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United States Government Accountability Office
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February 23, 2009

The Honorable Robert C. Byrd
Chairman
Subcommittee on Homeland Security
Committee on Appropriations
United States Senate

The Honorable David Price
Chairman
Subcommittee on Homeland Security
Committee on Appropriations
House of Representatives

Subject: *DHS: Organizational Structure and Resources for Providing Health Care to Immigration Detainees*

Recent events have drawn attention to the health care provided to detainees held by U.S. Immigration and Customs Enforcement (ICE), a component of the Department of Homeland Security (DHS).[1] For fiscal year 2004 through fiscal year 2007, ICE reported that 69 detainees died while in ICE custody, and during 2008, national news organizations investigated and published reports of the circumstances surrounding several detainee deaths. Other reports have also outlined concerns about the health care provided to detainees. For example, in 2007, the DHS Office of the Inspector General (OIG) found problems with adherence to ICE's medical standards at two ICE facilities it reviewed where detainee deaths had occurred.[2] Additionally, members of Congress, the media, and advocacy groups have raised questions about the health care provided to detainees in ICE custody. An explanatory statement accompanying the fiscal year 2009 DHS appropriations act directed ICE to fund an independent, comprehensive review of the medical care provided to persons detained by DHS and identified $2 million for that purpose.[3]

[1]Under the Immigration and Nationality Act, ICE is authorized to arrest, detain, and remove certain individuals from the United States. 8 U.S.C. §§ 1226, 1227, 1229, 1229a, 1231, and 1357. We refer to these individuals as "detainees."

[2]Department of Homeland Security, Office of the Inspector General, *ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities* (Washington, D.C.: June 2008).

[3]See Comm. Print of the Comm. on Approp., U.S. House of Rep., Explanatory Statement related to the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, Pub. L. No. 110-329, Div. D., p. 636 (Oct. 2008). Section 4 of Pub. L. No. 110-329 provides that the Explanatory Statement shall have the same effect with respect to the allocation of funds and the implementation of the act as if it were a joint explanatory statement of a committee of conference.

ICE was created in March 2003 as part of DHS.[4] From fiscal year 2003 through fiscal year 2007, the average daily population of detainees in ICE custody increased by about 40 percent, with the most growth occurring since fiscal year 2005.[5] In fiscal year 2007, ICE held over 311,000 detainees at more than 500 detention facilities. Most of these were Intergovernmental Service Agreement (IGSA) facilities—state and local jails under contract with ICE to hold detainees. Some ICE detainees received health care services from IGSA staff, IGSA contractors, or community medical providers, and other ICE detainees received health care provided or arranged by the Division of Immigration Health Services (DIHS). DIHS is mainly comprised of contract employees and officers from the U.S. Public Health Service (PHS) Commissioned Corps—a uniformed service of public health professionals who are part of the Department of Health and Human Services (HHS) and who provide services in different settings, including ICE detention facilities.

In light of questions about the health care provided to detainees in ICE custody, you requested information about ICE's organizational structure and its health care resources for detainees. This report provides (1) a description of ICE's organizational structure for providing health care services to detainees, which includes our review of the relevant agreements between DHS and HHS regarding DIHS; (2) information about ICE's annual spending and staffing resources devoted to the provision of health care for detainees, and the number of services provided; and (3) an assessment of whether ICE's mortality rate can be compared with the mortality rates of the Federal Bureau of Prisons (BOP) and the U.S. Marshals Service (USMS)—two entities that are responsible for holding certain persons, such as criminals.

We took the following steps to develop our findings. To describe ICE's organizational structure for providing health care services to detainees, including interagency agreements, we reviewed pertinent reports issued by government agencies and interagency agreements regarding DIHS, and we also interviewed agency officials.[6] To determine the annual health care spending, staffing, and services provided to ICE detainees, we examined ICE's fiscal year 2003 through fiscal year 2007 data for these three areas. To determine whether ICE's mortality rate could be directly compared with the mortality rate for BOP or USMS, we examined ICE mortality data and information about the health care goals, services, and populations for ICE, BOP, and USMS.

We assessed the data DHS provided and we worked with DHS to address discrepancies. Subsequently, we determined that the data we used were sufficiently reliable for our purposes. Throughout our work, we used data on the average daily population—the number of beds ICE used for detainees on an average day during a fiscal year—because ICE was not able to provide reliable data on the number of unique individuals detained per fiscal year. We conducted our work from July 2008 to February 2009 in accordance with all sections of

[4]Responsibility for detainees was transferred from the Department of Justice's Immigration and Naturalization Service (INS) to DHS's ICE.

[5]The scope of our work was primarily limited to detainees who were in ICE custody due to immigration violations and who were held at facilities that serve adults. Some of these facilities are owned and operated by ICE, some operate under contracts with ICE, and some operate through service agreements with ICE. We did not include detainees held by the Bureau of Prisons (BOP) for committing a criminal offense.

[6]The government reports we reviewed were issued by GAO, the DHS OIG, and the Congressional Research Service. We interviewed agency officials from DHS, ICE, HHS, DIHS, BOP, and USMS.

GAO's Quality Assurance framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient, appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained and the analysis conducted provide a reasonable basis for any findings and conclusions.

On December 18, 2008, we briefed your staff on the results of this work. The briefing slides, included as enclosure I, have been updated to include more current information. This report formally conveys the information presented during that briefing and officially transmits our work to the Secretary of DHS and the Acting Secretary of HHS.

In summary, we reported the following findings:

- ICE's organizational structure for providing health care to detainees is not uniform across facilities. In fiscal year 2007, 21 DIHS-staffed facilities provided or arranged for health care for about 53 percent of the average daily population of detainees, while 508 IGSA facilities provided or arranged for health care for the remaining detainees—about 47 percent of the population. In addition, recent agreements with HHS reassigned medical personnel to DHS. DHS officials told us that a total of 565 direct health care providers and administrative staff were affected by these agreements.

- Although ICE's health care data are not complete, the available data on health care spending, staffing, and services provided generally showed growth in all three areas. For instance, from fiscal year 2003 through fiscal year 2007, reported expenditures for medical claims and program operations increased by 47 percent, while the average daily population of detainees increased by about 40 percent.

- ICE's mortality rate cannot be directly compared with BOP's or USMS's mortality rate. This is due to differences in the three agencies' health care goals and scopes of services, as well as to demographic differences among the ICE, BOP, and USMS detainee populations.

Based on our work, we have identified a number of issues that may merit further assessment in the $2 million external study that ICE was directed to fund. These are shown in enclosure I and relate to data availability and some aspects of program oversight.

Agency Comments and Our Evaluation

We provided HHS and DHS with drafts of this report for their review and comment. HHS had no general comments but made a technical comment, which we addressed. DHS provided written comments (reprinted in enclosure II) and technical comments that we incorporated as appropriate.

DHS disagreed with the way we presented some of the information in our briefing report. First, the agency pointed out that we did not clearly differentiate between the HHS entity named DIHS and the identically-named ICE program, and that our report could lead to the incorrect conclusion that the HHS entity or its public health personnel were transferred to ICE. Noting that DIHS was not transferred from HHS, DHS explained that ICE established its own organization that it also named DIHS, to preclude confusion among field offices. In our report, we state that, prior to October 1, 2007, DIHS was a component of HHS's Health Resources and Services Administration (HRSA). As we also state in our work, DHS officials

told us that ICE now has a component known as DIHS that provides health care services to detainees. We did not determine whether DIHS was transferred from HHS to DHS. Although DHS was unable to provide an official organizational chart that shows the placement of DIHS, we understand that the two DIHS entities shared the same name, and that the entity bearing that name now exists only in DHS's ICE.

Second, DHS stated that we erroneously asserted that health care providers within what DHS referred to as HHS's DIHS report to ICE's Office of Detention and Removal Operations. The agency stated that ICE does not impinge on the autonomy of HHS's health care professionals who provide services to detainees. As our work indicates, HHS informed us that its DIHS ceased to exist as a component of HHS as of October 1, 2007. However, PHS officers are detailed to ICE's DIHS under the Memorandum of Agreement between HHS and DHS. DHS officials previously informed us that DHS does exercise some control over DIHS general policy development as well as other administrative matters. We also clearly stated in our work, however, that DHS officials told us that their agency does not have supervisory control over clinical decisions made by DIHS personnel.

Third, DHS wrote that we erroneously implied that ICE lacks basic information about the cost of health care services provided to detainees held at IGSAs. The agency noted that the cost for basic health care services provided to detainees is built into the per diem payment IGSAs receive. Although the estimated cost of basic services is covered under the per diem rate for housing detainees, DHS officials cautioned us during the course of our work that such payment does not represent actual expenses incurred. Therefore, IGSA expenditures for providing basic health care cannot be separately identified under the current payment method. As a result, ICE may not have the information needed to determine whether the IGSA per diem rate is adequate or excessive for the delivery of basic health care services.

Fourth, DHS commented that ICE uses the Treatment Authorization Request (TAR) system as a tool for authorizing payment for services provided to ICE detainees and that the TAR can identify health-related procedures and visits. This seems to imply that the TAR routinely provides ICE with additional cost information. However, the description of the TAR system shown in the agency's "DIHS Medical Dental Detainee Covered Services Package,"[7] as well as our interviews with senior ICE program staff, do not support this position. Rather, the TAR system is used to obtain approval that authorizes payment for off-site, nonroutine health care services. As such, it is not designed to track health care spending and is not used to routinely report information on health care expenditures by facility type.

