



Report to the Ranking Member,
Committee on Homeland Security,
House of Representatives

February 2016

IMMIGRATION DETENTION

Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care

GAO Highlights

Highlights of [GAO-16-231](#), a report to the Ranking Member, Committee on Homeland Security, House of Representatives

Why GAO Did This Study

DHS is responsible for providing safe, secure, and humane confinement for detained aliens who may be subject to removal or have been ordered removed from the United States. GAO was asked to examine the provision and oversight of medical care in immigration detention facilities. This report examines the extent to which DHS (1) has processes for administering detainee medical care and maintaining cost information for care, (2) monitors and assesses compliance with medical care standards, and (3) oversees processes to obtain and address complaints about detainee medical care.

GAO reviewed ICE data and information on costs, detention population, standards, and oversight for 165 facilities that held detainees for more than 72 hours in fiscal year 2015. GAO also reviewed complaint processes, interviewed DHS and ICE officials, and visited 12 facilities selected based on detainee population and facility type, among other factors. The visit results are not generalizable, but provided insight to the provision of medical care.

What GAO Recommends

GAO recommends that DHS, among other things, ensure payments for medical care are supported by authorizations, conduct trend analyses of oversight data, and track all medical complaints received by DHS entities. DHS concurred with the recommendations and identified planned actions to address the recommendations.

View [GAO-16-231](#). For more information, contact Rebecca Gambler at (202) 512-8777 or gambler@gao.gov.

February 2016

IMMIGRATION DETENTION

Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care

What GAO Found

The Department of Homeland Security's (DHS) U.S. Immigration and Customs Enforcement (ICE) oversees basic on-site medical care at all facilities, as required by ICE detention standards, but does not maintain complete information about medical care costs. The ICE Health Service Corps (IHSC) provided direct care to detainees at 19 over-72-hour facilities and oversaw care at the remaining 146 non-IHSC-staffed facilities in fiscal year 2015. At all facilities, IHSC uses an electronic system, the Medical Payment Authorization (MedPAR) system, to approve or deny off-site care requests for detainees; such requests could include dental visits or surgical needs. IHSC uses a system different from MedPAR to track costs or amounts paid for off-site care. The use of separate systems limits ICE's ability to link approvals and payments. For example, the number of claims paid for fiscal years 2012 through 2014 did not correspond to the number of IHSC MedPAR approvals for requested services for the same time period. While there are valid reasons for these differences, such as that approvals and claims could be made in different fiscal years, establishing a mechanism to more fully ensure that payments for off-site care are supported by the appropriate authorizations could help ICE monitor medical care costs and better validate payments.

ICE conducts medical care compliance inspections at individual facilities, but conducts limited analyses of inspection data across facilities and over time. ICE uses seven oversight mechanisms to monitor facilities' compliance with medical care detention standards, such as facility inspections and on-site detention monitors. The combined use of these oversight mechanisms resulted in more than 99 percent of ICE's average daily population (ADP) of approximately 28,000 detainees being covered by two or more mechanisms in fiscal year 2015. ICE's priority has been to focus on local, facility-specific issues rather than perform overarching analyses. For example, ICE does not utilize the data gathered through these mechanisms in a way that examines overall trends in medical care deficiencies. Conducting analysis of oversight data over time, by detention standards, and across facilities, consistent with internal control standards, could strengthen ICE's ability to manage and oversee the provision of medical care across facility types.

DHS has various processes to obtain and address the hundreds of medical care complaints it receives annually. Specifically, detainees can submit complaints regarding medical care directly to facilities or to one of various DHS entities, including the Office of Inspector General and Office for Civil Rights and Civil Liberties. These entities generally determine whether to take their own action on the complaints or forward them to ICE for resolution. These entities maintain complaint data in various ways, and IHSC, which is ultimately responsible for addressing medical complaints received, is developing and piloting a new system for managing tasks, including addressing complaints. However, internal control standards call for evaluation of performance over time, and it is unclear whether IHSC's new system will capture all medical complaints received by DHS or facilitate analyses of complaints over time and across facilities. Ensuring that a new tasking system would capture all complaints and facilitate analysis could improve DHS's decision-making for detainee medical care.

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Abbreviations

ADP	average daily population
AOR	area of responsibility
CBP	U.S. Customs and Border Protection
CMD	Custody Management Division
CRCL	Office for Civil Rights and Civil Liberties
DHS	Department of Homeland Security
DRIL	Detention and Reporting Information Line
DSM	Detention Service Managers
ERO	Enforcement and Removal Operations
FMC	Field Medical Coordinator
ICE	U.S. Immigration and Customs Enforcement
IGSA	intergovernmental service agreement
IHSC	ICE Health Service Corps
JIC	Joint Intake Center
JICMS	Joint Integrity Case Management System
MedPAR	Medical Payment Authorization Request
NDS	National Detention Standards
ODO	Office of Detention Oversight
OIG	Office of the Inspector General
OPR	Office of Professional Responsibility
ORSA	Operational Review Self-Assessment
PBNS	Performance-Based National Detention Standards
UAC	unaccompanied alien children
USMS	U.S. Marshals Service
VAFC	Veterans Affairs Financial Services Center

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February 29, 2016

The Honorable Bennie G. Thompson
Ranking Member
Committee on Homeland Security
House of Representatives

Dear Mr. Thompson,

The Department of Homeland Security's (DHS) U.S. Immigration and Customs Enforcement (ICE) is responsible for the apprehension, detention, and removal of aliens from the United States. Related to detention in particular, ICE has a responsibility to provide safe, secure, and humane confinement for detained aliens in the United States who may be subject to removal while they await the resolution of their immigration cases or who have been ordered removed from the United States. ICE detained an average daily population (ADP) of approximately 38,000 detainees in fiscal year 2014 and approximately 32,000 detainees in fiscal year 2015.¹ ICE addresses the medical needs of the detained population through a range of medical care services—from routine exams and tuberculosis screenings to off-site emergency room visits and chronic disease interventions. Non-governmental organizations and immigration advocacy groups have expressed concerns with the provision, quality, and oversight of medical care for detainees in ICE custody. For example, in July 2015, six non-governmental organizations jointly filed a complaint to DHS on behalf of women and children setting forth allegations of inadequate medical care at ICE's family residential centers.

