

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MOST INDIAN HEALTH SERVICE
PURCHASED/REFERRED CARE PROGRAM
CLAIMS WERE NOT REVIEWED,
APPROVED, AND PAID IN ACCORDANCE
WITH FEDERAL REQUIREMENTS**

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Office of Inspector General

<https://oig.hhs.gov>

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Report in Brief

Date: April 2020

Report No. A-03-16-03002

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

OIG has identified longstanding challenges, including insufficient oversight and limited access to specialists, that likely impact the quality of healthcare services provided to the American Indian and Alaskan Native community by the Indian Health Service (IHS). IHS provides eligible American Indians and Alaskan Natives with healthcare services through a network of federally or tribally operated healthcare providers. Through the Purchased/Referred Care (PRC) Program, IHS pays for private providers to deliver healthcare services unavailable through the IHS network.

We conducted this audit because of the significant magnitude and growth of IHS PRC Program funds and because previous OIG and Government Accountability Office reports highlighted concerns with the program.

Our objective was to determine whether IHS PRC Program claims were paid in accordance with Federal requirements.

How OIG Did This Audit

We reviewed 802,470 claims paid between October 2013 and June 2016 for 120,818 beneficiaries. These claims totaled \$672.4 million. We selected a random sample of 100 claims to measure PRC Program compliance with 9 Federal requirements. We reviewed only IHS-administered PRC program services.

Most Indian Health Service Purchased/Referred Care Program Claims Were Not Reviewed, Approved, and Paid In Accordance With Federal Requirements

What OIG Found

Of the 100 claims in our sample, 18 were paid in accordance with Federal requirements; however, the other 82 were not. These 82 claims did not meet 1 or more of the 9 requirements that we evaluated. The claims did not meet requirements for (1) beneficiary eligibility, (2) medical necessity and priority, (3) timeliness of notification of healthcare services, (4) IHS status as payor of last resort, (5) timeliness of claim approval, and (6) timeliness of claim payments. These errors occurred because IHS did not have controls in place to prevent its Referred Care Information System (RCIS) from accepting claims missing information. In addition, IHS and providers did not conduct timely tracking of certain processes, and providers did not always submit completed claims.

Based on our sample results, we estimated that 658,025 of the 802,470 total claims were not paid in accordance with Federal requirements.

What OIG Recommends and IHS Comments

We recommend that IHS (1) establish an edit in the RCIS to enforce the requirement that each beneficiary submits documentation showing that he or she meets the geographic component of IHS's eligibility requirements, (2) educate PRC Program staff about the importance of documenting their review of medical necessity and priority-level requirements, (3) conduct outreach to beneficiaries and providers to ensure they submit notifications of healthcare services within 72 hours (or 30 days for elderly and disabled beneficiaries), and (4) pay for healthcare services only after receiving all required alternate resource documentation and resolving all information gaps. We also made additional procedural recommendations.

IHS concurred with the intent of our first recommendation, concurred with the remaining recommendations, and described corrective actions that it plans to take or has already taken. IHS also provided additional support and suggested adjustments to certain numbers. We incorporated IHS's suggested adjustments as appropriate. We maintain that the facts of our report are valid and agree with the corrective actions that IHS has taken and plans to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Office of Inspector General (OIG) has identified longstanding challenges, including insufficient oversight and limited access to specialists, that likely reduce the quality of healthcare services provided to the American Indian and Alaska Native (AI/AN) community by the Indian Health Service (IHS). IHS provides eligible AI/ANs with healthcare services through a network of federally operated and tribally operated healthcare providers and urban Indian clinics. Through the Purchased/Referred Care (PRC) Program, IHS pays for private providers to deliver healthcare services unavailable through the IHS network. Total funding for the PRC Program grew 23.5 percent from \$779.9 million in fiscal year (FY) 2011 to \$963.5 million in FY 2019.

We conducted this audit because of the magnitude and growth of IHS PRC Program funds and because previous OIG and Government Accountability Office (GAO) reports highlighted concerns with the PRC Program.¹ Specifically, these reports addressed concerns related to Tribes paying more than the Medicare rates, issues with the timeliness of claim processing and PRC referrals, and issues regarding quality of care.

OBJECTIVE

Our objective was to determine whether IHS PRC Program claims were paid in accordance with Federal requirements.

BACKGROUND

The Indian Health Service

Within the Department of Health and Human Services, IHS's mission is to partner with AI/ANs to elevate their physical, mental, social, and spiritual health to the highest level. The goal of IHS is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all of the approximately 2.6 million people of the 574 federally recognized Tribes.

Each year, Congress appropriates funds for IHS programs. Over 60 percent of the IHS appropriation is administered by Tribes, primarily through self-determination contracts or self-

¹ *IHS Contract Health Services Program: Overpayments and Potential Savings* (OEI-05-08-00410), issued September 2009; *Capping Payment Rates for Nonhospital Services Could Save Millions for Contract Health Services* (GAO-13-272), issued April 2013; and *Opportunities May Exist To Improve the Contract Health Services Program* (GAO-14-57), issued December 2013.

governance compacts.² In FY 2018, IHS allocated approximately \$2.3 billion for direct-care services provided by federally and tribally operated hospitals, health centers, and health stations.

IHS Program Administration

Located in Rockville, Maryland, IHS headquarters provides general direction, policy development, and support for each of the 12 Area Offices³ and their healthcare delivery sites, which include hospitals, urgent-care clinics, and other types of facilities. Area Offices oversee the delivery of health services and provide administrative and technical support to the federally operated hospitals and clinics of the 170 geographically defined service units.⁴ In addition, each Area Office has staff dedicated to common services such as finance, administrative support, information technology, public health programs, and environmental health. See Appendix B for IHS-administered Area Office PRC Program expenditures for FYs 2014 through 2016.

IHS maintains its current policies, procedures, and operating standards in the Indian Health Manual (IHM). The IHM is the reference for IHS staff regarding IHS-specific policy and procedural information.⁵

IHS Purchased/Referred Care Program Overview

The PRC Program⁶ is integral to providing comprehensive healthcare services to AI/ANs. The IHS health system delivers care through direct-care services provided in IHS, Tribal, and Urban Indian health facilities (e.g., hospitals and clinics) and through PRC services provided by non-IHS providers. The general purpose of PRC is for IHS and Tribal facilities to purchase services from private healthcare providers in situations in which (1) no IHS or Tribal direct-care facility exists, (2) the existing direct-care service provider is incapable of providing required emergency or specialty care, (3) utilization of the direct-care service exceeds existing staffing, or

² Titles I and V of the Indian Self-Determination and Education Assistance Act (ISDEAA) (P.L. No. 93-638) allow Tribes to assume control and management of programs and services previously administered by the IHS. Since 1992, IHS has entered into agreements with Tribes and Tribal organizations to plan, conduct, and administer programs authorized under sections 102 and 504 of the ISDEAA.