Finally, DHS commented that we did not provide context on ICE's transfer practices. The agency noted that its operational needs for transferring detainees can relate to access to medical treatment, access to the courts, or efficiently completing their removal. We recognize that ICE transfer practices can have an impact on the health care provided to detainees—such as the need to rescreen a detainee after a transfer or the need to ensure that a transferred detainee's medical information can be accessed by the new facility. However, determining the appropriateness of ICE transfer policy or the rationale behind transfer decisions was beyond the scope of our work. The DHS OIG is currently conducting work on ICE transfers, which may help to inform the issues DHS noted.

[7]Division of Immigration Health Services, *DIHS Medical Dental Detainee Covered Services Package*, http://www.icehealth.org/managedcare/providers.shtm (accessed Feb. 13, 2009).

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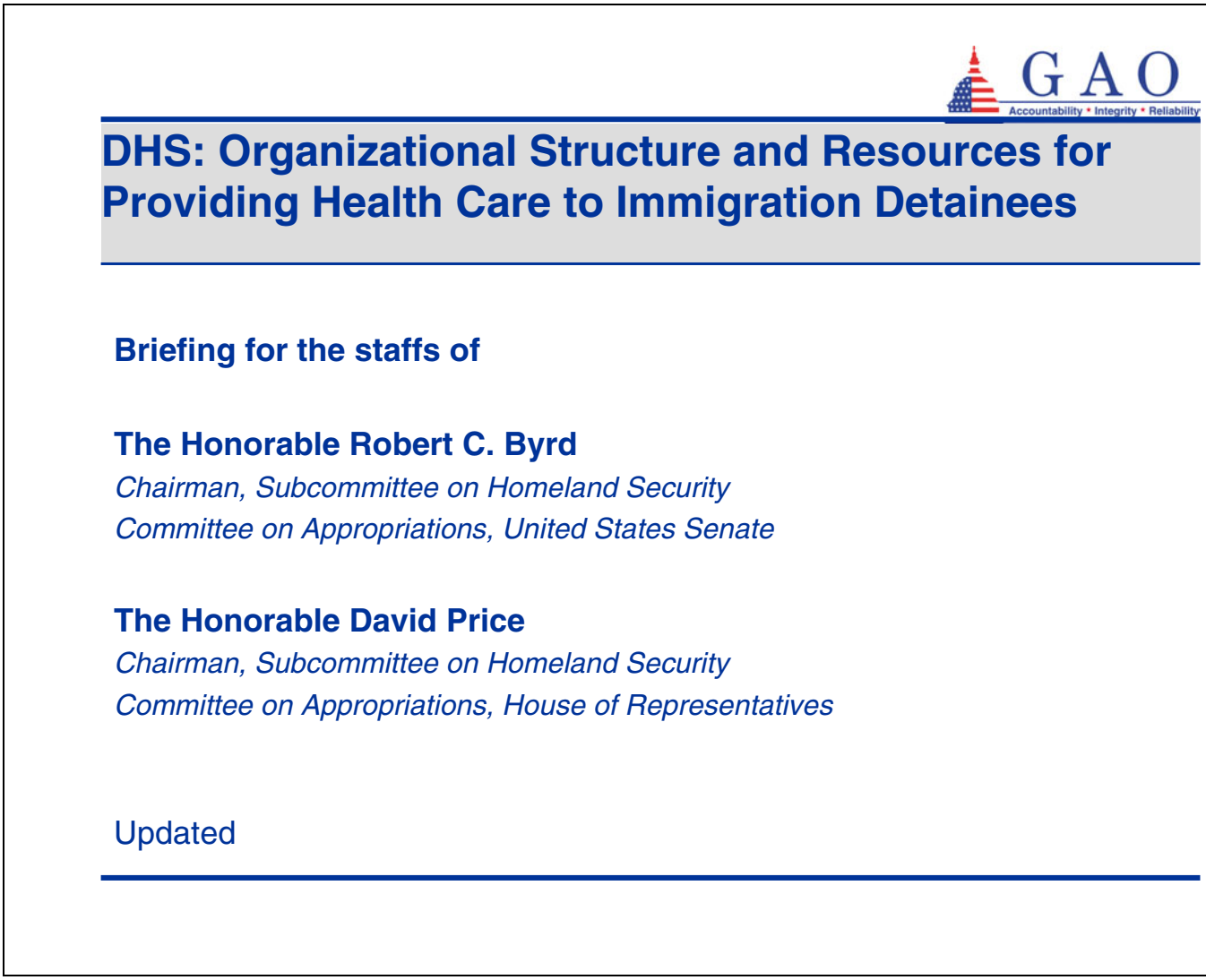
As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report for 30 days. At that time, we will send copies of this report to the Secretary of DHS and the Acting Secretary of HHS. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions or need additional information, please contact me at (202) 512-7114, or CackleyA@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report were Rosamond Katz, Assistant Director; Eleanor M. Cambridge; Joy L. Kraybill; Drew Long; Kevin Milne; and Katherine Wunderink.

Alicia Puente Cackley
Director, Health Care

Enclosures—2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Briefing for the staffs of
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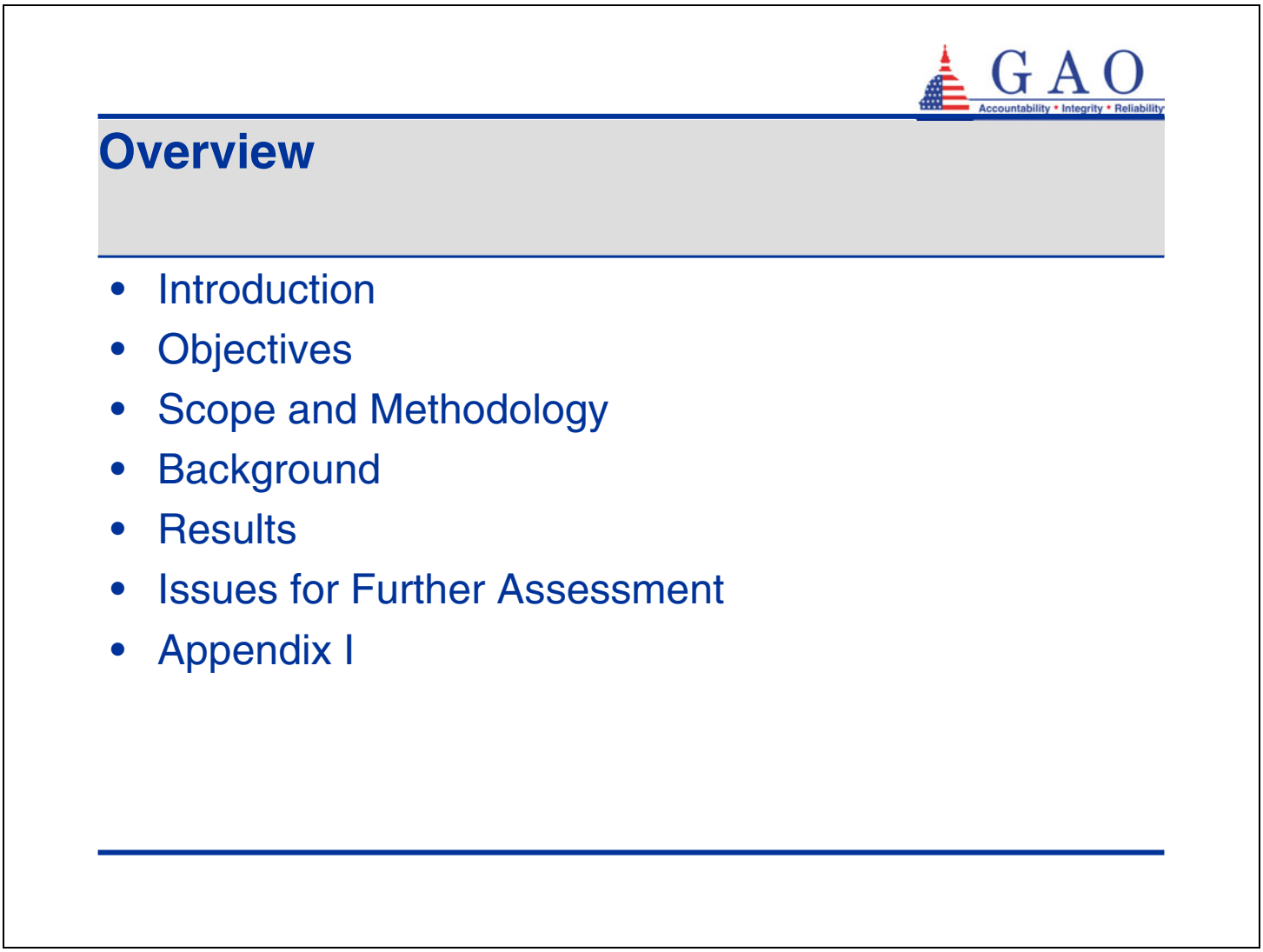
Updated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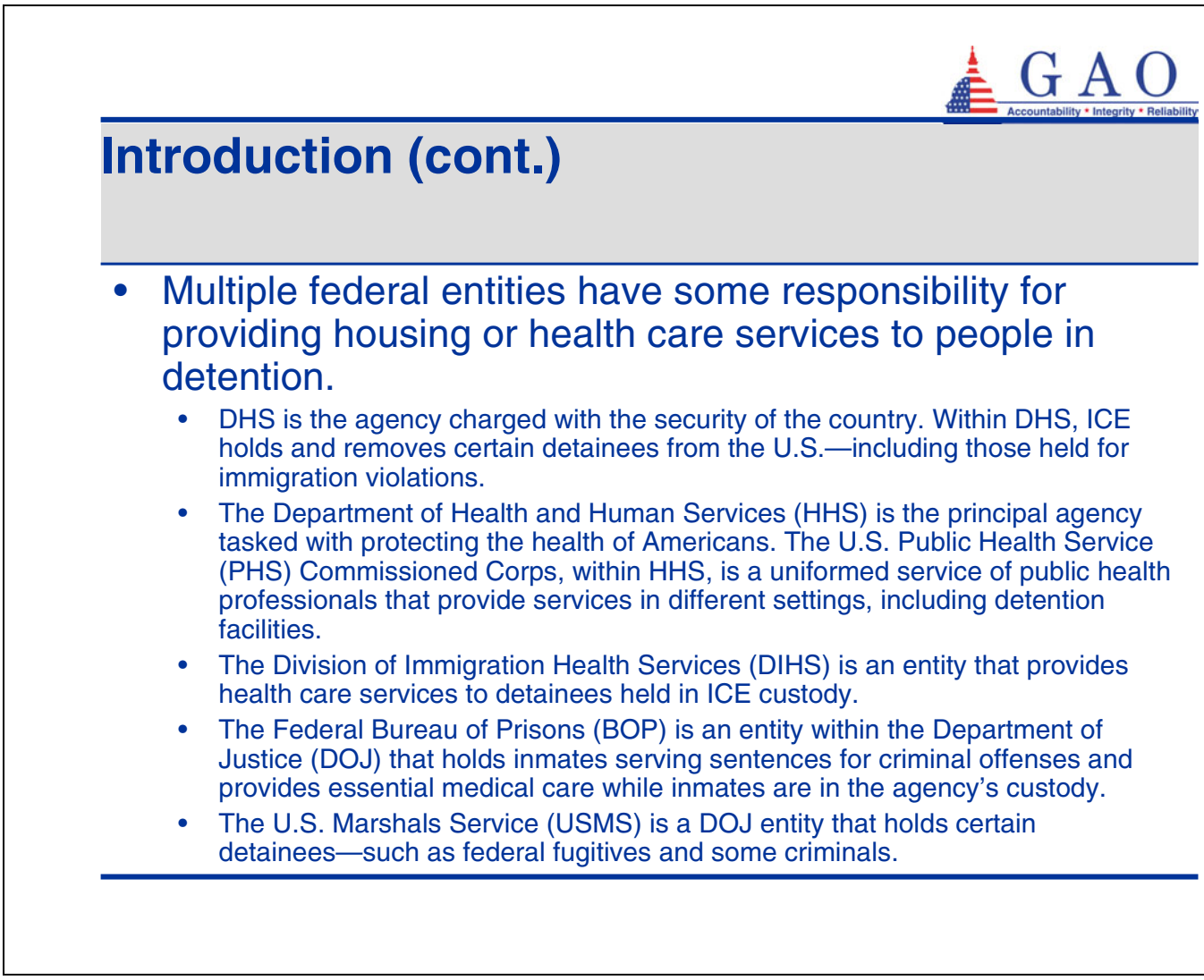
• Appendix I