ICE is responsible for overseeing medical care at immigration detention facilities, which are confinement facilities operated by or pursuant to a

¹This figure includes unaccompanied alien children housed by the Office of Refugee Resettlement in the Department of Health and Human Services, as well as individuals participating in the Mexican Interior Repatriation Program, a voluntary program that returns Mexican nationals found to be in the Sonora Arizona desert region of the United States unlawfully to their places of origin in the Mexican interior. Federal law requires that DHS maintain at least 34,000 detention beds. See Department of Homeland Security (DHS) Appropriations Act, 2016, Pub. L. No. 114-113, div. F, tit. II, 129 Stat. 2242; see also DHS Appropriations Act, 2015, Pub. L. No. 114-4, tit. II, 129 Stat. 39, 43; DHS Appropriations Act, 2014, Pub. L. No. 113-76, div. F, tit. II, 128 Stat. 5, 251.

contract or agreement with ICE that routinely hold persons for over 24 hours pending resolution or completion of immigration removal operations or processes. Within ICE, Enforcement and Removal Operations (ERO) oversees the confinement of ICE detainees across facilities in accordance with immigration detention standards. ERO's Custody Management Division (CMD) manages the planning and acquisition of detention facilities and oversees the regular monitoring and inspection of facilities for standards compliance. The ICE Health Service Corps (IHSC), within ERO, oversees the administration and costs of medical care at all detention facilities and directly provides care to approximately 40 percent of detainees. IHSC also addresses complaints regarding detainee medical care received by other DHS components. The Office of Detention Oversight (ODO), within ICE's Office of Professional Responsibility (OPR), serves as an oversight body for ERO and conducts periodic inspections of a sample of detention facilities. The Joint Intake Center (JIC), operated by OPR and U.S. Customs and Border Protection (CBP) Internal Affairs, receives allegations of misconduct involving ICE and CBP employees and contractors and assigns the information for appropriate action or investigation. The JIC also receives complaints from detainees, as does the ICE Detention and Reporting Information Line (DRIL) helpline. Within DHS, both the Office of the Inspector General (OIG) and the Office for Civil Rights and Civil Liberties (CRCL) receive complaints through telephone, mail, and electronic communication regarding detainee medical care at facilities.

In October 2014, we reported on ICE's management and oversight of immigration detention facility standards and costs.² Specifically, we found that, while ICE had various mechanisms to collect and assess data on detention costs, it did not have complete data for the tracking and managing of costs across facilities and facility types. Errors in the recording of data by ICE field operators produced limitations that made it difficult for ICE to accurately record expenditures for all facilities, including those for medical care. We also found that ICE's oversight mechanisms resulted in differing inspection results, and that ICE offices did not have sufficient communication about inspection results to determine whether the oversight mechanisms functioned as intended. We recommended that ICE assess the extent to which it has appropriate internal controls for

²GAO, *Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Facility Costs and Standards*, [GAO-15-153](#) (Washington, D.C.: Oct. 10, 2014).

tracking and managing detention facility costs and develop additional controls as necessary, and that ICE review the reasons for differences between inspection results and assess the extent to which differences reflect broader issues with the inspection mechanisms themselves to help ensure that the mechanisms work as intended. DHS concurred and subsequently reported on ongoing actions taken to address these recommendations.

You asked us to review DHS's allocation of medical care resources, its assessment of compliance with medical standards in detention facilities, and its processes for addressing medical care complaints filed by or on behalf of detainees. This report addresses the following questions: To what extent does DHS (1) have processes for administering medical care to immigration detainees and maintaining information on costs associated with care, (2) monitor and assess compliance with medical care standards at detention facilities, and (3) oversee processes to obtain and address complaints about medical care in immigration detention facilities?

To address these questions, we assessed DHS's cost maintenance, oversight, and grievance processes at 165 facilities used by ICE in fiscal year 2015 to hold detainees for periods longer than 72 hours. This report focuses on over-72-hour facilities because detainees are more likely to need medical attention when held for longer periods of time. We visited a purposive, non-generalizable sample of 12 detention facilities in Arizona, California, Illinois, Maryland, Missouri, Texas, and Wisconsin. We selected these facilities to reflect a mix of factors, such as facility type, detention standards governing the facility, the ICE Field Office Area of Responsibility, ADP, and recommendations made by DHS and non-governmental organizations that work with immigration detainees. We interviewed ERO field office officials, facility personnel, and detainees about medical care at facilities. The information we obtained from our facility visits cannot be generalized to all facilities or detainees, but offers insight into the processes used by DHS to provide and oversee detainee medical care.

To determine the processes of administering medical care to detainees, we reviewed ICE documents, including the IHSC Policy Manual, a July 2015 IHSC Operational Memorandum, and other documentation related to its mission of overseeing and providing medical care to detainees. In addition, we interviewed relevant ICE headquarters and regional officials, as well as ICE and detention facility officials associated with visits to 12 facilities about the processes of providing medical care. To determine the extent to which DHS maintains information on the costs associated with

medical care, we reviewed information about authorizations and payments for off-site care for over-72-hour facilities operating in fiscal years 2012 through 2014. To determine the reliability of medical claims and expenditure data, we reviewed documentation and a prior GAO report, and interviewed agency officials. We determined that some of these data were sufficiently reliable to provide a general indication of approximate costs for some, but not all, medical care expenditures. We discuss these data in more detail later in the report. We assessed ICE practices for administering off-site medical care and the agency efforts to track and utilize cost data against *Standards for Internal Control in the Federal Government*.³

To determine the extent to which DHS monitors compliance with medical care standards, we analyzed the percentage of ADP covered by each of ICE's oversight mechanisms in 2015, the year for which the most recent data were available. Specifically, we determined which individual over-72-hour facilities utilized various oversight mechanisms—detention standards inspections, medical care audits, ODO inspections, and on-site monitoring—and calculated their ADP as a percentage of ICE's total fiscal year 2015 ADP using ICE population data. To determine the reliability of these data, we reviewed ICE documentation and interviewed officials knowledgeable about the creation, use, and storage of the data. We determined that these data were sufficiently reliable for our purposes. We also identified overlapping oversight mechanisms to determine the percentage of ADP covered by multiple forms of oversight. We reviewed ICE documents and interviewed agency officials to determine how each oversight mechanism is intended to function. To determine the extent to which DHS assesses medical care compliance at facilities, we reviewed ICE documents and interviewed agency officials to determine use of inspection results, and assessed whether DHS uses results in accordance with *Standards for Internal Control in the Federal Government*.⁴

To determine the extent to which DHS oversees immigration detention medical care complaint mechanisms, we analyzed and compared CRCL, DRIL, IHSC, JIC, and OIG processes for obtaining and addressing

³GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington D.C.: Nov. 1999).