³ Area Offices: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland, and Tucson. IHS has direct-care facilities in every Area except for the Alaska and California Areas.

⁴ A service unit is an administrative subunit of an IHS Area that is responsible for providing IHS services within a particular geographic area. Service units may be operated by IHS or a Tribe.

⁵ IHS, IHM, chapter 1, part 1, § 1-1.2. On February 28, 2019, IHS updated IHM, part 2, chapter 3, "Purchased/Referred Care." For this audit, we used the version that took effect on May 8, 2008, because it was in effect during our audit period. All IHM citations in this report are to the May 8, 2008, version.

⁶ IHS, "Purchased/Referred Care History." Available online at <https://www.ihs.gov/prc/history/>. Accessed on May 8, 2019. The program name changed from the Contract Health Services program to the PRC Program during our audit period. Throughout this report, we refer to the program as the PRC Program.

(4) supplementation of alternate resources (e.g., Medicare, Medicaid, or private insurance) is required to provide comprehensive healthcare to eligible AI/ANs. PRC services may include inpatient, outpatient, laboratory, dental, radiological, pharmaceutical, and ambulatory services.

The PRC Program process consists of three stages. The process begins when a beneficiary is either admitted for emergency healthcare services or submits a request for nonemergency healthcare services. First, the IHS Area determines whether the beneficiary is eligible for PRC Program services. Second, the IHS Area assesses the beneficiary's requested healthcare services and decides whether to approve the healthcare services. Finally, the IHS Area coordinates billing and payment on the claim.

PRC Program guidelines require AI/ANs to provide verifiable documentation to support why the requested or claimed healthcare services qualify for the PRC Program. The combination of an increasing AI/AN population, limited funding, medical cost inflation, and limited competitive pricing options makes strict adherence to program guidelines vital to ensuring that the PRC resources are used in the most effective manner.

IHS Purchased/Referred Care Program Eligibility

PRC Program services are available to persons of AI/AN descent. To be eligible for PRC Program services, an individual must reside within the United States on a federally recognized reservation or within a PRC delivery area.⁷ The individual must also be a member of a Tribe located on the reservation where the member resides or maintain close economic and social ties with a Tribe located on that reservation.⁸

Exceptions exist for students who are temporarily absent from their PRC delivery area because of full-time study and individuals who are temporarily absent from the PRC delivery area because of travel or employment. Other persons who leave the PRC delivery area and are neither students nor individuals absent because of travel or employment continue to be eligible for PRC Program services for up to 180 days after their departure.⁹ A non-AI/AN woman pregnant with an eligible AI/AN's child is also eligible for PRC services during her pregnancy and the postpartum period (generally about 6 weeks after delivery).¹⁰ Service areas may also have additional local eligibility rules. If local eligibility rules and Federal requirements conflict, Federal requirements prevail.¹¹

⁷ The PRC delivery area encompasses the reservation, the counties that border the reservation, and other specified lands (42 CFR § 136.22(a)(6)).

⁸ 42 CFR § 136.23(a).

⁹ 42 CFR §§ 136.23(b) and (c).

¹⁰ 42 CFR § 136.12(a).

¹¹ IHS, IHM, part 2, chapter 3, 2-3.6(b).

IHS Purchased/Referred Care Program Service Approval Process

The PRC Program is not an entitlement program; thus, when there are insufficient funds to provide the volume of PRC services requested or claimed, services are determined on the basis of relative medical need in accordance with established medical priorities.¹² To qualify for the PRC Program, healthcare services that an eligible individual needs must be medically necessary and not available at an accessible IHS or Tribal facility.¹³ In addition, all nonemergency healthcare services must be approved by the IHS Area's PRC committee before the healthcare services are provided, and beneficiaries or their representatives must notify IHS within 72 hours after any emergency healthcare services are provided. Elderly and disabled beneficiaries have 30 days to notify IHS of emergency healthcare services.¹⁴

The IHS Area's PRC review committees review PRC referral requests and claims to determine medical priority and rank based on relative medical need. PRC review committees review both emergency and nonemergency healthcare services; the review occurs after emergency healthcare services are provided but before nonemergency healthcare services can be provided. If the PRC review committee determines that requested nonemergency healthcare services do not have a high enough medical priority, it may not approve the referral. (See Figure 1 on the following page.) The IHS medical priority levels are Priority Level I – Emergent or Acutely Urgent Care Services, Priority Level II – Preventive Care Services, Priority Level III – Primary and Secondary Care Services, Priority Level IV – Chronic Tertiary Care Services, and Priority Level V – Excluded Services.¹⁵

IHS has 5 days to either approve or deny the nonemergency notification of requested healthcare service or the emergency healthcare service claim. During the 5 days, IHS ensures that it has adequate funds to cover those services that are authorized in accordance with IHS-approved policies and procedures and to ensure that eligible beneficiaries receive treatment for the most serious illnesses and injuries.¹⁶

¹² IHS, IHM, part 2, chapter 3, 2-3.8.

¹³ IHS, IHM, part 2, chapter 3, 2-3.5.

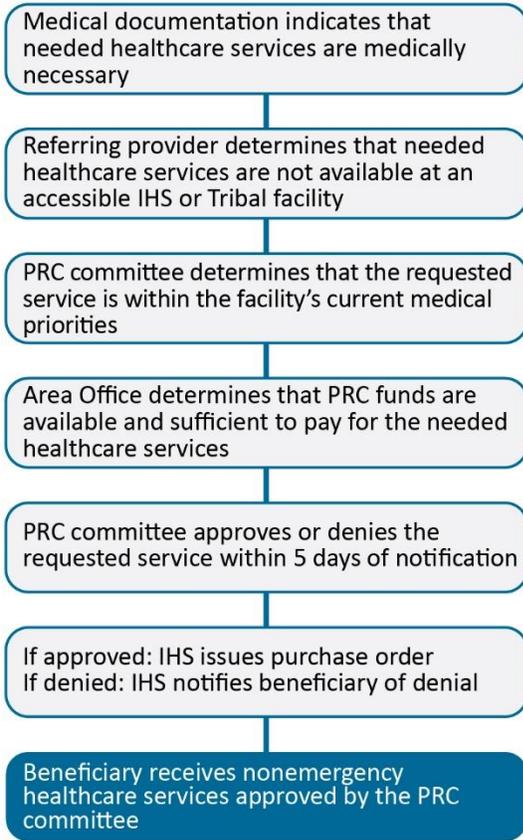
¹⁴ IHS, IHM, part 2, chapter 3, 2-3.9.