Introduction

- In fiscal year (FY) 2007, the Department of Homeland Security's (DHS) U.S. Immigration and Customs Enforcement (ICE) detained over 311,000 individuals at more than 500 detention facilities.[1] We refer to these individuals as "detainees."[2]
- Questions have been raised by members of Congress, the media, and advocacy groups about the health care provided to detainees in ICE custody. From FY 2004 through FY 2007, ICE reported that 69 detainees had died in ICE custody.
- An explanatory statement accompanying the FY 2009 DHS appropriations act directed ICE to fund an independent study on the health care services ICE provides to detainees and identified $2 million for this purpose.

[1] ICE was created in March 2003 as part of DHS. Responsibility for detainees was transferred from the Department of Justice's Immigration and Naturalization Service (INS) to DHS's ICE. Under the Immigration and Nationality Act, ICE is authorized to arrest, detain, and remove certain individuals from the United States. 8 U.S.C. §§ 1226, 1227, 1229, 1229a, 1231, and 1357.
[2] The scope of our work was primarily limited to detainees who were in ICE custody due to immigration violations and who were housed at facilities that serve adults. Some of these facilities are owned and operated by ICE, some operate under contracts with ICE, and some operate through service agreements with ICE. We did not include detainees held by the Bureau of Prisons (BOP) for committing a criminal offense.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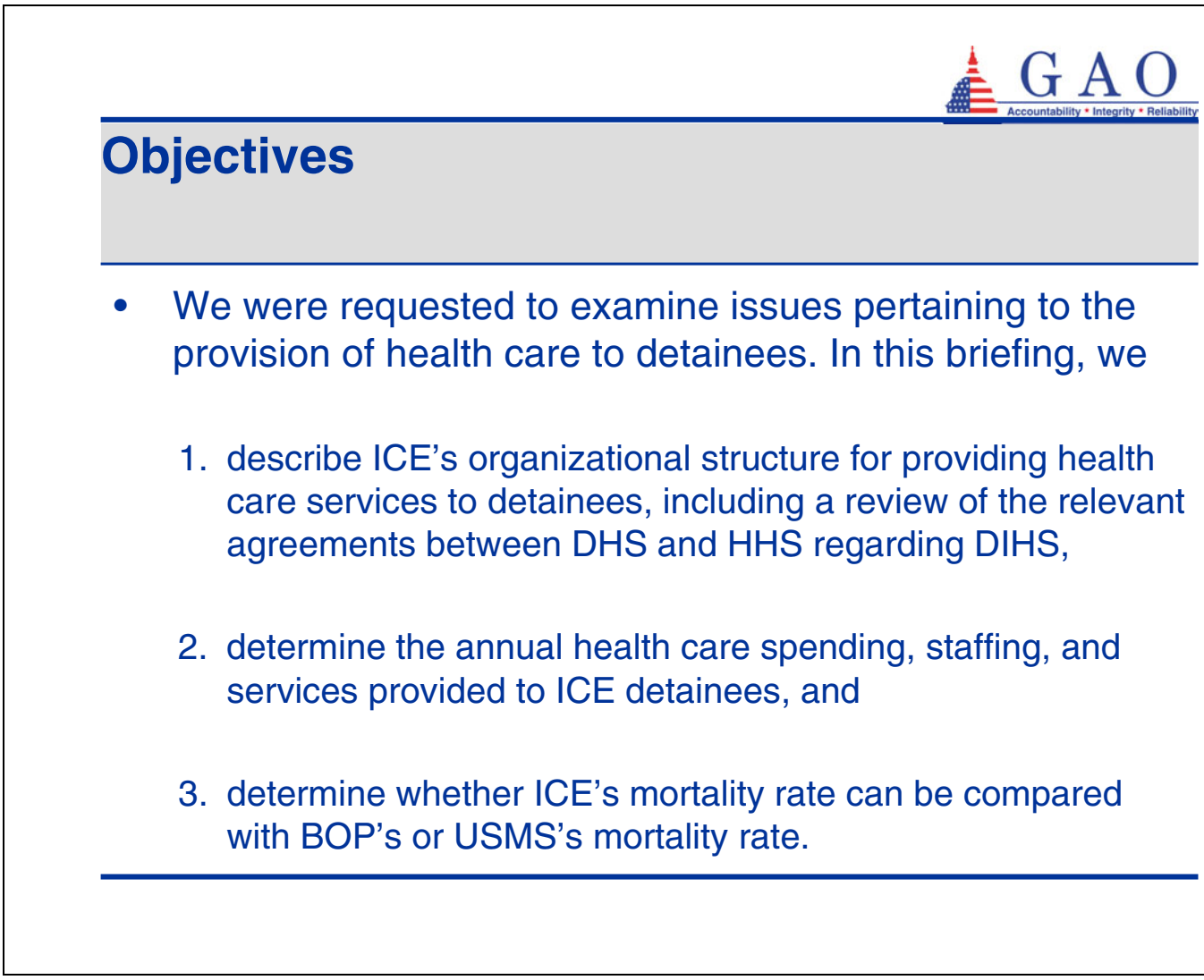
Introduction (cont.)
• Multiple federal entities have some responsibility for providing housing or health care services to people in detention.
• DHS is the agency charged with the security of the country. Within DHS, ICE holds and removes certain detainees from the U.S.—including those held for immigration violations.
• The Department of Health and Human Services (HHS) is the principal agency tasked with protecting the health of Americans. The U.S. Public Health Service (PHS) Commissioned Corps, within HHS, is a uniformed service of public health professionals that provide services in different settings, including detention facilities.
• The Division of Immigration Health Services (DIHS) is an entity that provides health care services to detainees held in ICE custody.
• The Federal Bureau of Prisons (BOP) is an entity within the Department of Justice (DOJ) that holds inmates serving sentences for criminal offenses and provides essential medical care while inmates are in the agency's custody.
• The U.S. Marshals Service (USMS) is a DOJ entity that holds certain detainees—such as federal fugitives and some criminals.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Objectives
• We were requested to examine issues pertaining to the provision of health care to detainees. In this briefing, we
1. describe ICE's organizational structure for providing health care services to detainees, including a review of the relevant agreements between DHS and HHS regarding DIHS,
2. determine the annual health care spending, staffing, and services provided to ICE detainees, and
3. determine whether ICE's mortality rate can be compared with BOP's or USMS's mortality rate.