⁴[GAO/AIMD-00-21.3.1](#).

complaints; analyzed fiscal year 2014 complaint data—the most recent data maintained by these DHS entities’ data systems at the time of our review; and reviewed ICE detention and family residential standards that govern facility grievance systems. We also reviewed and analyzed CMD, ODO, and Operational Review Self-Assessment (ORSA) grievance standard inspection data for calendar and fiscal year 2014 to assess the extent to which inspections found deficiencies in grievance standards. To determine the reliability of the complaint and inspection results data, we reviewed documentation, interviewed agency officials, and conducted testing. We determined that CRCL, DRIL, JIC, and OIG complaint data, and CMD, ODO, and ORSA inspection data were sufficiently reliable for our purposes. We chose not to use IHSC’s data on complaints because IHSC’s system did not include all complaints IHSC addressed in fiscal year 2014. Specifically, DRIL complaints addressed by IHSC were not included in IHSC’s data system until fiscal year 2015. We also interviewed DHS, ICE, and facility officials about their guidance, procedures, and any complaint data maintained; and assessed processes against applicable detention standards and *Standards for Internal Control in the Federal Government*.⁵ Additional details on our scope and methodology are contained in appendix I.

We conducted this performance audit from October 2014 to February 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

ICE confines detainees in civil custody, not criminal custody or in a punitive manner, for the administrative purpose of holding, processing, and preparing them for removal from the United States.⁶ According to ICE data, during fiscal year 2015, the agency housed an average of 28,000

⁵[GAO/AIMD-00-21.3.1](#)

⁶The Immigration and Nationality Act, as amended, grants ICE the authority to detain aliens awaiting decisions about their removal from the United States as well as aliens ordered removed, and mandates that ICE detain certain categories of aliens. See 8 U.S.C. §§ 1225, 1226, 1226a, 1231.

detainees each day and held those detainees for an average of about 34 days.⁷ ICE detains a mixture of men, women, and children, and in fiscal year 2015, approximately 84 percent of ICE's 28,000 ADP was male and 16 percent was female.⁸

In fiscal year 2015, ERO oversaw the detention of aliens held by ICE in 165 over-72-hour facilities managed in conjunction with private contractors and state and local governments.⁹ The fiscal year 2015 ADP in these facilities totaled approximately 28,000 detainees. Table 1 describes the types of facilities utilized by ICE, and shows the number of such facilities in operation during fiscal year 2015 and the percentage of the over-72-hour ADP located at each facility type during that period.

⁷This figure excludes unaccompanied alien children housed by the Office of Refugee Resettlement in the Department of Health and Human Services, as well as individuals participating in the Mexican Interior Repatriation Program. The fiscal year 2015 ADP including these individuals equaled approximately 32,000 detainees.

⁸Accompanied children detained by ICE are held at family residential facilities with their mothers and siblings. Barring exceptional circumstances, any federal department or agency, including ICE, must transfer unaccompanied alien children (UAC) to the Department of Health and Human Services Office of Refugee Resettlement's custody within 72 hours of determining that they are UAC. See 8 U.S.C. § 1232(b)(3). UAC are children under the age of 18 who do not have lawful immigration status in the United States, and with respect to whom there is no parent or legal guardian in the United States or no parent or legal guardian in the United States available to provide care and physical custody. 6 U.S.C. § 279(g)(2). There is ongoing litigation before the U.S. Court of Appeals for the Ninth Circuit (*Flores v. Lynch*, Case No. 15-56434 (9th Cir. Filed Sept. 18, 2015)) regarding the 1997 Flores settlement agreement which sets minimum nationwide standards for the detention, release, and treatment of minors in DHS custody. In this case, DHS appealed an order of the U.S. District Court for the Central District of California (*Flores v. Lynch*, Case No. CV 85-04544 DMG (Ex) (C.D. Cal. Aug. 21, 2015)) in which the court found, among other things, that the agreement encompasses both accompanied and unaccompanied minors, and ordered DHS to release class members subject to specific provisions of the agreement during the pendency of removal proceedings.

⁹This count does not include holding facilities, hospitals, juvenile facilities, or facilities used by the Office of Refugee Resettlement in the Department of Health and Human Services for the purpose of housing unaccompanied alien children.

Table 1: U.S. Immigration and Customs Enforcement (ICE) Over-72-Hour Detention Facility Types and Detainee Populations, Fiscal Year 2015