¹⁵ IHS, IHM, part 2, chapter 3, 2-3.21.

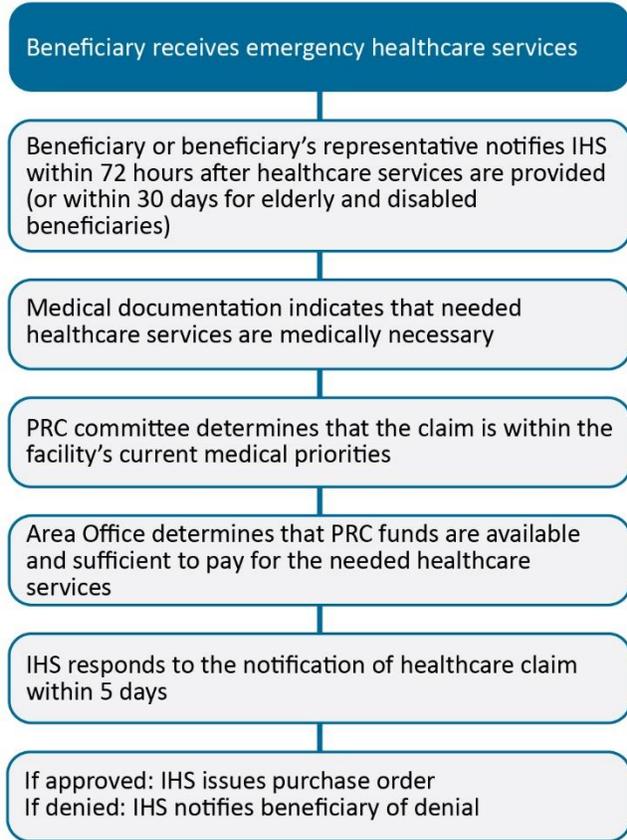
¹⁶ IHS, IHM, part 2, chapter 3, 2-3.22.

Figure 1: Purchased/Referred Care Program Service Approval Process

For nonemergency healthcare services:



For emergency healthcare services:



After this process is complete, all approved emergency and nonemergency claims begin the claim payment process.

IHS Purchased/Referred Care Program Claim Payment Process

The PRC Program is the payor of last resort.¹⁷ Before the PRC Program makes a payment, the beneficiary must apply for and expend all available alternate resources (e.g., Medicare, Medicaid, private insurance, and State or other health programs). (See Figure 2.) IHS issues a purchase order to a provider authorizing payment for services; the purchase order states which alternative resources were applied to the claim. IHS sets annual goals for issuing purchase orders in a timely manner.

After the services have been provided and authorized by a purchase order, the provider submits the claim with an explanation of benefits to the fiscal intermediary, which processes and pays the claim at Medicare-like rates within 30 days of the date of submission as required by IHS payment policy.

The Referred Care Information System

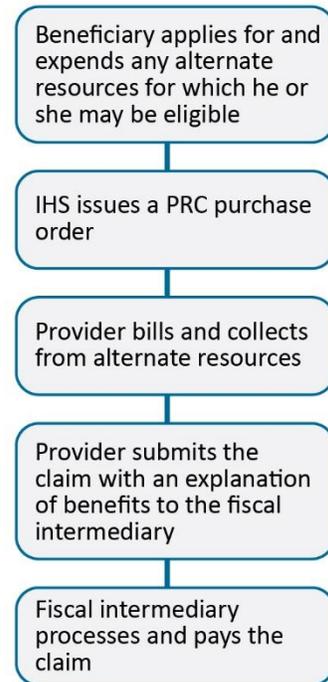
IHS's Referred Care Information System (RCIS) automates the referral process and maintains records on referred care services. The RCIS tracks all referred care, including referrals to IHS or Tribal providers, other non-IHS facilities, and external contracted providers. The RCIS functions allow each IHS facility to customize options to meet its needs.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 802,470 claims paid between October 1, 2013, and June 30, 2016 (audit period), for 120,818 beneficiaries. These claims totaled \$672.4 million paid by IHS's fiscal intermediary, BlueCross BlueShield of New Mexico, for 10 IHS-administered Areas. We audited only claims for IHS-administered PRC Program services and did not audit those PRC Program services that were tribally administered.

We selected and audited a random sample of 100 paid claims to measure PRC Program compliance with Federal requirements. Specifically, we audited the claims to determine whether the PRC Program claims were paid in accordance with Federal requirements located at 42 CFR section 136 for (1) beneficiary eligibility, (2) medical necessity and priority, (3) availability of funds, (4) timeliness of notification of healthcare services, (5) IHS status as

Figure 2: Purchased/Referred Care Program Claim Payment Process



¹⁷ 42 CFR § 136.61.

payor of last resort, (6) timeliness of claim approval, (7) timeliness of purchase orders, (8) timeliness of claim payment, and (9) use of a Medicare-like payment rate.¹⁸

We conducted this performance audit 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.

Appendix A contains the details of our audit scope and methodology, Appendix C contains the details of our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

Of the 100 claims in our sample, 18 were paid in accordance with Federal requirements; however, the other 82 were not. These 82 claims did not meet 1 or more of the 9 requirements that we evaluated. The claims did not meet requirements for:

- beneficiary eligibility (9 claims),
- medical necessity and priority (11 claims),
- timeliness of notification of healthcare services (36 claims),
- IHS status as payor of last resort (16 claims),
- timeliness of claim approval (32 claims), and
- timeliness of claim payment (4 claims).

These errors occurred because IHS did not have controls in place to prevent the RCIS from accepting claims missing residence information, Tribal association information, and committee review documentation. In addition, IHS and providers did not conduct timely tracking of certain processes, and providers did not always submit completed claims.

Sampled claims met the other three Federal requirements that we evaluated, which were (1) availability of funds, (2) timeliness of purchase orders, and (3) use of a Medicare-like payment rate.

Based on our sample results, we estimated that 658,025 of the 802,470 total claims were not paid in accordance with Federal requirements.

¹⁸ We did not determine the dollar amount associated with incorrect payments.