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Scope and Methodology[3]

- We reviewed pertinent reports issued by GAO, the DHS Office of the Inspector General, and the Congressional Research Service. These reports pertained to ICE's organizational structure and the health care services provided to ICE detainees.
- We reviewed agreements in place between DHS and HHS regarding DIHS.
- We interviewed officials from DHS, ICE, DIHS, HHS, BOP, and USMS.
- We examined data on ICE's FY 2003 through FY 2007 health care expenditures, staffing, and services provided. We also examined mortality data for ICE detainees and information about the health care goals, services, and populations for ICE, BOP, and USMS.[4]
- We assessed the data DHS provided and we worked with DHS to address discrepancies. Subsequently, we determined that the data were sufficiently reliable for our purposes.

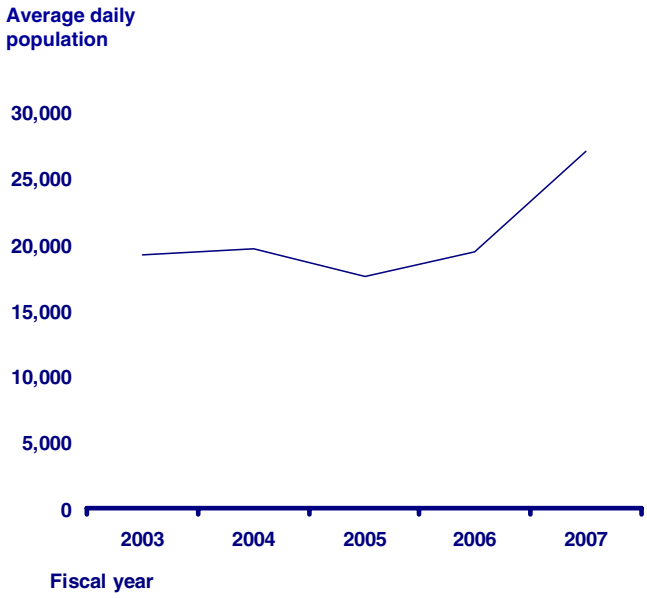
[3] We conducted our work from July 2008 to February 2009 in accordance with all sections of GAO's Quality Assurance framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient, appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained and the analysis conducted provide a reasonable basis for any findings and conclusions.

[4] FY 2007 was generally the most recent year of data available. Unless otherwise indicated, the data we present reflect the detainees held at three types of facilities: Service Processing Centers (SPC), Contract Detention Facilities (CDF), and Intergovernmental Service Agreement (IGSA) facilities.

Background

Reported average daily population of detainees in ICE custody, FY 2003–FY 2007

- The average daily population of detainees in ICE custody increased by about 40 percent from FY 2003 through FY 2007, with the most growth occurring since FY 2005.
- The average daily population of detainees is the most reliable and readily available population measure DHS was able to provide. It indicates the number of detainee beds ICE used on an average day during a fiscal year. ICE computes the average daily population by dividing the annual number of bed days used by 365.



Source: GAO analysis of DHS data.

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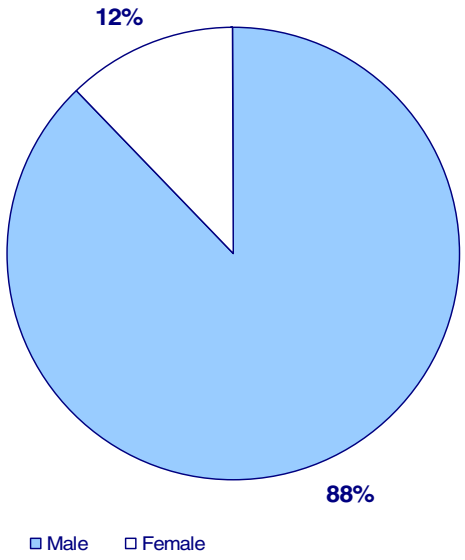
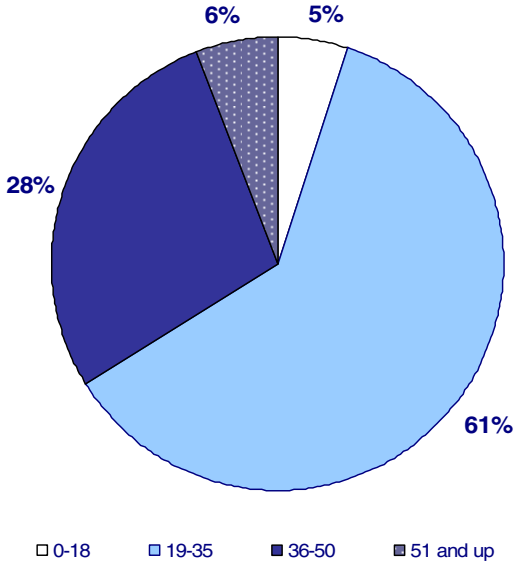
Background (cont.)

Gender and age of ICE's reported average daily population, FY 2007



Source: GAO analysis of DHS data on total average daily population.



Source: GAO analysis of DHS data on total average daily population.

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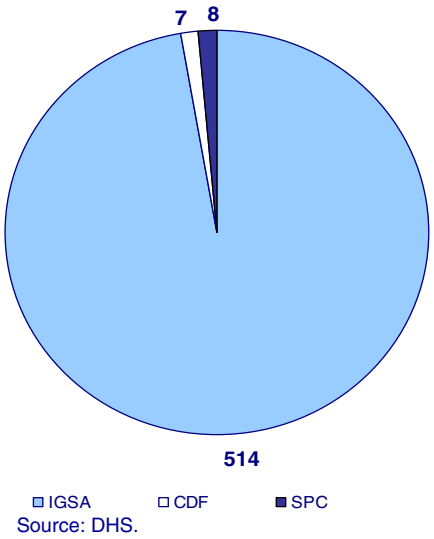
Background (cont.)

Number and type of detention facilities used by ICE, FY 2007

- Most ICE detainees are housed in three types of detention facilities:
  - Service Processing Centers (SPC):
    8 federal facilities operated by ICE to hold detainees
  - Contract Detention Facilities (CDF):
    7 facilities operated by private contractors specifically to hold detainees
  - Intergovernmental Service Agreement (IGSA) facilities:
    514 state and local jails under contract with ICE to hold detainees[5]



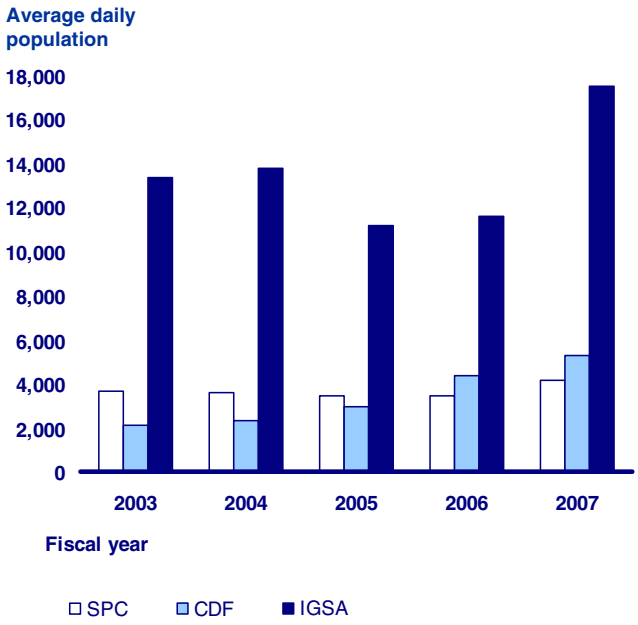
Source: DHS.

[5] DHS officials stated that the 514 IGSA facilities include over 300 facilities that each generally report a total of more than 60 days of detainee bed use per year. The other IGSA facilities report less activity—some report a total of only one or two nights of detainee bed use per year.

Background (cont.)

ICE's reported average daily population by facility type, FY 2003–FY 2007

- IGSAs house the majority of the detainee population. In FY 2007, almost 65 percent of the average daily population was housed at an IGSA.
- From FY 2003 through FY 2007, the average daily population at IGSAs grew by about 31 percent.



Source: DHS.

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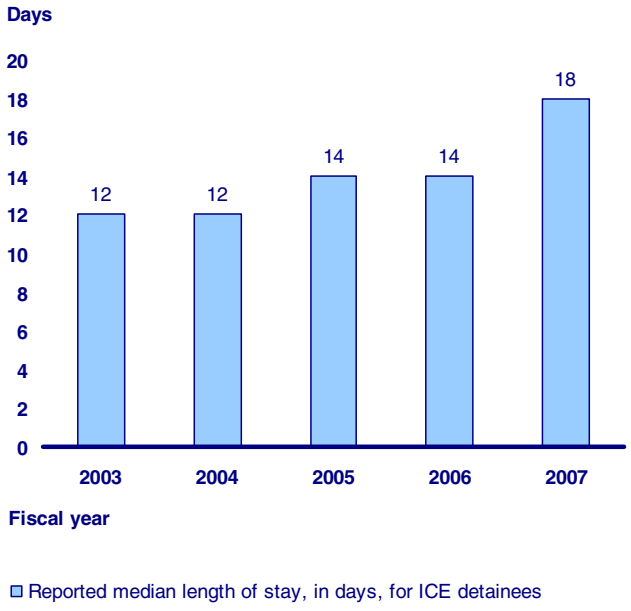
Background (cont.)