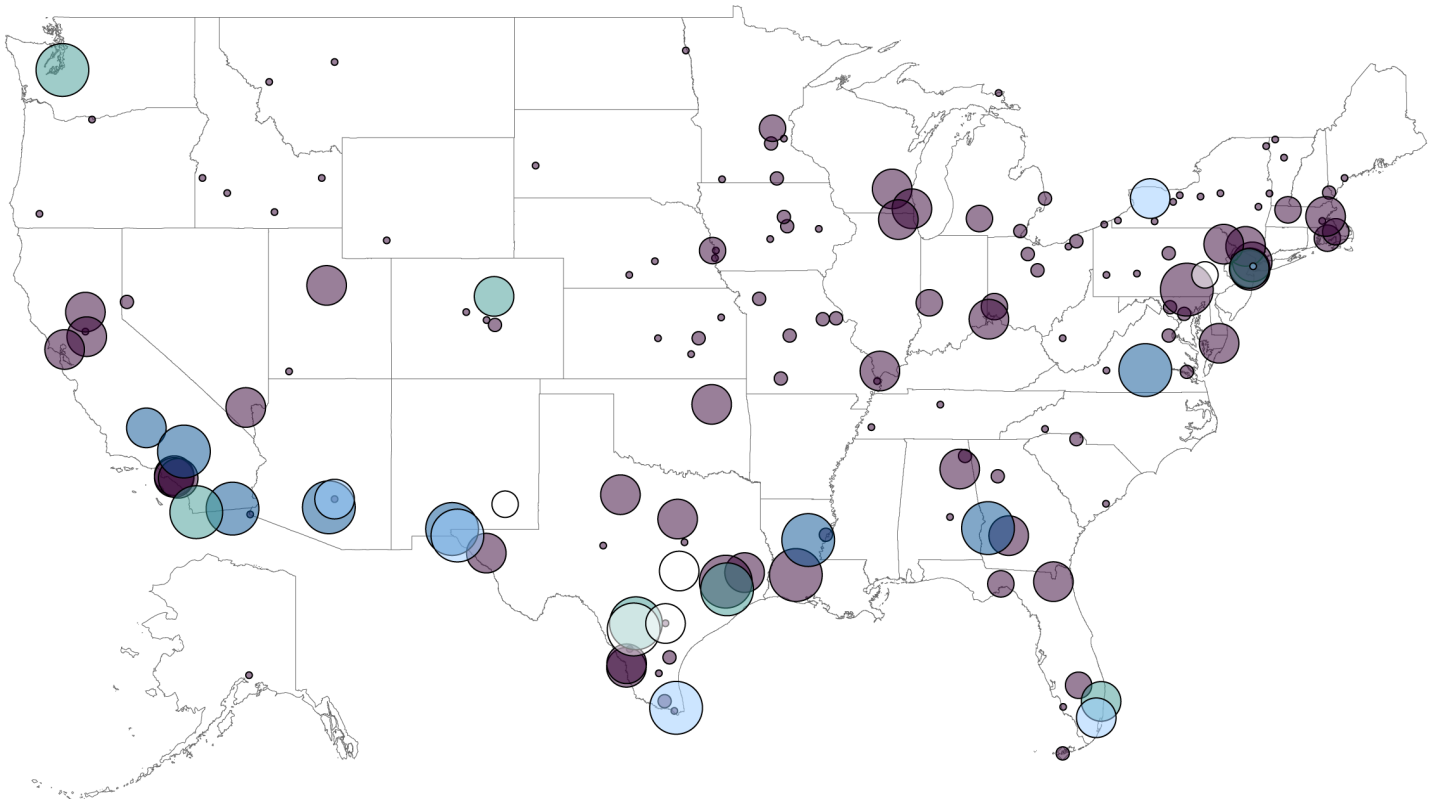
Facility type	Description	Number of facilities	Percentage of Average Daily Population (ADP)
Service processing center	Facility owned and primarily operated by ICE; exclusively houses ICE detainees	6	10.6
Contract detention facility	Facility owned and operated by private company under direct ICE contract; exclusively houses ICE detainees	7	18.7
Non-dedicated intergovernmental service agreement (IGSA) facility	Facility owned by state or local government or private entity, operating under a cooperative agreement with ICE; houses ICE detainees and other confined populations, either together or separately	76	23.9
Dedicated IGSA facility	Facility owned by state or local government or private entity, operating under a cooperative agreement with ICE; exclusively houses ICE detainees	8	25.8
Family residential facility	Facility owned and operated by state or local government or private entity; exclusively houses women and children detained by ICE	5	6.6
U.S. Marshals Service (USMS) intergovernmental agreement or contract facility	Facility owned by state or local government or private entity, operating under an agreement or contract with USMS; houses ICE detainees and other confined populations, either together or separately	63	14.4

Source: GAO analysis of ICE information. | GAO-16-231

ICE utilizes detention facilities located across the United States. Facilities housing larger populations or exclusively ICE detainees are generally concentrated along the southern border of the United States. Other facilities are distributed throughout the rest of the country. Figure 1 shows the size, type, and locations of ICE’s detention facilities that house detainees for periods longer than 72 hours.¹⁰

¹⁰ICE’s detention facilities are distributed among 24 Areas of Responsibility, each of which contains an ERO field office.

Figure 1: U.S. Immigration and Customs Enforcement (ICE) Detention Over-72-Hour Facility Locations, Fiscal Year 2015



Legend

Size indicates average daily population

- 0-10
- 11-50
- 51-100
- 101-500
- greater than 500

Color indicates facility type

- Family residential facility
- Service processing center
- Contract detention facility
- Dedicated intergovernmental service agreement facility
- Nondedicated ICE intergovernmental service agreement facility, or U.S. Marshals Service intergovernmental agreement, or contract facility

Source: GAO analysis of ICE information; Mapinfo (map). | GAO-16-231

ICE uses four sets of detention standards to manage the conditions of confinement, including the provision of on-site and off-site medical care, for detainees at over-72-hour facilities—the 2000 National Detention Standards (NDS), the 2007 Family Residential Standards, and the 2008 and 2011 Performance-Based National Detention Standards (PBNDS). The applicable set of standards used at each facility is included in the

facility's contract or agreement. Facilities of the same type, therefore, may follow different sets of detention standards depending on the applicable set of standards specified in the facility's contract or agreement. Table 2 provides information about each set of standards used by ICE, as well as the number of facilities following those standards and the percentage of the over-72-hour ADP covered by each set of standards during fiscal year 2015. For a discussion about how these standards have evolved over time, see appendix II.

Table 2: U.S. Immigration and Customs Enforcement (ICE) Detention Standards, Fiscal Year 2015

Standard	Description	Number of Facilities ^a	Percent of Average Daily Population (ADP) ^b
2000 National Detention Standards (NDS)	The 2000 NDS are a set of standards intended to govern the conditions of confinement at ICE detention facilities. They dictate how facilities should operate to ensure safe, secure, and humane confinement for immigration detainees, laying out requirements that covered facilities must meet to remain in operation.	115	17.6
2007 Family Residential Standards	ICE approved the Family Residential Standards in 2007 to apply to its facilities that house families in detention. The standards are based on ICE analysis of family detention operations and state statutes that affect children.	5	6.6
2008 Performance-Based National Detention Standards (PBNDS)	ICE revised its standards to align with the fourth edition of the <i>American Correctional Association's Performance-Based Standards for Adult Local Detention Facilities</i> . This version introduces expected outcomes, or results that the required procedures found in the standards are expected to accomplish.	17	13.6
2011 PBNDS	The 2011 version of the standards, like the 2008 PBNDS, outline expected outcomes for each standard. This version also introduces optimal provisions, which are non-mandatory, and which represent optimal levels of compliance with the standards.	27	62.3

Source: GAO analysis of ICE information. | GAO-16-231

Notes: U.S. Marshals Service intergovernmental agreement facilities are under agreements to adhere to Department of Justice detention standards. Facilities under private contract with the U.S. Marshals Service are to adhere to the Federal Performance-Based Detention Standards, which incorporate elements of American Correctional Association standards, Department of Justice standards, and the 2000 NDS. In addition, for ICE inspection purposes, ICE holds facilities affiliated with the U.S. Marshals Service to one of the four ICE standards listed above.