THE PURCHASED/REFERRED CARE PROGRAM DID NOT MEET BENEFICIARY ELIGIBILITY REQUIREMENTS

Federal Requirements

The PRC Program pays for healthcare services provided to persons of AI/AN descent belonging to the AI/AN community served by IHS or Tribal facilities and programs (42 CFR § 136.12). An individual may be eligible for IHS services if he or she is regarded as AI/AN by the community in which he or she lives as evidenced by Tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in Tribal affairs, or other relevant factors in keeping with Bureau of Indian Affairs general regional practice (42 CFR § 136.12(a)). The IHM, section 2-3.6, states that an AI/AN claiming eligibility for PRC Program services is responsible for furnishing the IHS Area's Chief Executive Officer (CEO) with verifiable documentation to substantiate his or her claim of eligibility for healthcare services. This section of the IHM also states that each facility should establish a policy on documentation that AI/AN may use as proof of eligibility.

To be eligible for PRC Program services, an individual generally must either reside within the United States on a reservation located within a PRC delivery area or reside within a PRC delivery area and either:

- be a member of a Tribe located on a reservation or a member of a Tribe for which the reservation was established or
- maintain close economic and social ties with a Tribe either located on the reservation or for which the reservation was established (42 CFR § 136.23(a)).

Unless otherwise established by the Tribe, an individual with close economic and social ties is defined as an individual who:

- is employed with a Tribe whose reservation is located within the PRC delivery area in which the individual lives,
- is married to an eligible member of the Tribe, or
- has been determined by the Tribe to have close economic and social ties with the Tribe whose reservation is located within the PRC delivery area in which the individual resides and has a certification to that effect from the Tribe (IHM § 2-3.6(C)).

There are certain exceptions to this eligibility criteria for pregnant non-AI/AN women and eligible AI/AN individuals temporarily absent from their regular PRC delivery area. A non-AI/AN woman pregnant with an eligible AI/AN's child is eligible for PRC Program services during her pregnancy and through the end of the postpartum period, which is generally about 6 weeks after delivery. If the woman is not married to the eligible AI/AN under applicable State or Tribal law, paternity must be acknowledged in writing by the AI/AN or determined by order of a court

of competent jurisdiction. In addition, foster children, full-time students, transients, and other individuals may receive exceptions to the geographic requirement (42 CFR § 136.23).

Eligibility Documentation Was Missing

Of the 100 claims in our sample, we found that 9 were paid without the necessary documentation to establish that the beneficiary met eligibility requirements. Specifically, provider and IHS files for the beneficiaries associated with eight claims listed only a post office (P.O.) box for the beneficiary's address, and the files for the beneficiary associated with one claim did not provide documentation that the beneficiary was either a member of a Tribe or an individual with close economic or social ties to a Tribe.

For the eight claims that listed a P.O. box for the beneficiary's address, the beneficiary's file did not include a physical address or other descriptions or indicators to show that the beneficiaries resided on a federally recognized reservation or within a PRC Program delivery area.¹⁹ For the claim missing Tribal membership information or documentation of close economic or social ties to a Tribe, the claim did not include a Tribal enrollment number, and the beneficiary's file listed the beneficiary as a non-Tribal member, listed the beneficiary's Indian blood quantum²⁰ as "unspecified," and did not include any other evidence that the beneficiary met the PRC Program's eligibility criteria.

Based on our sample results, we estimated that 72,222 of the 802,470 claims did not meet eligibility requirements.

These errors occurred because the RCIS did not have system edits in place and IHS facilities did not have controls in place to prevent staff from accepting claims that used a P.O. box as the address documenting eligibility for PRC Program services and claims that had missing Tribal association documentation. As a result, IHS may have provided and paid for PRC Program services for ineligible individuals.

¹⁹ We concluded that a claim that listed a P.O. box as the beneficiary's address had an eligible address if the claim also had a physical address or other description or indicator showing that the beneficiary lived on a federally recognized reservation or within a PRC delivery area.

²⁰ Blood quantum is the degree of Indian blood as computed from ancestors of Indian blood who were listed on a roll or other document acceptable to the Secretary of the Interior or his or her authorized representative. The Certificate of Degree of Indian Blood is issued by the Department of the Interior's Bureau of Indian Affairs.

THE PURCHASED/REFERRED CARE PROGRAM DID NOT MEET MEDICAL NECESSITY AND PRIORITY REQUIREMENTS

Federal Requirements

According to 42 CFR section 136.23(e), if funds are insufficient to provide the necessary amount of PRC Program services for a population residing in a PRC Program delivery area, the IHS Area must establish a medical priorities list formulated on the basis of relative medical need.

Under IHM Exhibit 2-3-D, each IHS Area's CEO should establish PRC review committees to authorize payment for PRC Program referrals in compliance with the IHS Area's medical priorities list. Among other things, the committee determines whether the beneficiary is eligible for PRC Program services and if the service being requested or claimed meets the medical necessity requirements and then assigns a priority level to the service being requested or claimed.

Committee Review Documentation Was Missing

Of the 100 claims in our sample, 11 did not have documentation showing that committee review occurred before the claim was approved. IHS paid these 11 claims without this documentation.

Based on our sample results, we estimated that 88,272 of the 802,470 claims did not meet medical necessity and priority requirements.

These errors occurred because PRC staff did not document committee review in the RCIS, and providers either did not send records to IHS or sent incomplete records to IHS. For example, for one claim, IHS stated that the committee did not review the request for services because the provider did not submit documentation. When not all requested or claimed services are subjected to committee review, lower priority and less medically necessary claims may be approved before higher priority and more medically necessary claims. As a result of these errors, claims were paid without committee review.

THE PURCHASED/REFERRED CARE PROGRAM DID NOT MEET NOTIFICATION OF HEALTHCARE SERVICES REQUIREMENTS

Federal Requirements

Federal regulations at 42 CFR section 136.24(c) state that in emergency cases, the AI/AN, an individual or agency acting on behalf of the AI/AN, or the AI/AN's medical care provider must notify an IHS official of the admission or treatment of the AI/AN within 72 hours after the AI/AN begins treatment or is admitted to a healthcare facility. The 72-hour period may be extended if the provider determines that notification within the prescribed period was impracticable or that other good cause exists for the failure to notify IHS in a timely manner.

The Indian Health Care Improvement Act (IHCIA), 25 U.S.C. section 1646, allows elderly and disabled individuals 30 days to notify IHS of emergency medical care received from non-IHS medical providers or at non-IHS medical facilities.

Even though the Federal regulation establishes a 72-hour timeframe for IHS notification, IHS stated that its practice is to encourage providers to notify IHS and submit claims within 10 days after services are complete. Therefore, we accepted as allowable all claims submitted within 10 days after services were complete (30 days for elderly and disabled AI/AN).

Notifications of Healthcare Services Were Not Submitted in a Timely Manner

For 36 claims in our sample, we found that neither the providers nor the beneficiaries notified IHS within 72 hours (30 days for elderly and disabled AI/AN) as required that emergency services had been provided. In addition, providers did not submit claims within 10 days of providing services. Providers submitted the 36 claims for healthcare services between 12 and 821 days after the services were provided.