Reported length of stay in ICE custody, FY 2003–FY 2007

- From FY 2003 through FY 2007, the median length of stay for detainees increased from 12 days to 18 days.
- At ICE's discretion, detainees can be transferred between facilities, sometimes more than once. The agency estimated that the average detainee is booked into about 2 facilities while in ICE custody.



Source: DHS data on total average daily population.

Background (cont.)

ICE detention standards and medical care standards

- ICE developed detention standards designed to ensure facilities provide services that will protect detainees' lives and dignity. These detention standards are comprised of 41 standards that pertain to specific areas—such as medical care, food service, and environmental safety.

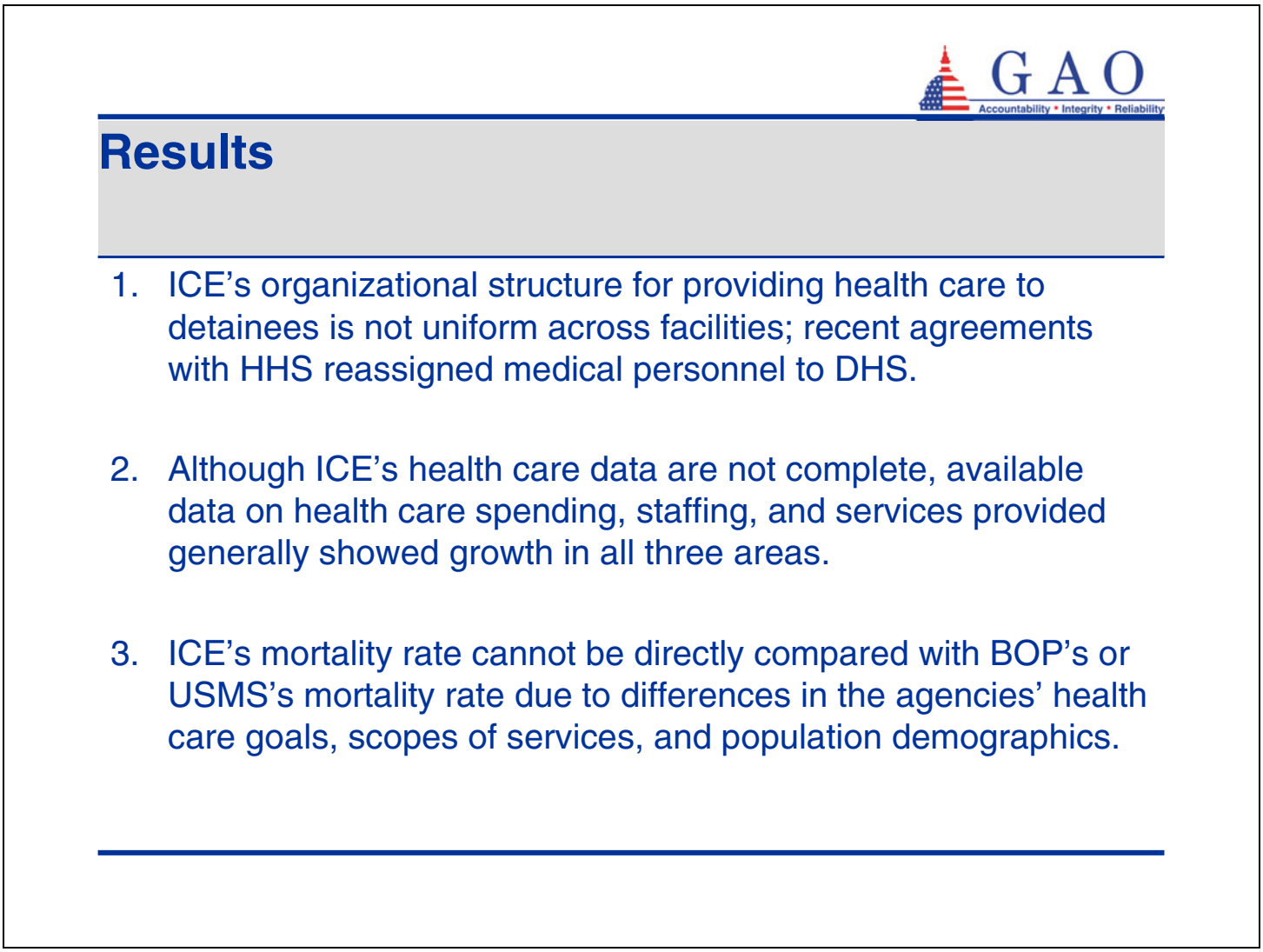
- ICE's medical care detention standards aim to ensure "that detainees have access to emergent, urgent, or non-emergent medical, dental, and mental health care that are within the scope of services provided by the DIHS, so that their health care needs are met in a timely and efficient manner."[6]

[6] *ICE/DRO Detention Standard: Medical Care,* http://www.ice.gov/doclib/PBNDS/pdf/medical_care.pdf (accessed Dec. 1, 2008). The medical care standard was revised by ICE during 2008.

Background (cont.)

ICE medical care standards

- ICE medical care standards include
  - an intake screening, including a tuberculosis screening, is to be performed for each detainee within 12 hours of their arrival at a new facility.
  - a physical examination is to be performed for each detainee within 14 days of arrival at a different facility. If a physical has been performed for the detainee within the last 90 days, a health care provider may determine that a new physical examination is not necessary.
  - when a facility is unable to provide certain need-based medical care, detainees can receive care from community medical providers.
  - if a detainee is transferred to another facility, the transferring facility must compose a "transfer summary" that includes the detainee's medical issues, any treatment provided by the facility, tuberculosis screening results, and at a minimum, a 7-day supply of any needed prescription medications.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Results
1. ICE's organizational structure for providing health care to detainees is not uniform across facilities; recent agreements with HHS reassigned medical personnel to DHS.
2. Although ICE's health care data are not complete, available data on health care spending, staffing, and services provided generally showed growth in all three areas.
3. ICE's mortality rate cannot be directly compared with BOP's or USMS's mortality rate due to differences in the agencies' health care goals, scopes of services, and population demographics.

1: ICE's organizational structure for providing health care to detainees is not uniform across facilities; recent agreements with HHS reassigned medical personnel to DHS

- ICE uses DIHS staff to provide or arrange for health care for some detainees, and uses IGSA staff to provide or arrange for health care for other detainees.
  - In FY 2007, DIHS staff provided care to detainees at 21 facilities—including 8 SPCs, 7 CDFs, and 6 IGSAs.[7] In some instances, this care can be supplemented by services from community medical providers.
  - In FY 2007, at the approximately 508 remaining IGSA facilities, detainee health care was provided or arranged for by the respective IGSA. DHS officials indicated that each IGSA may determine whether health care services for detainees will be provided by IGSA staff, contractors, or community medical providers.

[7] In FY 2007, these 6 IGSAs accounted for about 27 percent of the total average daily population for all IGSAs.

1: ICE's organization

DIHS providers differ from IGSA providers

- DIHS staff include PHS officers, contract employees, and civil servants. In FY 2007, about 46 percent of DIHS staff were PHS officers detailed to DHS, about 52 percent were contract employees, and about 2 percent were civil servants.[8]

- IGSA staff may include on-site clinicians, employed by a county public health service or under contract with the facility itself. Some IGSAs have no health care staff on-site and rely solely on community medical providers to deliver care.

[8] A "detail" is the assignment of a PHS officer or employee by HHS to another federal agency, to perform duties in support of that agency or the PHS. 42 U.S.C. § 215.

1: ICE's organization

DIHS provided or arranged for health care for about half of the detainee population in FY 2007

- In FY 2007, DIHS-staffed facilities provided or arranged for health care for about 53 percent of the average daily population of detainees.
- The proportion of the average daily population served by DIHS-staffed facilities grew from about 35 percent in FY 2003 to about 53 percent in FY 2007.
- In FY 2007, the remaining 508 IGSA facilities provided or arranged for health care for about 47 percent of the average daily population of detainees.

1: ICE's organization

In 2007 DIHS was removed from HHS's organizational chart; DIHS now reports to an ICE component

- Before October 1, 2007, DHS and HHS maintained annual interagency agreements through which DIHS provided detainee health care services for ICE. DIHS was a component of HHS's Health Resources and Services Administration (HRSA).
- The last interagency agreement was terminated as of October 1, 2007, and DIHS is no longer a component of HRSA. According to DHS officials, ICE has a component known as DIHS which provides health care services to detainees in support of ICE's overall mission.
- Some of the civilian staff formerly employed at HRSA's DIHS became employees of DHS during 2007.
- A 2007 Memorandum of Agreement between DHS and HHS placed PHS officers on detail to DHS on an open-ended basis, and allowed for additional PHS officers to be detailed in the future.
- DHS officials said that the termination of the interagency agreement and the development of the Memorandum of Agreement affected 565 direct health care providers and administrative staff—253 PHS officers, 301 contract employees, and 11 civil servants.