^aOne facility was not covered by ICE detention standards in fiscal year 2015, according to ICE data. The fiscal year 2015 ADP of this facility equaled 0 detainees.

^bValues in this column total 100.1 percent due to rounding.

During the entire fiscal year 2015 period, IHSC was responsible for providing direct medical care to detainees in 19 over-72-hour facilities used by ICE, comprising approximately 48 percent of the over-72-hour ADP.¹¹ Facilities serviced by IHSC included service processing centers, contract detention facilities, dedicated intergovernmental service agreement facilities, and family residential centers.¹² IHSC medical personnel are to provide medical, dental, mental health care, and public health services to detainees at these facilities. Similar services are to be provided by local government staff or private contractors at the remaining facilities, which are not directly operated by ICE. Although ICE delegates the on-site provision of medical care to other entities at these non-dedicated facilities, multiple ICE offices exercise oversight of medical care provided to all detainees, as discussed in more detail later in this report. In addition to on-site care, facilities may send detainees for emergency or specialty care to an off-site provider. In non-emergency situations, IHSC officials are to utilize a data system to review and approve off-site care requests prior to appointments. For emergency off-site visits, information is to be recorded in the same data system after care is provided.

Numerous DHS components are responsible for obtaining and addressing detainee complaints, and multiple ICE offices manage the oversight of detention standards. Table 3 identifies the key DHS components involved with detainee medical care and their primary roles and responsibilities in that context.

¹¹One over-72-hour facility was staffed by IHSC during fiscal year 2015, but was no longer in use at the end of the fiscal year; this facility is included in the count of 19 facilities receiving care from IHSC during all of fiscal year 2015.

¹²IHSC has the authority to provide health care to detainees, as well as to authorize treatment of detainees in hospitals outside of detention facilities while in ICE custody. See 42 U.S.C. § 249; 42 C.F.R. § 34.7(a). IHSC payments for medical services provided to detainees are limited to the amount billed, not to exceed the amount that would be paid for similar health care items and services under the Medicare program, and shall be deemed to be full and final payment. See 18 U.S.C. § 4006(b).

Table 3: Department of Homeland Security (DHS) Medical Care and Complaint Responsibilities in Detention Facilities

DHS Components and Offices	Roles and Responsibilities Pertaining to Detainee Medical Care
U.S. Immigration and Customs Enforcement (ICE)	
Enforcement and Removal Operations (ERO)	<ul style="list-style-type: none"> Identifies, apprehends, detains, and removes aliens from the United States Oversees the confinement of ICE detainees across facilities in accordance with detention standards
Custody Management Division (CMD)	<ul style="list-style-type: none"> Contracts with inspectors to conduct routine inspections of detention facilities to assess compliance with ICE detention standards and develops corrective actions plans, as necessary Oversees the on-site Detention Monitoring Program, which places ICE Detention Service Managers (DSM) at select facilities to monitor whether conditions of confinement, including medical care in consultation with IHSC, are in accordance with ICE detention standards Operates the Detention Reporting and Information Line (DRIL), which detainees and others can use to file complaints
ICE Health Service Corps (IHSC)	<ul style="list-style-type: none"> Serves as ICE medical authority for detainee health care issues and oversees administration and costs of medical care at all detention facilities Manages medical payment authorizations for detainee care Provides direct detainee care in some facilities and oversees care administered by non-IHSC providers in other facilities Investigates detainee complaints related to health care
Office of Professional Responsibility (OPR)	<ul style="list-style-type: none"> Investigates select allegations of misconduct involving ICE employees
Office of Detention Oversight (ODO)	<ul style="list-style-type: none"> Serves as independent oversight body for ICE by conducting inspections to help further ensure compliance with detention standards Uses a risk-based methodology to inspect facility compliance with detention standards that directly affect detainee health, safety, or well-being
Joint Intake Center (JIC)	<ul style="list-style-type: none"> Receives allegations of misconduct involving ICE and Customs and Border Protection employees and contractors and assigns the information for appropriate action or investigation
Office of the Inspector General (OIG)	<ul style="list-style-type: none"> Operates a hotline to receive complaints of DHS employee and contractor misconduct, as well as medical care complaints Has investigative primacy for all complaints against DHS, including ICE and contractor staff, regardless of avenue used to report
Office of Civil Rights and Civil Liberties (CRCL)	<ul style="list-style-type: none"> Receives and investigates complaints regarding detention conditions and potential violations of detainees' rights by DHS employees, contractors, or officials Consults with ICE in the development of detention standards

Source: GAO analysis of DHS information. | GAO-16-231

DHS Has Established Processes for Providing Detainee Medical Care, but Does Not Have Complete Data on Costs for Care

All Detention Facilities Provide On-site Medical Care

DHS has established processes for the provision of routine medical care on-site at both IHSC and non-IHSC staffed facilities. Federal law authorizes the provision of medical care to immigration detainees,¹³ and ICE detention standards require facilities to implement actions to provide for the general safety and health of individuals held in civil immigration detention. As such, all facilities that house detainees for over 72 hours—whether a small county jail that contracts with ICE to hold 10 detainees or an ICE-operated facility with 1,000 detainees—maintain and operate some type of on-site clinic. At a minimum, facilities must maintain a clinical setting that serves as an area to conduct required physical exams, as well as treatment for routine non-emergency conditions required by ICE detention standards. Although not generalizable to all detention facilities, in our site visits to 12 detention facilities, we observed a range of clinical areas that reflected differing levels of on-site care capability. Figures 2 and 3 depict detention facility medical clinics. See appendix III for a fuller analysis of our site visit observations, including the results of our interviews with 120 detainees at 12 facilities.

¹³See 42 U.S.C. § 249 (Medical Care and Treatment of Quarantined and Detained Persons); 42 C.F.R. § 34.7(a) (medical and other care for those in DHS custody). In addition, arriving aliens are to be detained in order to facilitate their physical and mental examination for purposes of admission to the United States. 8 U.S.C. § 1222.

