders—and one of these programs reported that related delays could be significant. Furthermore, IHS officials noted that, pursuant to agency practice, CHS funding has been used only to pay for services and not to increase staffing levels. As a result, recent increases in CHS funds have resulted in increased workloads, but staffing levels to manage the workloads have not increased. Staffing levels can affect the timeliness of payment for services, particularly for self-referrals where the entire process for determining eligibility for CHS payment does not begin until after the service is provided.

Officials from a few CHS programs also noted that funding issues could result in delays issuing a purchase order authorizing CHS funding, which would delay payments. In our prior work, some providers told us that delays in receiving payment from CHS of several months, or in some cases years, tended to occur when the CHS program's funding for the

³⁰According to the model, each facility that issues 50 or more purchase orders should have a CHS Manager staff and one CHS staff position for every 700 purchase orders issued annually. Plus, the facility should have a data entry clerk if the CHS program uses the automated system for referrals.

fiscal year had been depleted.³¹ Again, as with other issues we have noted, funding shortages affect the amount of time it takes to pay providers for self-referrals more than IHS referrals because the self-referral service is already provided before the program determines if funds are available while for an IHS referral, the service can be postponed until funds become available.

Local CHS Program Practices for Implementing CHS Eligibility Regulations Vary, which May Contribute to Variations in Timeliness for Aspects of the Provider Payment Process

We found variation in local CHS program practices for implementing CHS eligibility rules, which may contribute to the variation in timeliness of the provider payment process across IHS areas. IHS officials said they allow flexibility in local CHS program practices because each has a different set of circumstances to consider. These circumstances include challenges regarding CHS funding levels among areas, state Medicaid program procedures for verifying eligibility, providers' familiarity with the CHS program, and the number of staff available to determine CHS eligibility for services.

During our interviews, IHS area and local CHS program officials reported differences in practices that could contribute to variation in the amount of time overall it takes to pay providers. Examples of these differences include:

Consideration of alternate resources. Local CHS programs varied in the actions they took while they were determining the extent of patients' alternate resources. One practice IHS area office officials said some local CHS program staff used, in certain circumstances, was to issue purchase orders to providers before patients' alternate resources were confirmed. In these cases, if the FI paid the claim before alternate resources were confirmed, the FI would seek to recover from the provider any overpayments for services covered by these alternate resources.

In contrast, some IHS area and local CHS program officials told us they do not issue purchase orders authorizing CHS payment for services until the availability of all possible alternate resources has been determined. Officials in one IHS area noted that they do this to preserve their limited CHS funds and provide access to care to

³¹[GAO-11-767](#).

as many patients as possible. Officials in this area reported that they were not able to fund all Priority 1 cases and that issuing purchase orders and obligating CHS funds before alternate resources were confirmed could cause them to exhaust their CHS funds even earlier.

Requests for information from providers. Officials from some local CHS programs reported that they set time limits for providers to submit medical documents and deny CHS funding if providers do not submit the documents within that time. These limits ranged from a week to 45 days, and some of these programs automatically issued a denial if the medical documentation was not provided either at the same time the program was notified that services had been provided or by the specified time limit. CHS officials said these denials could be reconsidered if sufficient medical documentation were subsequently provided. In contrast, officials from another CHS program reported that it does not have established time limits within which providers must submit medical documentation.

Determination of medical priority. One practice that certain local CHS program officials reported was to make all decisions about the medical priority of requested services at their program's weekly medical committee meeting. In contrast, another reported practice was to have almost all medical priority determinations made by a clinician as soon as all necessary information is received. (Those determinations are subsequently reviewed by the committee.) A combination of both of these practices was also reported by another CHS program we spoke to, in which decisions on less complex cases were made by a clinician as soon as all necessary information was received, while determinations for more complicated cases waited until the next weekly medical committee meeting,

New Coverage Options in PPACA May Provide IHS an Opportunity to Simplify CHS Eligibility Rules

New health care coverage options available to many IHS beneficiaries as a result of provisions in PPACA could provide IHS with an opportunity to simplify the complex eligibility rules of the CHS program. IHS has stated that its overall service goal is to elevate the health status of American Indians and Alaska Natives to the highest possible level. However, as we and others have reported, limits on available resources have affected the services available to American Indians and Alaska Natives through the CHS program. For example, although funding for the CHS program significantly increased in recent years, IHS has reported that at current funding levels, most programs are approving only medically emergent referrals (Priority 1) and less urgent, routine or preventive care is deferred or denied pending additional appropriations. According to IHS, limits on available funding for the CHS program have caused the agency to establish its complex requirements for determining eligibility for CHS funds—including reliance on a medical priority rating system and limiting eligibility to individuals who reside in CHSDAs. These mechanisms are intended to enhance IHS's ability to stretch limited CHS dollars and extend services to more American Indians and Alaska Natives. As we previously reported, however, many American Indians and Alaska Natives may gain new health care coverage beginning in 2014 as a result of PPACA, which could alleviate some constraints on CHS program funds.³²

