

**Memorandum**

Date JAN 21 1999
From June Gibbs Brown *June G Brown*
Inspector General
Subject Review of the Indian Health Service's Contract Health Services Program
(CIN: A-15-97-50001)
To Michael H. Trujillo, M.D., M.P.H., M.S.
Director
Indian Health Service

The attached final report provides you with the results of our review of the Indian Health Service's Contract Health Services (CHS) Program, with a particular focus on the agency's reimbursement of inpatient care.

In written comments dated December 1, 1998, IHS officials fully concurred with our findings and recommendations and outlined an action plan to implement the recommendations. We appreciate the cooperation extended to us throughout the review by IHS officials responsible for the CHS Program.

We would appreciate your views and the status of actions taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact Joseph J. Green, Assistant Inspector General for Public Health Service Audits, at (301) 443-3582.

To facilitate identification, please refer to Common Identification Number A-15-97-50001 in all correspondence related to this report.

EXECUTIVE SUMMARY

BACKGROUND

The Indian Health Service (IHS) provides or funds comprehensive health services for American Indians and Alaska Natives (AI/ANs). When IHS cannot provide needed health care in its own facilities, its Contract Health Services (CHS) program coordinates and pays for care provided by private providers. All IHS services are provided using discretionary appropriated funding, which recently, has not kept pace with inflation. While other Federal purchasers of health care have legislation requiring private hospitals to offer services at favorable Medicare rates, IHS does not have this legislative advantage. Therefore, IHS uses voluntary procurement activities to negotiate purchase agreements with willing hospitals, many of which still do not offer Medicare rates.

OBJECTIVE

The objective of our review was to determine the amount of savings IHS would realize by obtaining legislation requiring inpatient CHS providers to accept reimbursement rates not to exceed the Medicare rates, as payment in full for inpatient CHS services.

SUMMARY OF FINDINGS

As a Federal purchaser of inpatient health care from the private sector, IHS should be receiving rates commensurate with other Federal agencies who engage in similar purchases. However, we determined that IHS paid an aggregate of \$4.8 million more than the Medicare rates for services provided in Fiscal Year (FY) 1995—an amount that included \$8.2 million of payments to hospitals over Medicare rates, which is reduced by \$3.4 million for certain instances where IHS actually paid hospitals less than Medicare rates. The IHS is paying too much because there is no law requiring providers to offer Medicare or lower rates, and the agency has not been fully successful in its efforts to obtain favorable rates through contracts and other procurement mechanisms. If IHS were to have legislation requiring the favorable Medicare rates, the funds saved could be applied to the backlog of patient services that cannot be accommodated in the CHS program.

RECOMMENDATIONS

We recommend that the Director of IHS:

1. Update IHS' FY 1999 legislative proposal, "IHS Contract Care," to incorporate the potential savings presented in this report. We believe the savings stated in this report represent the most current and accurate estimations.
2. Forward the updated CHS legislative proposal to the Department of Health and Human Services (HHS) for appropriate dissemination to parties involved in the legislative decision making process.
3. Identify elements to be included in the required implementing regulations, and begin to formulate IHS' implementing materials.
4. Continue to pursue the most favorable rates at hospitals that have previously offered less than Medicare rates, and strategically identify and pursue other opportunities where lower rates may be negotiated.

In its December 1, 1998 written comments on our September 22, 1998 draft report, IHS fully concurred with our recommendations. The IHS confirmed that implementing the recommendations will result in its ability to purchase additional health services. Further, IHS stated that the proposed legislative changes will also benefit tribal and urban CHS programs, which were not in the scope of our review.

We have summarized IHS' comments regarding the implementation of our recommendations in the report section entitled, "IHS Comments and OIG Response." In addition, IHS provided technical comments, which we have incorporated where appropriate. The IHS general comments are included in the appendix.

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INTRODUCTION

BACKGROUND

A Vital Part of the IHS' Health Care Delivery System is its Contract Health Services Program

The IHS has the responsibility to provide comprehensive health services to more than 1.4 million AI/ANs in order to achieve its mission to elevate their health status to the highest possible level. To meet its mission, IHS delivers needed health care services to eligible AI/ANs. Health care is provided in two ways. First, "direct care" services are provided in service units operated by IHS or by tribes through self-determination agreements.¹ Direct care facilities include hospitals, health centers, and school health centers, which are located on or near Indian reservations and in urban settings. Second, because IHS cannot provide all of the medical services needed by AI/ANs, it operates the CHS program to obtain necessary services from the private sector.