Figure 2: Single exam room at facility housing about 70 detainees



Source: GAO. | GAO-16-231

Figure 3: Medical reception area and multiple exam rooms at facility housing over 500 detainees



Source: GAO. | GAO-16-231

In addition, all facilities regardless of size or facility type must employ credentialed healthcare professionals, such as registered nurses and physicians, according to ICE detention standards. ICE detention standards provide specific professional requirements for facility staff that perform particular tasks. For example, trained facility corrections officers can ask standardized medical intake questions to detainees upon their arrival, but 2011 ICE standards state that only qualified licensed health providers may conduct comprehensive health assessments, including a physical examination and mental health screening.

ICE Has Varying Information about On-site Medical Care Costs and Could Better Link Approvals for Off-site Care to Costs

ICE has varying information about the costs of providing on-site medical care to detainees across the types of facilities ICE uses to house detainees; that is, medical care provided to detainees within the facilities. ICE also has data on requests for off-site medical care, including whether those requests were approved or denied, but could improve the mechanisms and processes associated with linking data on approved requests to costs paid for off-site services.

On-site medical care costs. The amount and type of information that ICE maintains on costs for medical care provided on-site varies by facility type. For example, at the 19 over-72-hour facilities where IHSC provided direct medical care to detainees in fiscal year 2015, ICE maintained medical expenditure data in its accounting system of record, the Federal Financial Management System. Based on these data, the total cost of providing medical care to detainees at IHSC-staffed facilities was about \$150 million in fiscal year 2013, \$212 million in fiscal year 2014, and \$206 million in fiscal year 2015. At the other approximately 140 facilities utilized in fiscal year 2015 where IHSC did not directly employ medical staff, costs for medical care are typically included in each facility's per diem rate for housing detainees. In these instances, ICE pays a set fee per day per detainee. As we noted in our October 2014 report on immigration detention costs and standards, however, limitations in ICE's data on overall facility costs, including costs for medical care, preclude using the data to track and manage costs across individual facilities and facility types.¹⁴ Furthermore, our 2014 report found significant coding errors in cost data entered to the Federal Financial Management System, raising questions about the reliability of the medical care expenditures figures cited above. In our 2014 report, we recommended that ICE assess the extent to which it has appropriate internal controls for tracking and managing detention facility costs and develop additional controls as necessary. ICE concurred and subsequently reported on actions taken to address these recommendations. For example, DHS reported in February 2015 that ICE had created a tool to help track costs for each detention facility, but as of January 2016, ICE had not fully assessed the extent to which the tool is an appropriate internal control for tracking and managing detention facilities costs and whether additional controls are necessary. In addition, ICE reported that it is planning upgrades to the Federal Financial Management System that could mitigate data reliability issues, but ICE

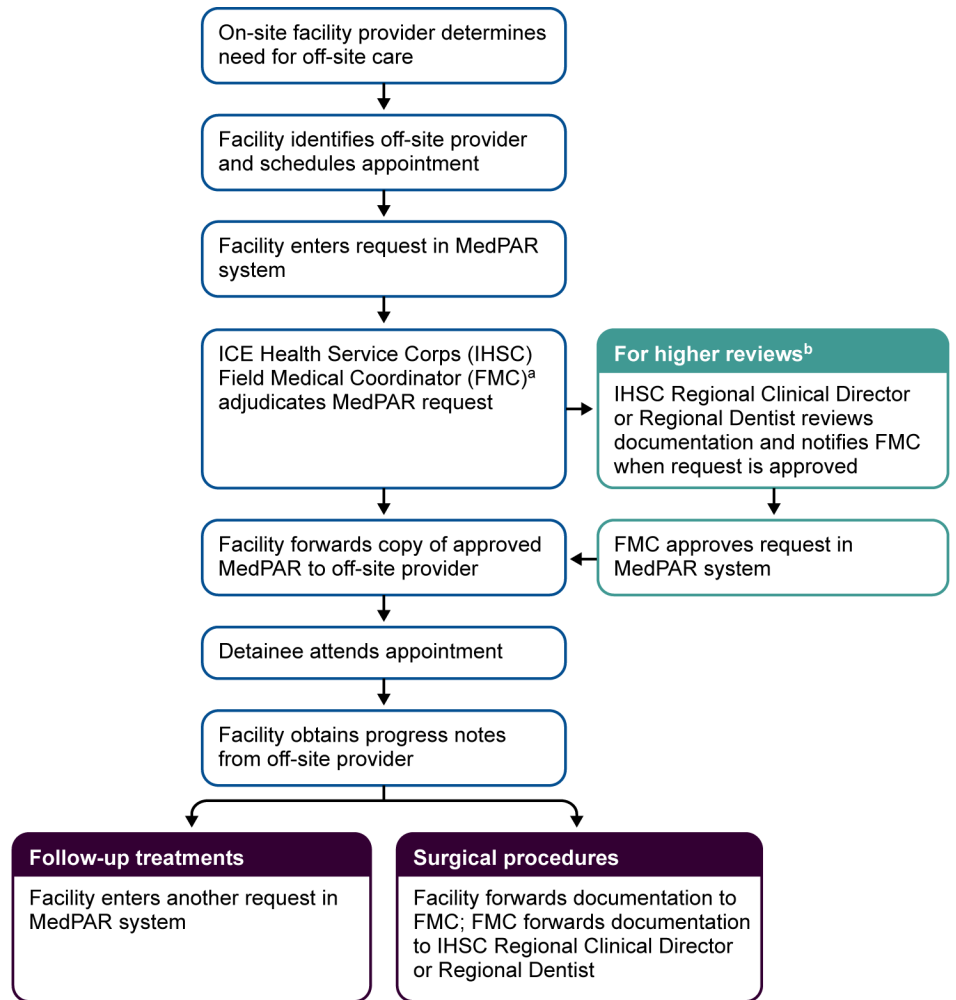
¹⁴[GAO-15-153](#).

had not yet completed these updates as of January 2016. We continue to believe that ICE should take efforts to better track and maintain reliable overall detention cost information, including medical care expenditures.