For example, a beneficiary was admitted to the hospital on August 2, but neither the hospital nor the beneficiary notified IHS about the healthcare services until November 20, which was 110 days after admission. Because the hospital began providing healthcare services on the day the beneficiary was admitted and because the beneficiary was neither elderly nor disabled, IHS should have been notified within 72 hours of admission. If the beneficiary had been elderly or disabled, the hospital and the beneficiary would have had 30 days to notify IHS.

Based on our sample results, we estimated that for 288,889 of the 802,470 claims neither the beneficiary nor the provider submitted the claim or notified IHS within 10 days in accordance with the IHS notification requirement.

These errors occurred because IHS and healthcare providers did not adhere to the policies in place. When notifications of healthcare services are not submitted in a timely manner, claims processing may be delayed, and the PRC Committee may not have accurate information about availability of funds.

THE PURCHASED/REFERRED CARE PROGRAM DID NOT COMPLY WITH PAYOR OF LAST RESORT REQUIREMENTS

Federal Requirements

IHS is the payor of last resort for persons eligible for the PRC Program and is not responsible for payment for PRC Program services if the beneficiary is eligible for an alternate resource such as private insurance, Medicaid, or Medicare (42 CFR § 136.61). In addition, the IHM, section 2-3.8, states that an individual is required to apply for an alternate resource if there is reasonable indication that the individual may be eligible for the alternate resource.

The RCIS User Manual, section 3.10.2, states that if the beneficiary has possible alternate resources, IHS must send a letter (Written Notice, Patient Requirement for Application

Alternate Resources) to the beneficiary asking him or her to apply to that alternate resource. It also states that in accordance with IHS regulations at 42 CFR part 136, subpart C,²¹ a patient is required to make a good-faith effort to complete an application for alternate resources. The letter gives the beneficiary all of the pertinent referral information needed for the patient to comply.

Alternate Resource Documentation Was Not Submitted to IHS

For 16 claims in our sample, beneficiaries did not provide documentation to IHS indicating whether they had alternate resources.

Based on our sample results, we estimated that for 128,395 of the 802,470 claims, beneficiaries did not provide documentation to IHS indicating whether they had alternate resources.

These errors occurred because IHS did not ensure that all beneficiaries completed the Written Notice, Patient Requirement for Application Alternate Resources, which documents whether the beneficiary had alternate resources. For those claims with missing alternate resource documentation, IHS paid the claims as though the beneficiary had no alternate resources. As a result, IHS may have paid for services that a third party was responsible for paying.

IHS DID NOT MEET REQUIREMENTS FOR APPROVING PURCHASED/REFERRED CARE PROGRAM CLAIMS

Federal Requirements

Section 220 of the IHCA directs the PRC Program to issue an approval or a denial within 5 days of notification of healthcare service claims. Section 220 states that if IHS does not respond to a notification of a healthcare services claim within 5 working days, IHS must accept and approve the healthcare services claim.

Claims Were Not Approved Within the Required Timeframe

IHS did not approve 32 claims for services in our sample within 5 days as required. The 32 claims included 22 of the 71 emergency claims in our sample and 10 of the 29 nonemergency claims in our sample. For example, one claim was approved 41 days after it was submitted. For this claim, IHS was notified on April 22, 2015, but did not approve the claim until June 2, 2015.

Based on our sample results, we estimated that 256,790 of the 802,470 claims were not approved within 5 days as required.

These errors occurred because PRC committees did not follow established procedures for approving or denying claims within 5 days. Because IHS did not approve claims within 5 days,

²¹ The RCIS User Manual references 42 CFR part C, but this citation does not exist; the reference is likely to 42 CFR part 136, subpart C.

provider payments may have been delayed. Also, if IHS does not respond to claims in a timely manner, it may be required to accept claims that should be denied.

IHS DID NOT MEET REQUIREMENTS FOR PAYING PURCHASED/REFERRED CARE PROGRAM CLAIMS

Federal Requirements

The IHM, section 2-3.22, states that “The Service shall pay a completed contract care service claim within 30 days after completion of the claim, in accordance with the Prompt Payment Act 31 U.S.C. 3901.”

Once IHS approves a healthcare service, the provider submits the corresponding claim to IHS’s fiscal intermediary for payment. To conform to Federal prompt payment requirements,²² IHS’s contract²³ and quality control plan with its fiscal intermediary requires that 97 percent of complete claims must be paid within 30 calendar days of claim submission.

Claims Were Not Paid Within the Required Timeframe

IHS’s fiscal intermediary did not pay four complete claims in our sample within 30 days of the date of submission.

Based on our sample results for complete claims, we estimated that 32,099 of the 802,470 claims were not paid within 30 days from the date of submission.

These errors occurred because IHS did not have procedures in place to track claims submitted for payment, and because of human error. As a result, IHS could be liable for paying interest for claim payments that were not paid within 30 days. IHS was not required to pay interest on any of the claims in our sample but confirmed that of the 802,470 claims we reviewed, it paid interest on 7,595. On April 29, 2019, IHS stated that it had begun monitoring claim payments on a monthly basis.

THE PURCHASED/REFERRED CARE PROGRAM MET REQUIREMENTS FOR AVAILABILITY OF FUNDS, TIMELINESS OF PURCHASE ORDERS, AND USE OF A MEDICARE-LIKE PAYMENT RATE

Availability of Funds Requirement Was Met

An officer or employee of the United States Government may not make or authorize an expenditure or obligation exceeding the amount available in an appropriation or involve the Government in a contract or obligation for the payment of money before an appropriation is

²² 5 CFR § 1315.4(g).

²³ IHS Fiscal Intermediary Contract §§ 6.1 and 3.2.4.1.1.

made unless authorized by law (31 U.S.C. § 1341). PRC Program funds are no-year funds which do not have a definite period of availability for obligation.

PRC Program funds were correctly appropriated to cover expected healthcare service costs, and the expenses did not exceed appropriated funds. In addition, the PRC Program was funded with no-year funds. Therefore, IHS complied with requirements for availability of funding when administering the PRC Program.

Timeliness of Purchase Orders Requirement Was Met

The Government Performance and Results Modernization Act of 2010 (GPRA standards) (P.L. No. 111-352) requires Federal agencies to demonstrate that they are using their funds effectively to meet their missions. The GPRA standards require agencies to set specific annual targets for specific performance measures and report their results at the end of each year. IHS's GPRA standards goal for 2014, 2015, and 2016 was to issue purchase orders in an average of 74 days from the service end date, thereby notifying the fiscal intermediary that a claim is ready to be processed.