If a better match is achieved between available funding and overall CHS program demand, IHS could have the opportunity to streamline eligibility requirements for the CHS program and to expand the services it pays for with CHS funds, assuming appropriation levels for the CHS program are maintained. Because the CHS program is generally the payer of last resort, if more American Indians and Alaska Natives gain new coverage, services that would have previously been paid for by the CHS program will be paid for by other payers. In addition, because some American Indians and Alaska Natives will have access to benefits packages through these other coverage options—benefits packages that may be more comprehensive than the IHS benefits available to them now—more may choose to obtain care outside of the IHS system entirely. This could help free up some CHS program funds, potentially creating a better match between available funding and overall program demand.

³²[GAO-13-553](#).

Some uncertainty remains, however, about the extent to which American Indians and Alaska Natives will obtain new health care coverage when PPACA is fully implemented. For example, not all states may choose to expand their Medicaid programs. In addition, we have reported previously on the challenges American Indians and Alaska Natives may face enrolling in Medicaid and other public insurance programs.³³ Some barriers are unique to the American Indian and Alaska Native population—such as individuals believing they should not have to apply for other public insurance programs because the federal government has a duty to provide them with health care as a result of treaties with Indian tribes. In our prior work, we recommended that IHS increase its direct outreach to American Indians and Alaska Natives who may be eligible for new coverage options to help ensure significant new enrollment in these options.³⁴

Conclusions

The current CHS program's eligibility requirements reflect the method that IHS has chosen to stretch its funding to ensure that the most critical health services can be provided to the maximum number of beneficiaries. However, determining eligibility for CHS funding—including the need to ascertain each time a referral is received whether the patient met residency requirements and the service met medical priorities—is inherently complex. As currently structured, it is highly unlikely that the CHS program will be as quick a payer as some other payers because of the cumbersome steps involved in determining eligibility for each service.

PPACA will expand existing sources of health coverage and create new ones for American Indians and Alaska Natives, and this could affect the CHS program in a number of ways. In particular, if these changes significantly reduce the demand placed on CHS program funds, IHS may have the opportunity to not only pay for a greater range of services but also restructure the CHS program to include less stringent eligibility requirements. For example, increased availability of CHS funding due to increased access among American Indians and Alaska Natives to other sources of health care coverage options under PPACA could give IHS the opportunity to establish a set of defined benefits for IHS beneficiaries,

³³See GAO, *Medicare and Medicaid: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes*, [GAO-08-724](#) (Washington, D.C.: Jul. 11, 2008).

³⁴[GAO-13-533](#).

which would alleviate the need for CHS programs and providers to carry out time-consuming medical priority determinations. The opportunity also may arise for IHS to make other changes, such as issuing a form of eligibility card to CHS-eligible patients to help providers understand when to send claims to IHS, and to which local CHS program a claim should be sent, helping improve the timeliness of provider payments.

In the interim, while the changes from PPACA are taking effect, IHS has the opportunity to continue to make improvements to the CHS program, including how it assesses the timeliness of provider payments and how it aligns CHS program staffing levels with workloads, and to proactively consider ways to streamline CHS eligibility requirements.

Recommendations for Executive Action

In an effort to ensure that IHS has meaningful information on the timeliness with which it issues purchase orders authorizing payment under the CHS program and to improve the timeliness of payments to providers, we recommend that the Secretary of HHS direct the Director of IHS to:

- modify IHS's claims data system to separately track IHS referrals and self-referrals, revise the GPRA measure for the CHS program so that it distinguishes between these two types of referrals, and establish separate timeframe targets for these referral types; and
- improve the alignment between CHS staffing levels and workloads by revising its current practices, where appropriate, to allow available funds to be used to pay for CHS program staff.

In addition, as HHS and IHS monitor the effect that new coverage options available to IHS beneficiaries through PPACA have on CHS program funds, we recommend that the Secretary of HHS direct the Director of IHS to proactively develop potential options to streamline program eligibility requirements.

Agency Comments and Our Evaluation

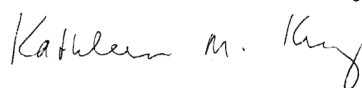
We provided a draft of this report to HHS for review and received written comments, which are reprinted in appendix I. In its comments, HHS concurred with two of our recommendations and did not concur with one recommendation.

HHS concurred with our recommendation that IHS modify its claims data system to separately track IHS referrals and self-referrals, revise the GPRA measure for the CHS program so that it distinguishes between these two types of referrals, and establish separate timeframe targets for these referral types. HHS also concurred with our recommendation that as HHS and IHS monitor the effect that new coverage options available to IHS beneficiaries through PPACA have on CHS program funds, IHS proactively develop potential options to streamline program eligibility requirements. HHS agreed with the premise that Medicaid eligibility expansion and private insurance for more American Indians and Alaska Natives will reduce the demand for CHS services and noted that IHS will monitor the effects of new coverage on program funds and develop options to improve and streamline the CHS program processes.