The CHS Program, established in the Code of Federal Regulations, Title 42, Section 36.21-36.25, funds a wide range of health care including primary care provider services, laboratory, dental, radiology, transportation, and pharmacy services in inpatient, ambulatory, and emergency care settings. The regulations permit CHS funds to be expended for the following circumstances: (1) no readily accessible direct care facility of the type needed exists; or (2) the IHS or tribal direct care facility does not support a required emergency and/or speciality care for the patient.

All IHS programs must operate within available discretionary appropriated funding, which recently has not kept pace with inflation. For example, over the 10-year period, FY 1987 to FY 1996, IHS' budget increased 121 percent; however, when inflation² is taken into account, the increase is only 24 percent. According to IHS, these budgetary constraints result in its programs being funded at only 60 to 70 percent of the level of need, and some programs are well below these levels. With its recent reorganization, IHS is responding to its fiscal challenges and changing health care practices. For example, by streamlining operations and focusing on supporting local, tribal, and urban health programs, IHS is trying to maintain essential health services as its overall funding has diminished in real purchasing power.

¹ Congress passed the Indian Self-Determination and Education Assistance Act to provide tribes the option of assuming from IHS the administration and operation of health services and programs in their communities.

² These statistics are from IHS' "1996 Trends in Indian Health," and are based on constant 1995 dollars using consumer price index for medical care, 1986-95, and the 1996 budget inflation factor, 5.3 percent.

The CHS program is greatly affected by this loss of purchasing power because its costs are not controlled by IHS, but are determined by the private sector health care market. While the CHS program³ currently spends more than a third of a billion dollars for private sector health care, its level of need is not fully funded. This is very apparent in the operation of the CHS program, as it has had to implement a medical priority system to ensure funding is available throughout the year for urgent or emergent care; consequently lower priority care must be denied or deferred. This limitation on the delivery of health care exists even though during the last 10 years, the CHS program almost doubled in its appropriated funding—increasing from obligations of \$201 million in 1988 to an appropriation of over \$373 million in FY 1998.

In 1998, CHS accounted for 25 percent of IHS' clinical services budget and 18 percent of the total IHS budget. The CHS program uses the services of approximately 9,000 providers nationwide, including over 1,000 hospitals providing inpatient care to IHS beneficiaries. As reported by the program's fiscal intermediary (FI), in FY 1995, over 15,000 inpatient hospital care admissions were coordinated by CHS, amounting to billed charges of \$163 million. Using negotiated contracts, IHS reduced the billed charges to the "IHS Allowed" amount of about \$108 million; and after alternate resources, such as private health insurance, were applied, IHS paid just over \$68 million.

How IHS is Charged and Pays for CHS

The IHS attempts to negotiate contracts or rate quotations according to its payment policy, "Reimbursement Rates for Health Care Services Authorized Under the Indian Health Service Contract Health Service Regulations" (51 Federal Register 23540, dated June 30, 1986). Under the policy, IHS seeks ". . . to purchase health services for Indian beneficiaries only with those hospitals, physicians, and other health care providers which agree to accept, as payment in full, reimbursement at rates no higher than the prevailing Medicare allowable rates" However, as some of IHS' user population live in remote, rural areas, and because of the nature of care provided through the CHS program (often specialty or emergency services), IHS cannot always select providers based solely on cost considerations.

³ The budget figures presented for the CHS program include funding provided to tribes through self-determination agreements. In FY 1995, over one-third of the CHS budget was distributed to tribes to administer and operate their own contract health care programs.

Through contracting support personnel in most of IHS' 12 administrative Area Offices, the CHS program uses the following procurement mechanisms to obtain hospital and other health services:

- ✓ conventional procurement contracts;
- ✓ rate quotation methodology agreements; and
- ✓ open market rates (IHS pays full billed charges).