For the 100 claims in our sample, IHS met its timeliness goal by issuing purchase orders in an average of 73.7 days. IHS also indicated that it was establishing two new tracking procedures to further improve timeliness of purchase orders.

Medicare-Like Payment Rate Requirement for Medicare Part A Claims Was Met

According to 42 CFR section 136.30, hospital inpatient and outpatient services under Medicare Part A²⁴ should be paid at no more than Medicare-like rates. Hospital outpatient services under Part B²⁵ are not subject to the Medicare-like rate requirement, and IHS facilities were not required to pay claims at the Medicare-like rate before March 21, 2017.

During our audit period, IHS paid the Part A hospital inpatient claims in our sample at Medicare-like rates. IHS was not required to pay Part B hospital outpatient service claims at the Medicare-like rate during our audit period. After our audit period, new requirements went into effect; those requirements stated that Part B hospital outpatient service claims must be paid at Medicare-like rates. Therefore, IHS met the Medicare-like rate requirement in effect during our audit period.

²⁴ Medicare Part A covers Medicare inpatient care, including care received while in a hospital; a skilled nursing facility; and, in limited circumstances, at home.

²⁵ Medicare Part B covers medical services and supplies that are medically necessary to treat a health condition. These services and supplies include outpatient care, preventive services, ambulance services, and durable medical equipment. Part B also covers part-time or intermittent home health and rehabilitative services such as physical therapy.

RECOMMENDATIONS

We recommend that the Indian Health Service:

- establish an edit in the RCIS to enforce the requirement that each beneficiary submits documentation showing that he or she meets the geographic component of IHS's eligibility requirements,
- educate PRC Program staff about the importance of documenting their review of medical necessity and priority-level requirements,
- conduct outreach to beneficiaries and providers to ensure that they submit notifications of healthcare services within 72 hours (or 30 days for elderly and disabled beneficiaries),
- pay for healthcare services only after receiving all required alternate resource documentation and resolving all information gaps,
- educate providers about informing beneficiaries that they must notify IHS if they have alternate resources that may cover health services,
- reeducate PRC Program staff about the importance of reviewing and responding to notifications of healthcare services on a timely basis, and
- work with IHS's fiscal intermediary to ensure that the fiscal intermediary pays completed claim requests within 30 days of claim submission and work with providers to ensure that they submit accurate and complete claims in a timely manner.

IHS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, IHS agreed with the intent of our first recommendation and concurred with the other six recommendations. In comments on our first recommendation, IHS stated it has developed a new form to manually track residency requirements instead of establishing a system edit. The form was released for use on September 23, 2019.

IHS also outlined the corrective actions that it has taken and plans to take to address the other six recommendations. These corrective actions include (1) educating PRC staff about medical necessity and priority level requirements and monitoring compliance with these requirements, (2) developing a poster for outreach and education on the requirement for notification of PRC authorizations, (3) educating PRC staff about the required documentation for alternative resources that cover health services and monitoring compliance with this requirement, (4) developing an online training module for providers about determining whether beneficiaries have alternative resources that cover health services, (5) updating the IHS training modules to train PRC staff about responding timely to notifications of healthcare services, and (6) working with the fiscal intermediary to avoid late payments and educating providers about submission

of complete and accurate claims. However, IHS did not agree with certain numbers cited in our draft report and provided additional support and suggested adjustments to those numbers.

We adjusted certain numbers in this report as appropriate based on the additional support IHS provided. However, we disagree with IHS about the number of sample claims that did not meet requirements for timely notification of emergency healthcare services and timely claim approval. IHS interpreted these requirements to apply to only a subset of emergency claims and determined whether that subset of emergency claims met these two requirements.²⁶ However, the timely notification of emergency healthcare services requirement applies to all emergency claims, and the timely approval of claims requirement applies to all emergency and nonemergency claims. In correspondence we received after IHS's official reply, IHS staff acknowledged that the timely approval requirement applies to all claims, both emergency and nonemergency. We maintain that the facts of our report are valid and that the corrective actions IHS described will help to ensure that claims are paid in accordance with Federal requirements.

IHS's comments are included in their entirety as Appendix E.

²⁶ IHS only reviewed emergency claims that resulted from beneficiaries self-referring themselves for emergency healthcare services and did not review those emergency claims that resulted from an IHS provider referring beneficiaries to emergency healthcare services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 802,470 claims paid between October 1, 2013, and June 30, 2016, for 120,818 beneficiaries. These claims totaled \$672,372,428 paid by IHS's fiscal intermediary, BlueCross BlueShield of New Mexico, for 10 IHS-administered Area Offices. We audited only claims for IHS-administered PRC Program services and did not audit those PRC Program services that were tribally administered.

We selected and audited a random sample of 100 paid claims to measure PRC Program compliance with Federal requirements. Specifically, we audited the claims to determine whether the PRC Program claims were paid in accordance with Federal requirements located at 42 CFR part 136 for (1) beneficiary eligibility, (2) medical necessity and priority, (3) availability of funds, (4) timeliness of notification of healthcare services, (5) IHS status as payor of last resort, (6) timeliness of claim approval, (7) timeliness of purchase orders, (8) timeliness of claim payment, and (9) use of a Medicare-like payment rate.

We did not audit the overall internal control structure of each Area Office. Rather, we audited only those internal controls related to our objective. We limited our audit to determining whether PRC Program claims were paid in accordance with Federal requirements.

We conducted our fieldwork from August 2016 to April 2019 at IHS's headquarters in Rockville, Maryland.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable PRC Program requirements;
- reviewed the RCIS User Manual;
- met with IHS officials to obtain background information regarding PRC Program budget and expenditures (Appendix C), performance measures and controls, and administration and claim processing;
- selected a random sample of 100 claims from the database of paid claims and determined whether those claims complied with Federal requirements; and
- discussed audit results and recommendations with IHS officials.

We conducted this performance audit 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.

**APPENDIX B: IHS-ADMINISTERED AREA OFFICE PURCHASED/REFERRED CARE PROGRAM
EXPENDITURES FOR FISCAL YEARS 2014 THROUGH 2016**

Service Area*	FY 2014	FY 2015	FY 2016	Total
Albuquerque	\$22,152,382	\$17,989,184	\$8,960,891	\$49,102,457
Bemidji	9,412,468	8,326,876	3,640,425	21,379,769
Billings	55,502,368	56,609,785	20,024,693	132,136,846
Great Plains	72,530,706	68,523,950	30,917,616	171,972,272
Nashville	2,150,245	1,606,447	264,212	4,020,904
Navajo	50,434,484	34,168,072	17,697,920	102,300,476
Oklahoma	40,945,467	40,318,240	17,008,798	98,272,505
Phoenix	35,431,260	23,410,399	9,072,060	67,913,719
Portland	6,355,028	5,144,800	1,950,054	13,449,882
Tucson	5,334,106	4,926,564	1,562,928	11,823,598
Total	\$300,248,514	\$261,024,317	\$111,099,597	\$672,372,428

* These are the 10 IHS-administered Area Offices. We did not review the other two Area Offices, California and Alaska, because they lack IHS-operated hospitals or clinics.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of inpatient and outpatient claims paid between October 1, 2013, and June 30, 2016, to PRC Program providers for beneficiaries IHS deemed eligible for services under PRC Program guidelines.