Off-site medical care process and costs. ICE has established processes and uses an electronic system to manage off-site care provided to detainees, and through this system, ICE maintains data on requests for off-site medical care and approvals or denials of those requests. ICE also uses a separate data system to maintain information on costs for approved services. However, ICE's system for managing the provision of off-site medical care does not provide ICE with the information needed to identify and assess trends across the types of off-site care requested or approved over time or across facility types, and ICE could better link data on approvals and amounts paid to improve ICE oversight of the costs of providing off-site medical care to detainees. First, with regard to ICE's system for managing off-site care provided to detainees, IHSC officials utilize the Medical Payment Authorization Request (MedPAR) system to approve or deny all individual detainee visits to off-site medical providers. This basic process is used for all detainees housed in all facility types. Figure 4 depicts the general process by which an on-site facility provider requests off-site care from IHSC approving officials.¹⁵

¹⁵Detainees may obtain emergency off-site care without a prior MedPAR approval; relevant information is entered in MedPAR after emergency off-site care is provided.

Figure 4: Medical Payment Authorization Request (MedPAR) Process for Requesting Off-site Medical Care



Source: GAO analysis of ICE Health Service Corps information. | GAO-16-231

^aDepending on the nature of the request, the request may be reviewed by an IHSC Managed Care Coordinator or Behavioral Health Unit Licensed Clinical Social Worker.

^bIHSC does not have written guidance for what requests warrant a higher level of review. Rather, the determination is made using professional judgement. Officials noted, however, that any type of surgical procedure, for example, would typically be subject to higher review.

According to IHSC officials, the majority of requests for off-site medical care are adjudicated by IHSC Field Medical Coordinators (FMC), who are responsible for coordinating medical services for ICE detainees. However, in some instances a higher level of review is needed, such as for surgical procedures, and requests are adjudicated by an IHSC

Regional Clinical Director or Regional Dentist.¹⁶ ICE has developed and issued various guidance documents related to the provision of off-site medical care for detainees. For example, IHSC issued a July 2015 Operations Memorandum that outlines the MedPAR request process. Moreover, the *IHSC Detainee Covered Services* guidance, issued in 2010 and under revision in fiscal year 2016, provides information about the MedPAR process and states that ICE “must provide medically appropriate treatment to ICE detainees who have identified any serious medical needs.” The guidance goes on to define “serious medical need” as a condition that when left untreated could result in further significant injury or unnecessary pain. According to IHSC data, from fiscal years 2012 through 2014, IHSC approved an average of about 45,000 MedPAR requests per year for ICE detainees to receive off-site care or services.

Although ICE uses the MedPAR system for recording requests for off-site medical care and approval or denial of those requests, limitations in the MedPAR system hinder ICE’s ability to use data in the system for identifying and assessing trends in off-site medical care for detainees, including emergency care. Specifically, the MedPAR system does not allow IHSC officials to search for or identify types of procedures or off-site medical care visits that were requested, approved, or denied, which limits ICE’s ability to analyze trends across types of care and facilities and make decisions about resource allocations for outside medical care. Thus, IHSC officials have visibility over individual MedPAR requests, but cannot sort or examine data by procedure or facility type. IHSC officials noted that in response to specific information requests, they sometimes manually search through MedPAR data, and acknowledged that more systematic, regular analysis would be useful for decision-makers. For example, a robust analysis of off-site care could better ensure that off-site care requests are adjudicated consistently across ICE areas of responsibility and facility types. This is important because MedPAR approvals and denials are primarily based on the professional judgment of the reviewer—there is currently no specific written clinical guidance on which to base approval decisions, according to IHSC officials. Although approval decisions are made on a case-by-case basis and dependent on the specific circumstances of the individual seeking care, representatives

¹⁶There are two IHSC Regional Clinical Directors serving the East and West regions of the country. Among other things, IHSC Regional Clinical Directors must be board certified in family medicine, internal medicine, or related medical specialty, and must have an unrestricted medical license in any state or territory in the United States.

from two immigration advocacy groups cited cases of surgical procedures, such as hernia operations, being approved in some instances but not in others, which they said was problematic.

Standards for Internal Control in the Federal Government notes that internal controls are an integral part of each system that management uses to regulate and guide its operations. The standards also state that control activities and communication of information are integral parts of an entity's planning, implementing, review, and accountability for stewardship of government resources and achieving effective results.¹⁷ Furthermore, the standards state that control activities, which include a wide range of diverse actions and maintenance of related records, need to be clearly documented and help to ensure that all transactions are completely and accurately recorded. Developing and implementing a mechanism to identify and assess trends in off-site medical care procedures across types of procedures and facilities would better position ICE to oversee off-site medical care provided to detainees and help ensure consistent decisions regarding such care are made.

Second, with regard to the linking of data on off-site medical care approvals with payments made to off-site providers, ICE detainee medical claims and payments to outside providers are managed by the Veterans Affairs Financial Services Center (VAFSC), but this system is not linked to IHSC's MedPAR system, according to IHSC officials. The VA system tracks monetary amounts for all payments to outside medical providers for services rendered to detainees—thus providing ICE with information for these costs. According to IHSC officials, from fiscal years 2012 through 2014, approximately 93,000 claims per year were paid to off-site providers for ICE detainee medical care. The total amount paid for this time period was approximately \$27 million per year, according to IHSC officials. However, the number of claims paid for fiscal years 2012 through 2014 did not correspond to the number of IHSC MedPAR authorizations, or approvals for requested services, for the same time period. Overall, there were approximately 144,000 more claims paid in VAFSC than approvals in MedPAR. Comparing figures for individual facilities during this period, in some cases VAFSC claims exceeded MedPAR approvals, and in some cases the MedPAR approvals were greater than VA claims. For example, in fiscal year 2012, 2,187 MedPAR

¹⁷[GAO/AIMD-00-21.3.1](#).

requests were approved for detainees in a county jail facility and 63 claims were paid. At one IHSC-staffed facility, 326 MedPAR requests were approved in fiscal year 2012, and 9,675 claims were paid. In explaining these apparent discrepancies, IHSC officials noted differences in provider billing practices and that some claims may not be paid in the same fiscal year that they were authorized. Officials also stated that multiple claims could be associated with individual authorizations. For example, an emergency room visit may require one MedPAR approval, but claims may be paid to multiple providers associated with the visit. We acknowledge these reasons for different numbers of claims and approvals; however, a mechanism to ensure that payments for off-site care are supported by the appropriate authorizations could provide DHS better assurance that the amount paid for claims corresponds to authorized services. In addition, by not connecting the types and frequency of authorized services with their actual costs, ICE is not well positioned to analyze larger trends related to off-site care and make resource allocation decisions.