Contracts and rate quotations for CHS inpatient care are usually stated in terms of: (1) a percentage (lower) of billed charges; (2) a percentage (higher, lower, or equal) of Medicare rates; (3) a per diem rate; or (4) the lower of Medicare or billed charges. Medicare "allowed" charges are developed by HHS Health Care Financing Administration (HCFA) for hospitals based on a prospective payment system using a Federal standardized payment amount⁴ adjusted by the Diagnosis Related Group (DRG) weight assigned to the discharge for a particular hospital stay.

To pay most providers, the CHS program contracts with Blue Cross and Blue Shield of New Mexico, Inc. (BCBSNM) for FI services, including: (1) operating a nationwide, centralized medical and dental claims processing and reimbursement system that entails determining appropriateness of payments based on established rates; (2) preparing and issuing payments and explanations of payments; and (3) coordinating alternate resources. Beyond the actual payment process, the FI provides comparative pricing information on hospitals to assist IHS in its patient placement decisions and procurement negotiation preparations.

**IHS Fiscal Year 1999 Legislative Proposal:
"IHS Contract Care"**

In September 1997, IHS forwarded its second version⁵ of a legislative proposal regarding reimbursement of private sector hospital services using Medicare rates through HHS to the Office of Management and Budget for consideration in the FY 1999 legislative cycle. The proposal outlines an amendment to Social Security Act Section 1866(a)(1) that would impose as a condition of participation in the Medicare program a requirement for hospitals to agree to accept rates no higher than the prevailing Medicare rates, as payment in full for treatment of CHS inpatient beneficiaries. Cognizant IHS officials have stated that the agency will negotiate waivers with hospitals demonstrating economic hardships related to implementation of the

⁴ The HCFA Federal standardized payment amount for hospitals is based on the geographical location of the hospital (large, urban, or other) plus a wage index.

⁵ The proposal IHS forwarded for the FY 1995 legislative cycle was not accepted by HHS because it was not limited to hospital inpatient care.

Medicare rates for IHS beneficiaries. The IHS amendment would be similar to amendments secured in 1987 by the Department of Defense's (DOD) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Department of Veterans Affairs (DVA). To date, Congress has not acted on this legislative proposal.

OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of our review was to determine the amount of savings IHS would realize by obtaining legislation requiring inpatient CHS providers to accept rates not to exceed the Medicare rates, as payment in full for inpatient CHS services.

SCOPE

Using information obtained from BCBSNM, we analyzed actual aggregate expenditure data for hospital inpatient care coordinated through CHS during FY 1995. Hospital inpatient care consists of routine and ancillary hospital charges, excluding physician fees. Our analysis included all claims from inpatient providers paid \$100,000 or more by IHS.⁶ This criteria resulted in the inclusion of 118 inpatient providers (hospitals) from a universe of 548, or 21 percent. While the analysis captured a small percentage of IHS' provider universe, these providers represented a significant percentage of IHS' inpatient activity in terms of the number of claims and dollar expenditures. Specifically, our analysis captured 14,613 of the 17,857 claims paid for the year, or 82 percent. These claims accounted for 85 percent of IHS payments (\$57,707,904 of \$68,233,150) to inpatient facilities for the period.

Our comparison of historical IHS costs to recalculated claims using the Medicare methodology did not require us to acquire an understanding of the internal controls used in the CHS medical claims process. However, because the majority of information used in our analysis was generated from the claims information processed by BCBSNM, we reviewed an internal control evaluation of its claims processing operations. An independent public accounting firm's August 1997 assessment of the FI's claims processing operation found no material weaknesses in its operations, including its reimbursement methodologies. The accounting firm's findings, coupled with the defined scope of its internal control review, provided reasonable assurance that the data processed and developed by the FI for this review are reliable.

⁶ Our analysis did not include review of CHS expenditures by self-determination tribes because we limited our review to payments for inpatient care made by BCBSNM, which at the time was not serving the self-determining tribes.