HHS did not concur with our recommendation that IHS improve the alignment between CHS staffing levels and workloads by revising its current practices, where appropriate, to allow available funds to be used to pay for CHS program staff. In its response, HHS stated its intent to continue to only use CHS appropriations to purchase health care services and not to fund program staff, noting that available CHS program funds have not been sufficient to pay for all services and that at some facilities, funding was only sufficient to cover cases with the highest medical priority. We acknowledge the difficult challenges and choices faced by CHS programs when program funds are not sufficient to pay for all needed services. However, IHS has noted the importance of the agency maintaining an adequate workforce and has established staffing standards for the CHS program. As we reported, some IHS officials noted that their number of staff was below the staffing ratio established in IHS's staffing standards model, and local CHS program officials told us that insufficient CHS program staffing levels have affected their ability to issue timely purchase orders. Further, recent increases in CHS funding for services have resulted in increased workloads, while staffing levels to manage the workloads have not increased. For these reasons, we continue to believe that IHS should improve the alignment between CHS staffing levels and workloads, making use of all available funding, including CHS program funds, when appropriate, to do so.

We are sending copies of this report to the Secretary of Health and Human Services, the Director of the Indian Health Service, appropriate congressional committees, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of the report. GAO staff who made major contributions to this report are listed in appendix II.



Kathleen M. King
Director, Health Care

List of Addressees

The Honorable Maria Cantwell
Chairwoman
The Honorable John Barrasso
Vice Chairman
Committee on Indian Affairs
United States Senate

The Honorable Peter DeFazio
Ranking Member
Committee on Natural Resources
House of Representatives

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

The Honorable Tim Johnson
United States Senate

The Honorable Lisa Murkowski
United States Senate

The Honorable John Thune
United States Senate

Appendix I: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

NOV 22 2013

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

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Indian Health Service: Opportunities May Exist to Improve the Contract Health Services Program" (GAO-14-57).

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

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "INDIAN HEALTH SERVICE: OPPORTUNITIES MAY EXIST TO IMPROVE THE CONTRACT HEALTH SERVICES PROGRAM" (GAO-14-57)

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

Recommendation 1:

Modify IHS's claims data system to separately track IHS referrals and self-referrals, revise the GPRA measure for the CHS program so that it distinguishes between these two types of referrals, and establish separate timeframe targets for these referral types.

HHS Response:

HHS concurs. IHS's referral data system will be modified to separately track IHS referrals and self-referrals, revise the GPRA measure for the CHS program so that it distinguishes between these two types of referrals and establish separate timeframe targets for these referral types.

Recommendation 2:

Improve the alignment between CHS staffing levels and workloads by revising its current practices, where appropriate, to allow available funds to be used to pay for CHS program staff.

HHS Response:

We do not concur. As documented in this report, prior GAO work has found that available CHS program funds have not been sufficient to pay for all eligible services. At some facilities, the amount of CHS funding available was only sufficient to cover cases with the highest medical priority – Priority 1 – emergent or acutely urgent care services that are necessary to prevent immediate death or serious impairment of health. CHS appropriations will continue to be used to purchase needed health care services for American Indian/Alaska Native (AI/AN) patients and not for CHS program staff.

Recommendation 3:

As HHS and IHS monitor the effect that new coverage options available to IHS beneficiaries through PPACA have on CHS program funds, we recommend that the Secretary of HHS direct the Director of IHS to proactively develop potential options to streamline program eligibility requirements.

HHS Response:

We concur with the GAO premise that Medicaid eligibility expansion and private insurance for more AI/ANs will reduce aggregate CHS demand. CHS restrictions currently apply CHS funds to a sub-set of AI/ANs and for a sub-set of health conditions. Since members of Federally recognized Tribes can be exempt from the shared responsibility and the requirement to be insured and 21 states are not expanding their Medicaid coverage, IHS will proactively monitor the effects of new coverage to IHS beneficiaries through ACA on CHS program funds and develop options to improve and streamline CHS program processes.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact name above, Gerardine Brennan, Assistant Director; George Bogart; Julianne Flowers; Natalie Herzog; Linda McIver; Laurie Pachter; and Michael Rose made key contributions to this report.

Related GAO Products

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

Indian Health Service: Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services. [GAO-13-272](#). Washington, D.C.: April 11, 2013.

Medicaid Expansion: States' Implementation of the Patient Protection and Affordable Care Act. [GAO-12-821](#). Washington, D.C.: August 1, 2012.

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.

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

Indian Health Service: Updated Policies and Procedures and Increased Oversight Needed for Billings and Collections from Private Insurers. [GAO-10-42R](#). Washington, D.C.: October 22, 2009.

Medicare and Medicaid: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes. [GAO-08-724](#). Washington, D.C.: July 11, 2008.

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

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