SAMPLING FRAME

The sampling frame was an Excel spreadsheet of 802,470 PRC Program claims totaling \$672,372,428 that were paid between October 1, 2013, and June 30, 2016.

SAMPLE UNIT

The sample unit was a PRC Program claim.

SAMPLE DESIGN

We used a simple random sample to evaluate the PRC Program claims.

SAMPLE SIZE

We selected a sample of 100 PRC Program claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services, statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the 802,470 claims. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG, Office of Audit Services, statistical software to estimate the percentage of PRC Program claims improperly paid during our audit period. We ran a separate estimate for each of the nine reviewed characteristics and used the lower limit of the 90-percent confidence interval. We also used the software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Results

Claims in Sample Frame	Sample Size	Eligibility Errors	Medical Necessity or Priority Errors	Timely Submission of Notification Errors	Payor of Last Resort Errors	Timeliness of Claim Approval Errors	Timeliness of Claim Payment Errors
802,470	100	9	11	36	16	32	4

Statistical Estimates

(Limits Calculated for a 90-Percent Confidence Interval)

	Percentage			Number		
	Lower Limit	Point Estimate	Upper Limit	Lower Limit	Point Estimate	Upper Limit
Claims With Eligibility Errors	4.776%	9.000%	15.179%	38,325	72,222	121,808
Claims With Medical Necessity or Priority Errors	6.293	11.000	17.550	50,497	88,272	140,832
Claims With Timely Submission of Notification Errors	28.004	36.000	44.634	224,725	288,889	358,172
Claims With Payor of Last Resort Errors	10.301	16.000	23.281	82,666	128,395	186,824
Claims With Timeliness of Claim Approval Errors	24.314	32.000	40.508	195,114	256,790	325,062
Claims With Timeliness of Claim Payment Errors	1.378	4.000	8.919	11,057	32,099	71,574
Overall Error Rate	74.486%	82.000%	88.031%	597,728	658,025	706,419

APPENDIX E: IHS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

DEC 12 2019

Indian Health Service
Rockville, MD 20857

To: Acting Inspector General

From: Principal Deputy Director

Subject: IHS Comments on OIG Draft Report: *Most Indian Health Service Purchased/ Referred Care Program Claims Were Not Reviewed, Approved, and Paid in Accordance With Federal Requirements*, A-03-16-03002

We appreciate the opportunity to review the draft Office of Inspector General (OIG) audit report titled *Most Indian Health Service Purchased/Referred Care Program Claims Were Not Reviewed, Approved, and Paid in Accordance With Federal Requirements*, A-03-16-03002. The IHS concurs with six of the seven recommendations and the intent of the remaining one OIG recommendation. However, the IHS disagrees with certain aspects of the findings leading to the conclusions in the broad title of the OIG report. As more fully detailed in the comments below, the IHS reviewed the specific OIG findings and disagrees with most of the “errors” in the categories audited, including: 1) timely submission of notifications; and 2) timeliness of claim approval. Regarding timely submission of notifications, the OIG identified 38 errors. The IHS reviewed the same data provided to the OIG and identified only two errors. Regarding timeliness of claim approval, the OIG identified 45 errors. The IHS reviewed the same data provided to the OIG and identified only 7 errors.

Below you will find a status update describing the status of actions taken to date to implement the OIG recommendations, and those planned in the near future.

OIG Recommendation No. 1 – The IHS concurs with the intent of this recommendation. *Establish an edit in the RCIS to enforce the requirement that each beneficiary submits documentation showing that he or she meets the geographic component of IHS’s eligibility requirements.*

Status of actions planned or taken to address Recommendation 1:

The Referred Care Information System (RCIS) is a referral software application in the Resource and Patient Management System (RPMS) that pulls demographic data from the Patient Registration software application in RPMS and is used in the direct care setting in the IHS. IHS direct care eligibility rules do not impose geographical limitations on beneficiaries for direct care. Geography is an additional eligibility factor only for the Purchased/Referred Care (PRC) program. Many IHS beneficiaries do not have the documentation that the IHS requires to verify their address because they do not have an established home address, use a post office box, or they may be homeless. In response to these circumstances, the IHS developed form IHS-976,

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Purchased/Referred Care Proof of Residency (PRF), to document residency in order to determine PRC eligibility. The form was released for use on September 23, 2019. Its use will improve the residency verification and documentation process for all beneficiaries. Evidence of the release of the new form is available upon request by the OIG.

OIG Recommendation No. 2 – The IHS concurs with this recommendation.
Educate PRC Program staff about the importance of documenting their review of medical necessity and priority-level requirements.

Status of actions planned or taken to address Recommendation 2:

IHS Headquarters PRC staff and Area PRC Officers will develop a corrective action plan to educate and monitor compliance with this requirement. Completion of this effort is expected by April 1, 2020.

OIG Recommendation No. 3 – The IHS concurs with this recommendation.
Conduct outreach to beneficiaries and providers to ensure that they submit notifications of healthcare services within 72 hours (or 30 days for elderly and disabled beneficiaries).

Status of actions planned or taken to address Recommendation 3:

The IHS developed a poster for outreach and education on notification for PRC authorization. The poster was approved on August 29, 2019, and provided to Area PRC Officers for distribution. Evidence of the release of the new poster is available upon request by the OIG.