METHODOLOGY

To accomplish our objective, we:

- ◆ Reviewed applicable laws, regulations, implementing guidelines, and previous reviews of the CHS program.
- ◆ Held discussions with CHS officials, including contacts with FI representatives, to gain an understanding of the operation of the program and to request and interpret the comparative pricing analysis.
- ◆ Requested the FI to extract FY 1995⁷ claim payments from its claims history files. These actual IHS claims were electronically recalculated using the Medicare and CHAMPUS reimbursement methodologies and rates for FY 1995. The results of these calculations were summarized and provided to us in detailed schedules identifying the totals for each of the 118 hospitals meeting our utilization criteria.⁸
- ◆ Reviewed an independent public accounting firm's August 1997 assessment of the FI's claims processing operation. The accounting firm found no material weaknesses in the FI's claims processing operations, including its reimbursement methodologies. The accounting firm's findings, coupled with the defined scope of its internal control review, provided reasonable assurance that the data processed and developed by the FI for this review are reliable.
- ◆ Performed computer analysis of the FY 1995 CHS hospital utilization data provided by the FI. Specifically, we compared and sorted the hospital data by dollar and percentage variance from Medicare. Furthermore, we distinguished hospitals who charged IHS more than Medicare from those who charged less.
- ◆ Obtained information on the procurement agreements used for each hospital in our analysis to determine whether certain mechanisms are favorable to others.

⁷ At the time of our request for information in April 1997, the FY 1995 claims data were the most complete of prior year data. The claims recalculation process required the FI to obtain CHAMPUS' claims processing software from its proprietary owner, delaying the final production of the comparative results until December 1997.

⁸ We requested comparative data for the CHAMPUS program because IHS' user population demographics more closely resembles it than Medicare. However, the comparative analysis showed that because CHAMPUS deviates from the Medicare methodology for certain providers, its methodology was not favorable to IHS. Therefore, we concentrated further analysis on the Medicare comparison.

In addition, we surveyed area office personnel involved in eight⁹ highly successful procurements to identify "best practices" that can be used in future negotiations. We also surveyed area office personnel knowledgeable about procurements at rates higher than the Medicare to determine hospital management's receptiveness to voluntary procurement arrangements.

- ◆ In coordination with IHS officials and the FI, identified the amount of additional inpatient, outpatient, and physician services, based on FY 1995 cost and utilization data, that could be funded with savings from reduced costs.
- ◆ Discussed IHS' proposal with HCFA officials, who supported an approach parallel to that used by DOD and DVA.
- ◆ Conferred with our legal counsel on various legal and regulatory issues involved in the review.
- ◆ Analyzed DOD CHAMPUS and DVA regulations to identify the various implementation strategies used by these agencies to determine their applicability for IHS.
- ◆ Received comments on a draft of this report from IHS officials, and have incorporated their views on the findings and conclusions, and actions planned in response to the recommendations.

We conducted our audit in accordance with generally accepted government auditing standards. Our audit was conducted at IHS headquarters in Rockville, Maryland, during the period January 1997 through July 1998.

⁹ We received responses concerning five of eight hospital procurements.

RESULTS OF REVIEW

As a Federal purchaser of inpatient health care from the private sector, IHS should be receiving rates commensurate with other Federal agencies who engage in similar purchases. However, we determined that IHS paid an aggregate of \$4.8 million more than the Medicare rates for services provided in FY 1995—an amount that included \$8.2 million of payments to hospitals over Medicare rates, which is reduced by \$3.4 million for certain instances where IHS actually paid hospitals less than Medicare rates. The IHS is paying too much because there is no law requiring providers to offer Medicare or lower rates, and the agency has not been fully successful in its efforts to obtain favorable rates through contracts and other procurement mechanisms. If IHS were to have legislation requiring the favorable Medicare rates, the funds saved could be applied to the backlog of patient services that cannot be accommodated in the CHS program.

CRITERIA: OTHER FEDERAL HEALTH CARE PROGRAMS PAY LOWER RATES THAN IHS FOR HOSPITAL INPATIENT CARE

The Federal Government operates several programs that purchase health care services from private sector providers. The largest of these programs is the Medicare program, which is estimated to purchase about 20 percent of all the health care provided in the United States. Other Federal health care programs, including DOD's CHAMPUS program and DVA, have successfully allied themselves to the Medicare program's purchasing power through amendments to Medicare's legislation (Social Security Act Section 1866(a)(1)) and agency-specific implementing regulations requiring hospitals to accept rates based on the Medicare methodology, as payment in full for services provided to their beneficiaries.