1: ICE's organization

DIHS reports to DHS on administrative matters

- DHS officials stated that the agency has some supervisory responsibilities over the movement and assignment of DIHS staff, as well as general DIHS policy development. According to DHS officials, DHS does not have supervisory responsibility over DIHS's clinical decision making.
- DHS officials indicated that DIHS reports to the Detention Management Division, which is located in ICE's Office of Detention and Removal Operations.
- DHS officials could not provide an official organizational chart to show DIHS's placement in DHS.

1: ICE's organization

Facilities do not use standardized record keeping or reporting to monitor health care services provided to detainees

- DIHS officials told us that they collect data on the health care services provided at the DIHS-staffed facilities.
  - At the 21 facilities that DIHS staffed in FY 2007, 9 recorded information electronically and 12 used paper records.
  - DIHS compiles a monthly report that incorporates data from the facilities it staffs, but officials told us that DIHS is not required to report data to DHS routinely.
- DHS officials confirmed that ICE does not routinely collect data on the health care services provided at the IGSAs that are not staffed by DIHS.
  - Officials stated that they do not know whether these IGSAs record health care information electronically or on paper.
  - Officials can obtain data from these IGSAs, but they need to request paper copies of individual detainee health records to compile any needed data, because IGSAs are not required to report data to DHS routinely.

1: ICE's organization

Facilities are responsible for transferring detainee medical information when detainees are transferred

- According to DHS officials, in FY 2007, ICE conducted about 261,000 transfers of detainees among facilities.
- DHS officials confirmed that ICE does not have a uniform method for routinely monitoring facilities' completion of medical transfer summaries at the time detainees are transferred, as required by ICE detention standards.

2: Although ICE's health care data are not complete, available data on health care spending, staffing, and services provided generally showed growth in all three areas

- Complete ICE health care expenditure data fall into three categories:
  - Program operations
    - salaries for DIHS staff—including PHS officers
    - transportation costs for DIHS staff
    - rent and information technology systems
  - Medical claims
    - medical claims submitted by community medical providers
    - pharmacy expenses, dental expenses, psychological care
  - Health care component of IGSA contract costs
    - any salaries for IGSA health care staff or costs for the health care services they provide—both of which are paid to IGSAs as part of their contract payments for housing detainees
- Data are not available on IGSA's health care costs, but data are available for program operations and medical claims.

2: Health care spending, staffing, and services

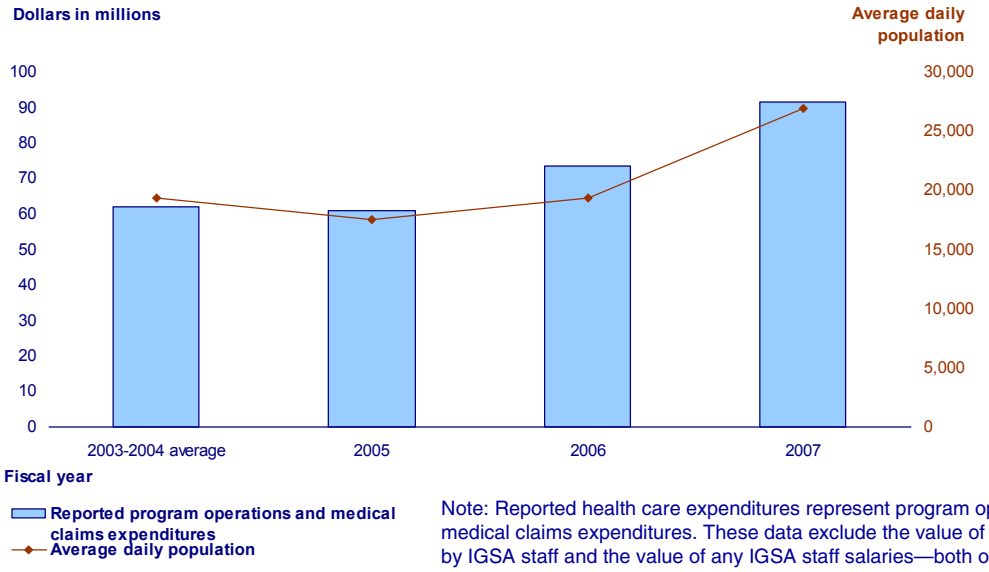
ICE's health care expenditure data only permit high-level analysis

- DHS officials confirmed that no itemized medical claims exist for health care services provided by DIHS staff. These costs are paid through DIHS staff salaries, which are included in program operations expenditure data.

- DHS officials confirmed that no data are available on the cost of health care services provided by IGSA staff. Payments for these items are included as part of the contracts IGSAs have with ICE. DHS officials confirmed that IGSA contract payments reimburse each IGSA's overall costs for housing detainees—precise costs cannot be identified.

2: Health care spending, staffing, and services

ICE's reported program operations and medical claims expenditures for detainees increased by 47 percent and average daily population increased by about 40 percent, FY 2003–FY 2007



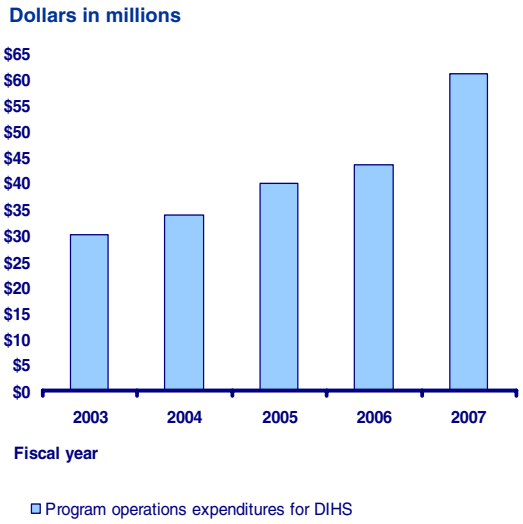
Note: Reported health care expenditures represent program operations and medical claims expenditures. These data exclude the value of services provided by IGSA staff and the value of any IGSA staff salaries—both of which are included in IGSAs' contract rates. FY 2003 and FY 2004 data were averaged to address a delay in medical claims payments that occurred when DHS changed its claims processing contractor.

Source: GAO analysis of DHS data.

2: Health care spending, staffing, and services

Reported program operations expenditures for DIHS increased, FY 2003–FY 2007

- From FY 2003 through FY 2007, spending for DIHS staff salaries and other program operations expenditures more than doubled.
- ICE officials primarily attributed this increase in spending to growth in the number of DIHS staff to support ICE detention operations.



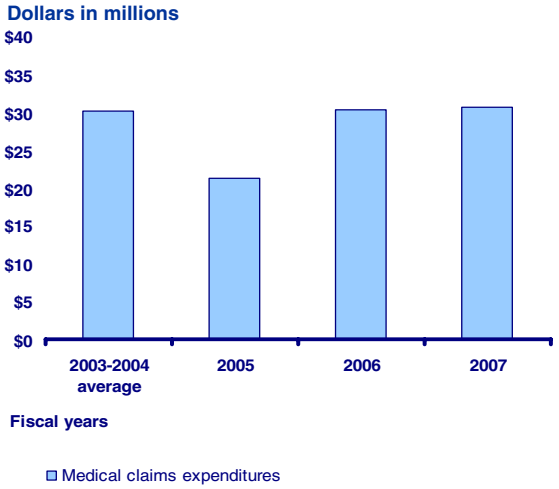
Note: Program operations expenditures include DIHS salaries, transportation, and related costs. These data exclude the value of IGSA staff salaries, transportation, and any other IGSA costs.

Source: DHS.

2: Health care spending, staffing, and services

Reported medical claims expenditures showed moderate fluctuation, FY 2003–FY 2007

- Medical claims expenditures ranged between $21.2 million and $30.7 million per year from FY 2003 through FY 2007.
- Claims for health care services provided by community medical providers are submitted to ICE's claims processing contractor, and these costs are included in the medical claims expenditure data. Care from community medical providers may supplement services provided by any of the IGSAs or by the 21 DIHS-staffed facilities.



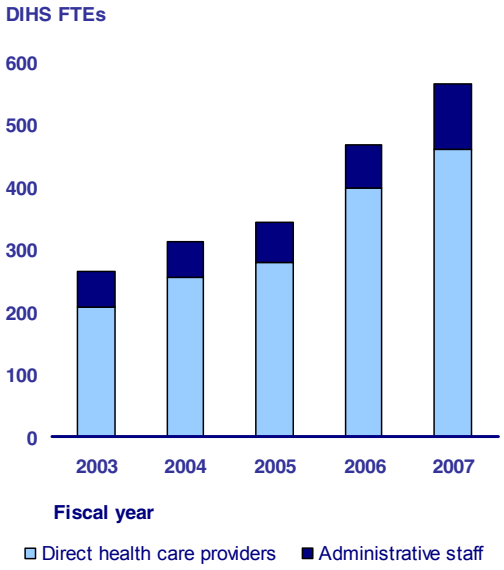
Notes: Medical claims expenditures include claims from community medical providers. DIHS providers do not submit claims. Reimbursement for IGSA staff providers' services is paid through the IGSAs' contract rates. FY 2003 and FY 2004 data were averaged to address a delay in medical claims payments that occurred when DHS changed its claims processing contractor.