Additional IHS Comments on OIG's findings

The 72-hour notification requirement in 42 Code of Federal Regulations (CFR) 136.24(c) applies to emergency cases. The similar provision in 42 CFR 136.24(b) applies to patient self-referrals in non-emergency cases, but patients typically are not self-referring for non-emergency care. Instead, the IHS PRC referral request originates within the service (e.g., when an IHS provider initiates a referral request for a beneficiary to receive health care services from a non-IHS provider) and the 72-hour notification requirement does not apply. Out of the 100 sample claims, the IHS identified 25 claims that involved self-referrals. Only 2 of those 25 self-referrals did not meet the 72-hour notification rule as required in 42 CFR 136.24. The other 75 claim referral requests were generated by IHS providers and do not invoke the requirements of 42 CFR 136.24. With regard to the example in the report, the IHS notes that the patient's notification was documented under the original referral number. This can be seen on the RCIS referral display dated May 4, 2017, 08:09:49, page 1 of 7. Subsequent claims related to this episode of care are recorded under the original referral number, with a suffix indicating order of receipt. The claim for air transport was received on December 12, 2013, and added to the original referral record with suffix A5 as indicated on RCIS referral display dated May 4, 2017,

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08:10:12, page 1 of 2. Additionally, the 10-day timeframe for submitting claims stated under the Provider Responsibilities on the IHS- 843-1A, Order for Health Services is a recommendation, not a requirement. According to 42 CFR 424.44(a)(1), unless certain exceptions are met “...the claim must be filed no later than the close of the period ending 1 calendar year after the date of service.” This filing deadline was incorporated into PRC payment rules. See, e.g., 42 CFR 136.30(h)(3) (adopting Medicare filing rules). According to IHS review, except for possibly 1 to 2 claims, all the claims met this requirement.

OIG Recommendation No. 4 – The IHS concurs with this recommendation.

Pay for healthcare services only after receiving all required alternate resource documentation and resolving all information gaps.

Status of actions planned or taken to address Recommendation 4:

IHS Headquarters PRC staff and Area PRC Officers will develop a corrective action plan to educate and monitor compliance with this requirement. Completion of this effort is expected by April 1, 2020. The IHS is updating the online PRC training modules, with an expected completion date of October 1, 2020. Once updated, the IHS will require all PRC staff to take the online training as a refresher course and will also require all new PRC staff to take the training during orientation to the PRC program. The IHS will conduct training sessions on PRC internal controls and authorities at the annual IHS Partnership Meeting and educate participants on the importance of responding timely to notification of health care services. The IHS has partnered with the Centers for Medicare & Medicaid Services, National Indian Health Board, and the National Congress of American Indians to provide alternate resource education, outreach, and enrollment events for IHS beneficiaries. The IHS has staff designated to assist beneficiaries in enrolling in alternate resources. The IHS will continue outreach and education and assistance in enrolling in alternate resources to beneficiaries.

OIG Recommendation No. 5 – The IHS concurs with this recommendation.

Educate providers about informing beneficiaries that they must notify IHS if they have alternate resources that may cover health services.

Status of actions planned or taken to address Recommendation 5:

The IHS will conduct education and outreach to PRC providers annually. The IHS will develop an online training module for providers, with completion expected by July 1, 2020. The IHS has developed educational posters that were approved on August 29, 2019, and have been provided to Area PRC Officers for use. The IHS will encourage Area and PRC programs to distribute the educational material to providers and to post this information within their facilities.

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IHS Comments on OIG Draft Report: *Most Indian Health Service Purchased/Referred Care Program Claims Were Not Reviewed, Approved, and Paid in Accordance With Federal Requirements*, A-03-16-03002

OIG Recommendation No. 6 – The IHS concurs with this recommendation.
Reeducate PRC Program staff about the importance of reviewing and responding to notifications of healthcare services on a timely basis.

Status of actions planned or taken to address Recommendation 6:

The IHS is currently updating the online training modules for PRC staff, with an expected completion date of October 1, 2020. Once updated, the IHS will require all PRC staff to take the online training as a refresher course and will also require all new PRC staff to take the training during orientation to the PRC program. The IHS will conduct training sessions on PRC internal controls and authorities at the annual IHS Partnership Meeting and educate participants on the importance of responding timely to notification of health care services. IHS Headquarters PRC staff and Area PRC Officers will develop a corrective action plan to educate and monitor compliance with this requirement. Completion of this effort is expected to be by April 1, 2020.

Additional IHS Comments on OIG's Findings

The IHS would like to note there is a difference between the requirements relating to notification of services and notification of a claim. 25 U.S.C. § 1621s requires the IHS to respond to a notification of a claim by a provider of a PRC service with either an individual purchase order or a denial of the claim within 5 working days after receipt of such notification. The five-day rule is usually triggered when providers submit claims in response to patient self-referrals, since prior authorization from the IHS has not been obtained. Typically, this requirement does not apply to non-emergency services, because a purchase order has been issued before the non-emergency services are provided. When a purchase order has not been issued in advance, the IHS may accept a claim as valid for PRC services when the notification of a claim contains the information required by 136.202 and meets the requirements of 42 CFR 136.24. According to the IHS review of the 100 sample claims, there were only 7 claims that did not meet the five-day rule. As for the example in the report, the IHS determined that the claim did meet the five-day rule. Notification for this case was received on March 14, 2016. According to the Medical History and Care Review Comments on RCIS referral display, May 11, 2017, 09:56:43, page 3 of 3, medical records and final charges were required before the case could be sent to review committee. On April 14, 2016, PRC staff indicated that all the necessary information was received. The case went to the review committee within 5 days and was approved on April 19, 2016.

OIG Recommendation No. 7 –The IHS concurs with this recommendation.
Work with IHS's fiscal intermediary to ensure that the fiscal intermediary pays completed claim requests within 30 days of claim submission and work with providers to ensure that they submit accurate and complete claims in a timely manner.

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Status of actions planned or taken to address Recommendation 7:

The IHS monitors late payments on a monthly basis. The IHS will continue to work with the fiscal intermediary (FI) to avoid late payments by encouraging the FI to push all payments prior to Unified Financial Management System (UFMS) closure monthly and at year end. The IHS will conduct education and outreach to PRC providers annually to include education on submission of complete and accurate claims.

Additional IHS comments on OIG's findings

The IHS identified four claims that did not meet the required timeframe. These four claims were paid 31-36 days after receipt. There was one claim paid on the 30th day; the IHS does not consider this a late payment. Three of the four late payments were due to UFMS year-end closure activities and the fourth was due to UFMS closure for system upgrades. The IHS acknowledges that systems closures are not the only reason for late payments. The IHS Office of Resource Access and Partnerships (ORAP) monitors late payments on a monthly basis. The FI contract standards maintain that 97 percent of all clean claims must be processed within 30 days. During the audit review period from January 2014 – June 2016, the FI maintained a 99.1 percent timeliness rate. During the past five years, 2014 – 2018, the FI maintained a 98.8 percent timeliness rate.

If you have specific questions about this response or to request documentation to support the information provided, please contact CDR John Rael, Director, ORAP, IHS, by telephone at (301) 443-0969, or Ms. Athena Elliott, Director, Office of Management Services, IHS, at (301) 443-5104.



for RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service