CONDITION: IHS PAYS TOO MUCH FOR INPATIENT CHS

In FY 1995, using the CHS "voluntary" payment policy, which does not have the force of law or regulation, IHS paid millions more to inpatient providers than it would have if Medicare was the required rate. For the 118 hospitals used most by IHS' CHS program, the agency paid a net of \$4.8 million more than the Medicare rate. Our more detailed analysis revealed even greater potential for savings if IHS' favorable procurement arrangements are continued. Specifically, if IHS had continued its rates for hospitals paying less than Medicare (totaling \$3.4 million in savings beyond Medicare), and paid Medicare rates for those that had charged more than Medicare, the agency could have saved \$8.2 million. We discuss these savings below.

**Applying the Medicare Rate to all
118 Hospitals Reviewed Showed IHS
Paid \$4.8 Million More Than Medicare Rates**

The IHS paid \$4.8 million higher than the Medicare rate at the 118 hospitals used most by CHS during FY 1995. As the following table illustrates, this figure represents the aggregate of IHS allowed charges compared to Medicare allowed charges for the same inpatient services. This analysis is predicated on the assumption that all of the providers, regardless of previous procurement arrangements with IHS, were reimbursed at the Medicare rate.

IHS Allowed Compared to Medicare Allowed for the Same Inpatient Services Provided At 118 Hospitals IHS Paid over \$100,000 in FY 1995	
IHS Allowed:	\$90,839,250
Medicare Allowed:	<u>\$86,071,082</u>
The IHS is Charged <i>More Than</i> Medicare Allowed	<u>\$ 4,768,168</u>

**Separating the Hospitals in Terms of Those
Paying Higher or Lower Than Medicare
Reveals an Even Greater Potential for Savings**

Because the \$4.8 million figure cited above nullifies favorable rates that IHS already had in some cases, we wanted to determine the total amount that IHS paid above the Medicare rate. To do this, we separated the 67 hospitals that charged more than Medicare from the 51 hospitals that charged less than Medicare. The following tables, containing data on the 118 hospitals used most by IHS CHS in 1995 for inpatient care, show that IHS paid \$8.2 million more than Medicare at 67 hospitals while paying \$3.4 million lower than Medicare rates at 51 hospitals. This analysis points out that the need for proposed legislation to require Medicare or better rates so that IHS can continue to enjoy the benefits of its previous successful procurement arrangements. By looking at the data in this manner, we determined that the savings potential is greater than the savings that would be realized by just comparing the IHS allowed to the Medicare allowed. This is because we are acknowledging that in some cases IHS is already receiving better-than-Medicare rates.

Hospitals Charging IHS Higher Than Medicare Rates (for Hospitals Where IHS Paid over \$100,000 in FY 1995)		
Percentage Higher Than Medicare	Number of Hospitals	Amount IHS Allowed is Higher Than Medicare Allowed
0% - 10%	27	\$402,784
11% - 40%	25	\$4,650,958
41% - 67%	15	\$3,096,471
Total	67	\$8,150,213

Hospitals Charging IHS Lower Than Medicare Rates (for Hospitals Where IHS Paid over \$100,000 In FY 1995)		
Percentage Lower Than Medicare	Number of Hospitals	Amount IHS Allowed is Less Than Medicare Allowed
(0%) - (10%)	43	(\$433,966)
(11%) - (31%)	5	(\$1,900,717)
(32%) - (50%)	3	(\$1,047,363)
Total	51	(\$3,382,046)

CAUSE: IHS DOES NOT HAVE LEGISLATION REQUIRING MEDICARE RATES AND ITS VOLUNTARY REQUESTS FOR MEDICARE RATES HAVE MET WITH MIXED RESULTS

Because IHS is not recognized in the Medicare rate legislation, as are other Governmental agencies funding private hospital care, it must negotiate its own rates with individual hospitals throughout the United States. As discussed below, IHS' voluntary procurement efforts have produced mixed results: some hospitals have not entered into any procurement agreement; some hospitals have agreements, but not necessarily at Medicare rates; and some hospitals have agreements with IHS to accept rates even lower than Medicare.