Source: GAO analysis of DHS data.

2: Health care spending, staffing, and services

DIHS staff increased, FY 2003–FY 2007

- From FY 2003 through FY 2007, the number of DIHS direct health care providers more than doubled—growing from 208 to 460 full-time equivalent staff (FTE).
- The number of DIHS administrative FTEs nearly doubled, from 57 in FY 2003 to 105 in FY 2007. In FY 2007, each administrative staff person supported roughly 4.4 direct health care providers.
- DIHS officials told us that they intend to increase their total staff to 900 FTEs by FY 2010.



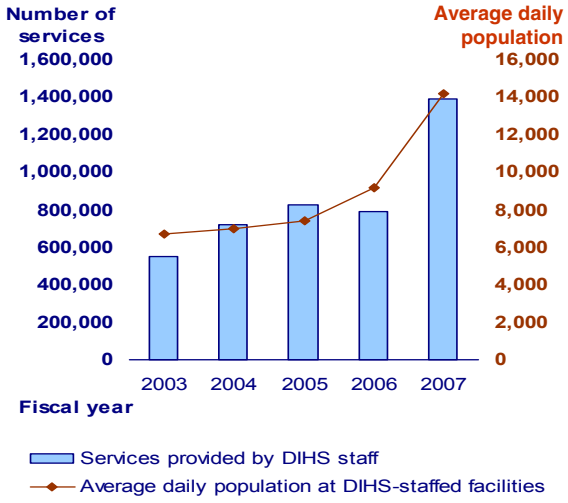
Note: These FTE data reflect staff at DIHS-staffed facilities, and do not include any staff at approximately 508 IGSAs.

Source: DHS.

2: Health care spending, staffing, and services

Total reported number of health care services DIHS provided to detainees increased, FY 2003–FY 2007

- The total number of health care services provided by DIHS more than doubled from FY 2003 through FY 2007.
- These data do not include health care services provided at approximately 508 IGSAs, because ICE does not routinely collect data on services provided at the facilities DIHS does not staff.



Note: These data reflect services provided at DIHS-staffed facilities and the average daily population at DIHS-staffed facilities. A "health care service" represents one encounter with a medical official or specially-trained detention officer.

Source: GAO analysis of DHS data.

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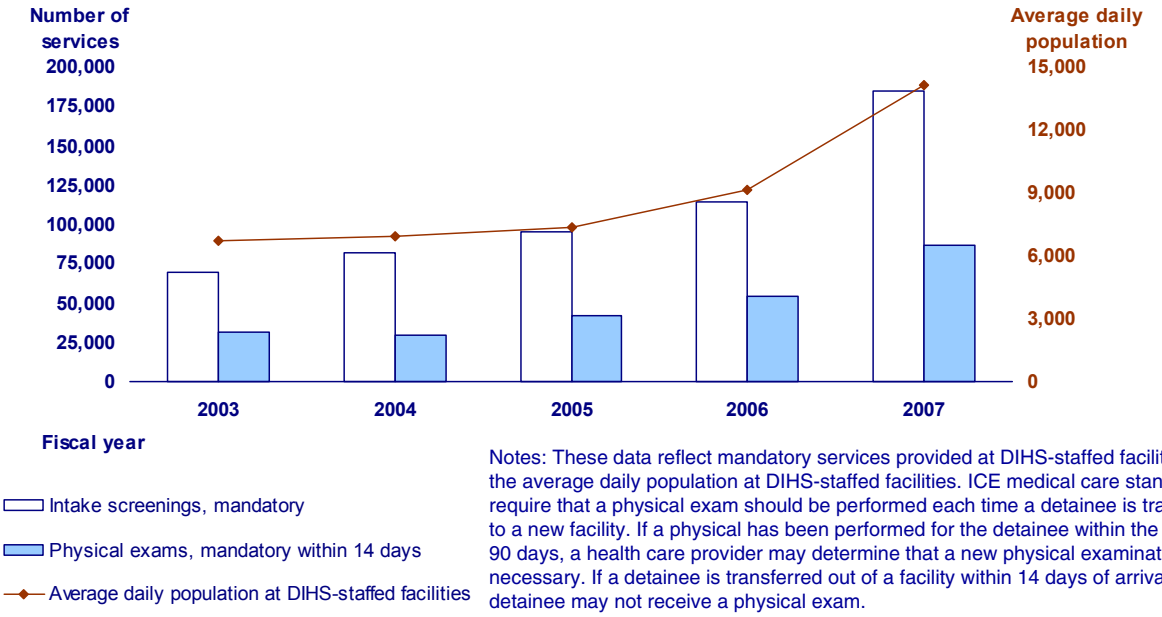
2: Health care spending, staffing, and services

DIHS reported increasing numbers of mandatory services, FY 2003–FY 2007

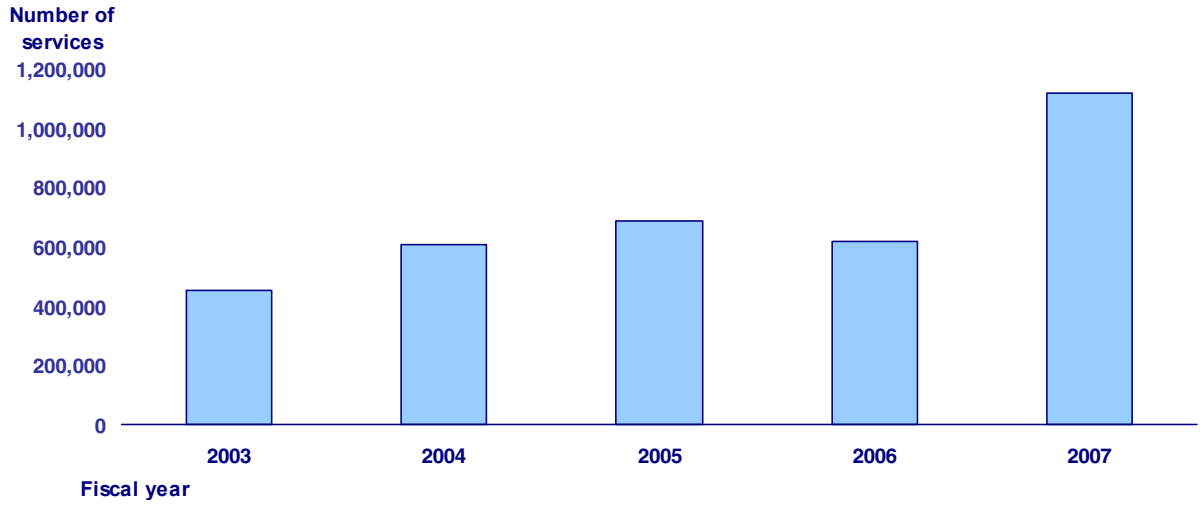


Notes: These data reflect mandatory services provided at DIHS-staffed facilities and the average daily population at DIHS-staffed facilities. ICE medical care standards require that a physical exam should be performed each time a detainee is transferred to a new facility. If a physical has been performed for the detainee within the last 90 days, a health care provider may determine that a new physical examination is not necessary. If a detainee is transferred out of a facility within 14 days of arrival, the detainee may not receive a physical exam.

Source: GAO analysis of DHS data.

2: Health care spending, staffing, and services

Reported number of need-based health care services provided by DIHS increased 148 percent, FY 2003–FY 2007



Notes: These data reflect services provided at DIHS-staffed facilities only. Need-based health care includes any services provided beyond mandatory intake screenings and physical exams. The specific types of need-based services that DIHS provides are shown in appendix I.

Source: GAO analysis of DHS data.

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3: ICE's mortality rate cannot be directly compared with BOP's or USMS's mortality rate due to differences in the agencies' health care goals, scopes of services, and population demographics

- The agencies' health care goals and the health care services each agency provides to their detainees differ. Also, lengths of stay and demographic data vary among ICE, BOP, and USMS detainee populations.

- Because of these differences, direct, meaningful comparisons between the three agencies' mortality rates cannot be made.