IHS Lacks Legislation Requiring Medicare Rates

The IHS is not obtaining the favorable Medicare rates that are available to other Federal agencies, such as DOD's CHAMPUS program and DVA, because it is not included in legislation requiring hospitals to accept these rates for inpatient services. Acknowledging this disparity, IHS has proposed legislation for FY 1999 that would require hospitals, as a condition of participation in the Medicare program, to accept Medicare rates, as determined by IHS in implementing regulations, as payment in full. The IHS has not yet started to outline or develop the implementing regulations needed for this proposal. The proposal also applies to tribal-operated contract health service programs under the Indian Self-Determination Act, Public Law 93-638.¹⁰

IHS' Voluntary Request for Medicare Rates has Met with Mixed Results

Despite IHS' request for Medicare rates, the agency actually paid more than those rates to a majority (57 percent) of hospitals in FY 1995. For 43 percent of the hospitals, however, the agency successfully negotiated rates at or below Medicare rates.

IHS does not have Procurement Arrangements with Many Hospitals

Across the nation, IHS' CHS program has tried to solicit bids for Medicare or better rates at hospitals where it sends patients; however, many hospitals do not respond to the request for proposals or rate quotation solicitations due to the voluntary nature of the IHS policy. As a result, IHS did not have any procurement arrangements with 27, or 23 percent, of the hospitals used most in FY 1995. Without such arrangements, the agency paid open market rates that were higher than Medicare at all but two of those hospitals, amounting to \$4 million in "overpayments," when compared to Medicare.

IHS Procurement Arrangements do not Necessarily Guarantee Medicare Rates

Of the 91 hospitals where IHS had procurement arrangements, we identified 42 where such arrangements did not yield Medicare rates, and in fact, resulted in \$4.2 million in "overpayments." This data suggested that the mere existence of a voluntary negotiated

¹⁰ According to CHS officials, tribal self-determination programs that can take advantage of the legislation by acquiring the ability to participate at Medicare rates will likely realize substantial savings. Currently, these individual tribes have very little leverage with providers, in terms of purchasing volume, to negotiate competitive rates. The additional savings that can be realized by individual tribes will increase the overall savings for IHS' entire CHS program.

procurement arrangement does not guarantee rates comparable to Medicare. Further, we noted that 3 of the 10 highest dollar volume hospitals in our analysis were reimbursed 11, 17, and 33 percent higher than the Medicare rate. We determined that if these three hospitals alone had accepted Medicare rates, IHS could have reduced its allowed costs by \$1.5 million.

IHS had Successful Negotiations at Some Hospitals

In 49 of the 118 hospitals used most by IHS' CHS in FY 1995, the agency successfully negotiated rates below Medicare, and in two instances, open market rates were lower than Medicare. The CHS procurements at these 51 hospitals resulted in \$3.4 million in "savings" as compared to the Medicare rates.

To understand how CHS procurements at these hospitals voluntarily obtained such favorable rates, we surveyed the IHS contracting officers responsible for the 8 most favorable contracts (i.e., those with contracts between 11 and 50 percent lower than Medicare). Based on responses received regarding five of the eight hospitals, we identified the following factors as contributing to successful IHS contracting: knowing in advance the utilization and costs data associated with target hospitals; obtaining Medicare information on the hospitals from the FI; combining purchasing power among areas to increase potential patient volumes; and conducting face-to-face meetings with hospital personnel to build and maintain ongoing positive business relationships. We concluded that successful negotiations required substantial IHS preparation and ongoing effort. We further noted that these eight hospitals were not the most high-volume providers, indicating that favorable rates are not necessarily dictated by dollar volumes.

EFFECT: REDUCING IHS' HOSPITAL INPATIENT COSTS WILL ENABLE IHS TO PROVIDE MORE HEALTH CARE SERVICES

According to CHS officials, savings that are realized through lower hospital costs would be used to provide more health care services to eligible Indians. Cognizant officials emphasized that IHS will use realized savings to reduce the number of needed CHS services that are deferred every year because they do not meet the program's funded priority level. Based on FY 1995 utilization and cost data, the FI estimated that more than 40,000 additional health care services, depending on the case mix—including hospital inpatient days, outpatient encounters, and physician services—could have been funded with the savings presented in this report.

**IHS Will Reinvest Cost Savings
into the CHS Program's Increasing
Number of Services that It Cannot Fund**

According to the Acting Director of IHS' Division of Managed Care, IHS will reinvest the savings it realizes with the reduced costs of the new legislation back into its CHS program. This will allow IHS to close the gap on the number of services that it currently cannot support. Because the CHS program operates with an appropriated budget, and demand for services outpaces funding, it could not provide over 90,000 recommended or requested services that did not meet an established level of medical priority in FY 1995. The IHS uses a medical priority system to ensure that funds are available first for emergent or urgent care throughout the year. Requested services not meeting the emergent or urgent criteria are frequently deferred or denied. In some locations, CHS officials reported that, on occasion, medical care in the highest priority level must be denied or deferred, due to a shortage of CHS funds.

**Over 40,000 Additional Health Service
Encounters Could have been Funded
in FY 1995 with \$8.2 Million Savings**

Based on the range of savings presented in our report, we determined that at the high end of our savings range, over a total of 40,000 additional inpatient days and health service encounters¹¹ could have been funded in FY 1995. This embraces every aspect of care funded by CHS, including inpatient hospital days, outpatient encounters, and physician or professional encounters.

This analysis was based on the unit cost of inpatient days, outpatient encounters, and physician encounters, using the percentage of actual dollar value utilization for each type of care paid by the FI for FY 1995. Using these parameters, the FI calculated the number of additional services that could have been funded using the savings range presented in this report.

The following table illustrates the number of services that could have been funded with our upper and lower savings estimates,¹² based on costs reported for these CHS services in FY 1995.

¹¹ An encounter is a measure of health care utilization for outpatient facility and physician services. A single encounter is the combination of all claim line items with the same provider, same dates of service, and same type of services for a given patient.

¹² The upper savings estimate of \$8.2 million for FY 1995, is based on IHS maintaining existing favorable rates, and realizing additional savings at hospitals that were charging higher than Medicare rates. The lower savings estimate of \$4.8 million is based on the aggregate savings potential if all 118 hospitals charged the Medicare rate.

Illustrative Effect of Potential Cost Savings: Number of Additional Services that Could have been Provided in FY 1995 (Based on Percentages of the Actual Dollar Value Utilization of Each Type of Care)				
Range of Potential Savings If IHS Used Medicare Rates In FY 1995	Number of Additional Services by Type of Care			
	Inpatient Days¹³	Outpatient Encounters	Physician/Professional Encounters	Total
\$4.8 Million	1,972	6,740	16,319	25,031
\$8.2 Million	3,370	11,521	27,893	42,784

CONCLUSIONS AND RECOMMENDATIONS

In an era of continually constrained budgets and increasing health care needs for a growing Indian population, IHS could benefit substantially if inpatient providers accepted reimbursement at a rate not to exceed the Medicare rate. Using Medicare rates, we estimated a minimum of \$4.8 million and the potential for up to \$8.2 million in cost savings for one year, which IHS could apply to seriously needed health care services. In the past, IHS has attempted with limited success to obtain Medicare rates from its CHS providers. We believe a law, similar to that provided to the DOD and DVA, would result in at least the minimum cost savings presented in this report.

We recommend that the Director of IHS:

1. Update the FY 1999 legislative proposal, "IHS Contract Care," to incorporate the savings presented in this report. We believe the savings stated in this report represent the most current and accurate estimations.
2. Forward the updated CHS legislative proposal to HHS for appropriate dissemination to parties involved in the legislative decision making process.
3. Identify elements to be included in the required implementing regulations, and begin to formulate IHS' implementing materials.

¹³ Inpatient services are a category of treatment based on the Diagnosis Related Group value calculated for the hospital admission.

4. Continue to pursue the most favorable rates at hospitals that have previously offered less than Medicare rates, and strategically identify and pursue other opportunities where lower rates may be negotiated. Specifically, IHS should actively pursue the highest volume providers for contract negotiations, and use comparative cost and utilization data the FI makes available to strengthen its negotiating position. This can be done by each area office or a special negotiating work group can be established.