3: Agency comparisons

Average lengths of stay, health care goals, and health care services of ICE, BOP, and USMS differ

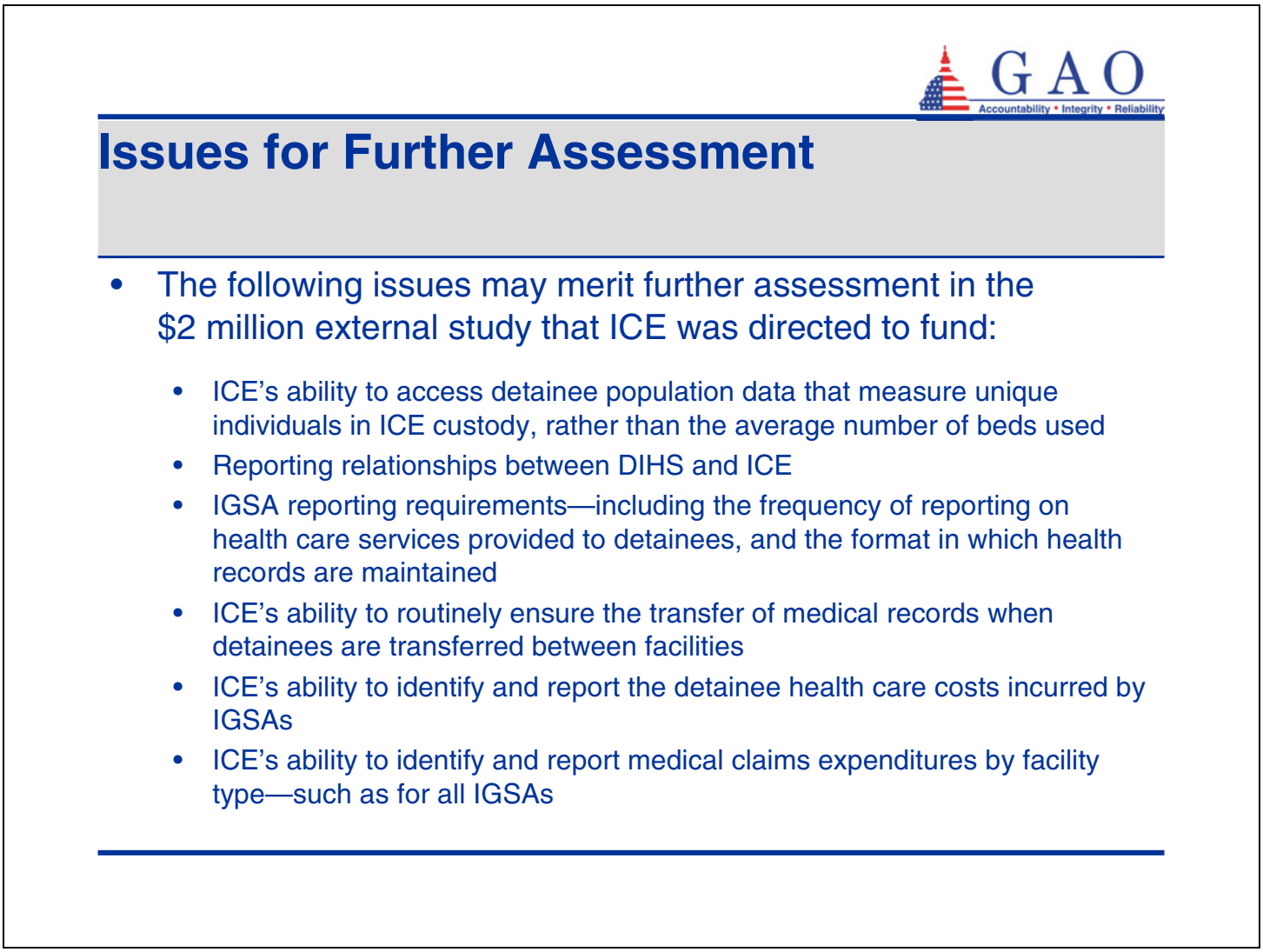
	ICE	BOP	USMS
Average length of stay	FY 2007 reported average length of stay: 37.1 days	Average sentence length as of July 1, 2007: 10.3 years	Not recorded
Health care goals	Access to health care within ICE's scope of service	Health maintenance throughout imprisonment	No health care goal
Health care services provided	Medically necessary, including some chronic and some preventive	Medically necessary, including chronic and preventive	Medically necessary, including some chronic

Source: DHS, BOP, and USMS.

3: Agency comparisons

Mortality rates for ICE, BOP, and USMS cannot be compared

- Limited availability of ICE data prevents meaningful mortality analyses.
  - According to DHS officials, some relevant information is unknown—such as detainees' comprehensive health histories.
  - Some relevant information within each detainee's file is not consistently recorded in standardized medical terms—such as detainees' causes of death.
- Differences among the ICE, BOP, and USMS populations prevent meaningful mortality comparisons.
  - The three populations exhibit different lengths of stay, average age, and other demographic information that would be needed to reliably compare the respective mortality rates.
  - The number of deaths in custody from FY 2004 through FY 2007 is low relative to the overall average daily population for the same time period.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Issues for Further Assessment
• The following issues may merit further assessment in the $2 million external study that ICE was directed to fund:
• ICE's ability to access detainee population data that measure unique individuals in ICE custody, rather than the average number of beds used
• Reporting relationships between DIHS and ICE
• IGSA reporting requirements—including the frequency of reporting on health care services provided to detainees, and the format in which health records are maintained
• ICE's ability to routinely ensure the transfer of medical records when detainees are transferred between facilities
• ICE's ability to identify and report the detainee health care costs incurred by IGSAs
• ICE's ability to identify and report medical claims expenditures by facility type—such as for all IGSAs

Appendix I:
DIHS health care services included in our analysis

- Mandatory services:
  - Intake screenings
  - Physical exams
- Need-based care service categories:
  - Sick call visits—scheduled visits for non-emergency health care requests
  - Urgent care visits—unscheduled visits for detainees who require a medical response
  - Dental health visits
  - Mental health visits
  - Chronic disease visits
  - Short stay unit visits—observation unit stays for detainees who have been determined to require close monitoring, but do not require a hospital stay
  - Pill line distributions—single distributions of prescription or over-the-counter medications

Enclosure II

Comments from the Department of Homeland Security

U.S. Department of Homeland Security
Washington, DC 20528

Homeland Security

February 11, 2009

Ms. Alicia Puente Cackley
Acting Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Cackley:

RE: Draft Report GAO-09-308R, DHS: Organizational Structure and Resources for Providing Health Care to Immigration Detainees (GAO Job Codes 290755 and 290727)

The Department of Homeland Security (DHS) appreciates the opportunity to review and comment on the presentation slides that were used in the U.S. Government Accountability Office's (GAO's) briefing of Congressional staff members and the GAO draft report based on those slides. The draft report and updated briefing slides included as an enclosure have no recommendations.

GAO's draft report presented information about three topics: (1) an assessment of whether the mortality rates of detainees held in U.S. Immigration and Customs Enforcement (ICE) custody can be compared with the mortality rates of prisoners held by the U.S. Marshals Service or incarcerated with the Federal Bureau of Prisons; (2) information about ICE's annual spending and staff resources devoted to providing health care for detainees, and the number of services provided; and (3) the ICE organizational structure for providing health care to detainees.[1]

GAO found that "the number of deaths in [ICE] custody from FY 2004 through FY 2007 is low relative to the overall average daily [detainee] population for the same time period." GAO also found that ICE substantially increased its funding and staffing for detainee health care in the FY 2003 – FY 2007 period examined. Indeed, GAO likely underreported ICE's actual spending on detainee health since "no data [is] available on the cost of health care services provided by IGSA [intergovernmental service agreement]

[1] Included in the information about ICE's structure, GAO also reviewed and reported on "the relevant agreements between DHS and HHS [the Department of Health and Human Services] regarding DIHS [the HHS Division of Immigration Health Services]. As the report notes, ICE contracts with HHS personnel within the U.S. Public Health Service to provide certain health care services to detainees.

www.dhs.gov

staff.[2]" These findings are notable, given that many detainees have received no or minimal health care in their lives prior to the initial medical screening the detainee receives in ICE custody.

ICE provided GAO significant documentary evidence and testimonial information about its organizational structure for providing health care to detainees but believes the GAO presentation needs further clarification.

The GAO draft report and slides pertaining to DIHS do not clearly differentiate between the HHS entity with that name and the similarly-named ICE program. For example, GAO's assertion that "[a]ccording to DHS officials, DIHS is now located within ICE" could lead to the incorrect conclusion that the HHS entity or its public health personnel were transferred to ICE, which has not occurred. Instead, ICE established its own organization, that it also named DIHS, to preclude confusion in the field. While this helps field personnel, it is understandable that GAO could misunderstand.

This confusion between the HHS and ICE entities bearing the same name is further reflected in GAO's erroneous assertion that the professional health providers within the HHS DIHS "report" to ICE's Office of Detention and Removal Operations (DRO). The implications of this confusion are profound, so it is important to state that ICE does not impinge on the professional autonomy of the health care providers providing services to detainees, and any contrary impression is inaccurate. The providers remain HHS employees.

Other information in the GAO briefing slides would also benefit from additional context, and ICE representatives welcome the opportunity to provide further clarification to members of Congress and their staffs at the upcoming hearing on detainee health care by the House Appropriations Committee, Subcommittee on Homeland Security that is currently scheduled for March 3, 2009.

For example, the GAO updated briefing slides imply that ICE lacks basic information about the cost of health care services provided to detainees housed at IGSA contract facilities. However, a cost for basic health care services is built into the daily rate of reimbursement for IGSAs, and a standard model is applied as it pertains to population volume. In addition, ICE uses the Treatment Authorization Request (TAR) system as a tool for authorizing payment for services provided to ICE detainees. TAR can identify health-related medical procedures, consultations, off-site specialist visits, hospitalizations and emergency room visits. The TAR captures services detainees need beyond routine medical care. This information can be obtained for both DIHS staffed facilities and IGSAs.

[2] ICE houses detainees in a mix of Federally owned and administered service processing centers and contract detention facilities that are not owned by the Federal government and for which ICE executes an intergovernmental service agreement (IGSA) with the state and local government or private sector owner.

Similarly, GAO reports that "the average detainee is booked into about 2 facilities while in ICE custody," but provides no context about ICE's operational needs in any given decision to transfer a detainee, including the efficient carrying out of a removal, affording the detainee access to the courts, or even providing access to medical treatment.

Technical comments have been provided under separate cover.

Sincerely,

Jerald E. Levine
Director
Departmental GAO/OIG Liaison Office

(290755)