IHS COMMENTS AND OIG RESPONSE

In its December 1, 1998 written comments on our September 22, 1998 draft report, IHS fully concurred with our recommendations. In its general comments, IHS confirmed that implementation of the recommendations will result in its ability to purchase additional health services.

Further, IHS stated that the proposed legislative changes will also benefit tribal and urban CHS programs, which were not included in the scope of our review, but constitute a growing portion of the CHS operation. Consequently, IHS was eager to point out that the savings described above pertain only to the portion of CHS authorized and coordinated by IHS. The proposed legislative changes will extend to tribally operated CHS activities, which will have the potential for proportional savings, depending on their inpatient care case mix.

The IHS general comments are included in the appendix. We have incorporated IHS' technical comments, where appropriate.



DEC 1 1998

Indian Health Service
Rockville MD 20857

TO: Inspector General

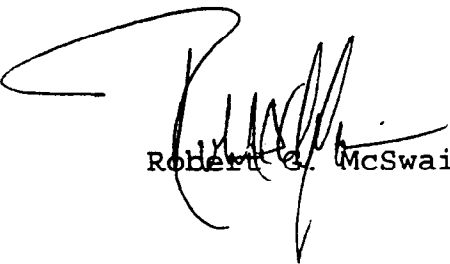
FROM: Director
Office of Management Support

SUBJECT: Indian Health Service's Comments on the Office of
Inspector General Draft Report, "Review of the Indian
Health Service's Contract Health Services Program,"
CIN: A-15-97-50001

Attached is the Indian Health Service's (IHS) comments on the Office of Inspector General (OIG) draft report, "Review of the Indian Health Service' Contract Health Services Program," CIN: A-15-97-50001.

The IHS has concurred with all four OIG recommendations and has taken corrective actions to ensure that all recommendations are fully implemented.

If you have any questions regarding this memorandum, please call Mr. Charles Miller, Management Analyst, Management Policy Support Staff, at (301) 443-9597.


Robert G. McSwain

Attachment

INDIAN HEALTH SERVICE COMMENTS ON THE OFFICE OF INSPECTOR
GENERAL (OIG) DRAFT REPORT, "REVIEW OF THE INDIAN HEALTH
SERVICE'S CONTRACT HEALTH SERVICES PROGRAM"
CIN # A-15-97-50001

General Comments

The Indian Health Service (IHS) commends the Office of the Inspector General (OIG) for developing a highly useful and beneficial report with such a positive potential outcome for American Indian and Alaska Natives patients. The report will not only benefit the IHS but the Tribal and Urban programs as well. The report clearly demonstrates the potential savings that will accrue as a result of implementation of the recommendations and will result in the ability to purchase additional services. The IHS continues to strive to maximize the Contract Health Service (CHS) dollar and applauds the cooperative nature of this analysis between the IHS and OIG.

OIG Recommendation

We recommend that IHS:

1. Update IHS' FY 1999 legislative proposal, "IHS Contract Care," to incorporate the potential savings presented in this report. We believe the savings stated in this report represent the most current and accurate estimations.

IHS Comment

We concur. The FY 1999 legislative proposal will be revised to include the potential \$8 million in savings. The IHS will submit the legislative proposal with the FY 2000 Budget legislative process.

OIG Recommendation

2. Forward the updated CHS legislation to the Department of Health and Human Services (DHHS) for appropriate dissemination to parties involved in the legislative decision making process.

IHS Comment

We concur. The IHS will submit the legislative proposal with the FY 2000 Budget legislative process.

OIG Recommendation

3. Identify elements to be included in the required implementing regulations, and begin to formulate IHS' implementing materials.

IHS Comment

We concur. There is one major element that the DMC staff believe is appropriate for regulation, and all activity is contingent on the legislative proposal moving successfully through administration and legislative channels. Written regulation will then follow and be dependent upon the final legislative language.

OIG Recommendation

4. Continue to pursue the most favorable rates at hospitals that previously offered less than Medicare rates, and strategically identify and pursue other opportunities where lower rates may be negotiated.

IHS Comments

We concur. The IHS will continue to strive to obtain discounted rates throughout Indian country.

Technical Comments

Office of Audit Services' Note: The IHS provided technical comments, which we have incorporated throughout the report, as appropriate; therefore, we have deleted them from the appendix.