IHSC officials acknowledged that the MedPAR system does not enable IHSC to track off-site care requests by procedure type, which could provide useful information about the magnitude and types of services needed across detention facilities and regions, and thus impact resource decisions. IHSC officials also noted that ICE does not routinely audit or systematically cross-check MedPAR authorizations and claims paid due to data system limitations. *Standards for Internal Control in the Federal Government* notes that internal controls are an integral part of each system that management uses to regulate and guide its operations, and that communication of information and control activities are an integral part of an entity's planning, implementing, review, and accountability for stewardship of government resources and achieving effective results.¹⁸ Furthermore, the standards state that control activities, which include a wide range of diverse actions and maintenance of related records, need to be clearly documented and help to ensure that all transactions are completely and accurately recorded. Developing and implementing a mechanism to better link approved requests for off-site medical care to data on amounts paid for off-site care would better position ICE to oversee and manage resources for detainee medical care. In addition, establishing stronger internal controls to ensure that payments for off-site

¹⁸[GAO/AIMD-00-21.3.1.](#)

care are supported by the appropriate authorizations could help ICE monitor medical care costs and better validate payments.

ICE Uses Various Oversight Mechanisms and Collects Medical Care Compliance Data at Individual Facilities, but Conducts Limited Analyses of Data across Facilities

ICE Uses Various Mechanisms to Oversee Facilities' Compliance with Medical Care Standards

ICE has various mechanisms to oversee medical care at facilities, and it uses a combination of these mechanisms to monitor conditions within a facility, including the quality of medical care. The primary mechanism used by ICE to monitor compliance with standards is the periodic inspection of facilities, overseen by CMD, against the NDS, PBNDS, or Family Residential Standards. These inspections covered approximately 74 percent of over-72-hour facilities used by ICE and more than 99 percent of ADP in fiscal year 2015.¹⁹ In accordance with ICE policy, in most cases, a contractor with CMD assesses the conditions in a facility by inspecting a list of items that correspond with detention standards.²⁰ The contractor identifies deficiencies to monitor the facility's compliance with an overall detention standard. For instance, a facility may be found

¹⁹In fiscal year 2015, ICE used a total of 165 facilities to hold detainees for over 72 hours, and 44 of those facilities did not receive inspections from ERO's Custody Management Division. The combined fiscal year 2015 ADP in these 44 facilities was approximately 100 detainees, or 0.36 percent of the total ADP during that time. Facilities that are used irregularly or infrequently, that is, for fewer than 60 man-days per year, are not required to undergo inspection, according to ICE documentation and a Custody Management Division official. Each man-day is counted as one detainee housed in a facility at midnight.

²⁰Approximately 30 over-72-hour facilities, housing less than 1 percent of ADP in fiscal year 2015, complete an Operational Review Self-Assessment each year. These assessments are performed by ICE Field Office or facility staff rather than a contractor.

deficient for the line item requirement concerning the storage of medical records, as seen in table 4 below, but still be found compliant with the overall Medical Care standard. Table 4 shows a sample of line items that fall under the Medical Care standard in the 2007 Family Residential Standards, as well as language used in the inspection tool to assess compliance with those line items.

Table 4: Sample of 2007 Family Residential Standards, Medical Care Standard Line Items

Medical Care Standard Line Item Language	Inspection Checklist Language
<p>Every facility shall directly or contractually provide to its resident population:</p> <ul style="list-style-type: none"> • Initial medical screening • Cost-effective primary medical and dental care as required by the health authority to maintain the health of the resident • Emergency care • Specialized health care, as deemed necessary by the health authority to maintain the health of the resident • Mental health care • Hospitalization as needed within the local community 	<ul style="list-style-type: none"> • Review resident handbook for information regarding medical/mental health/dental treatments provided for residents. • Are residents provided an initial medical screening within 7 days for adults/24 hours for minors? Review sample from intake from the last 2 weeks. • Are residents provided a dental screening within 14 days of arrival? Review sample of intake from the last 2 weeks. • Does the facility hold sick call 7 days a week? When is sick call? • How do residents get sick call request forms? Are they readily available?
<p>A designated health authority shall have the overall responsibility for health care services pursuant to a written agreement, contract, or job description. The health authority may be a physician, health services administrator, or health agency. When the health authority is other than a physician, final clinical judgment shall rest with a single, designated, responsible physician, referred to in this Residential Standard as the clinical director.</p>	<ul style="list-style-type: none"> • Who is the designated health authority at the facility? • Are the health care program and medical facilities under the direction of a health services administrator? • Are health care staff professional licenses and/or certifications verified? What is the schedule for confirming?
<p>Medical records shall be kept separate from residents' residential records, and stored in a securely locked area within the medical unit.</p>	<ul style="list-style-type: none"> • Are residents medical files kept separate from residential files? • Are medical records maintained and stored in a locked secure area in the medical unit?

Source: ICE. | GAO-16-231

ICE uses various other oversight mechanisms, like Field Medical Coordinator (FMC) site visits and on-site Detention Service Managers (DSM), to assess compliance with detention standards in more detail. For example, FMC site visits and IHSC quality improvement audits look at the quality of medical care at facilities in relation to detention standards by reviewing medical care processes in more detail than the CMD inspections described above, according to IHSC officials. Table 5 shows each mechanism that ICE uses, including a description of required frequency, where the mechanisms are used, and the type of oversight conducted. For a more detailed description of each mechanism, including recent results, see appendix IV.

Table 5: Description of U.S. Immigration and Customs Enforcement (ICE) Medical Care Oversight Mechanisms

	Mechanism	How Often	Which Facilities	What Is to be Done
Core Oversight	Custody Management Division (CMD) Inspections	Annual or biennial	Over-72-hour adult detention facilities with an average daily population (ADP) of at least 10 detainees	Checklist inspection against National Detention Standards (NDS) or Performance-Based National Detention Standards (PBNDS)
	Operational Review Self-Assessments (ORSA)	Annual	Over-72-hour facilities with an ADP of fewer than 10 detainees used for 60 or more man-days annually ^a	Checklist inspection against NDS
	Family Residential Inspections ^b	Monthly, semiannual, annual	Family residential facilities	Checklist inspection against the 2007 Family Residential Standards Includes a narrative aspect to look at the substance of deficiencies
Targeted Medical Oversight	Field Medical Coordinator (FMC) Site Visits	Every six months or as needed	Facilities not staffed by IHSC, which house detainees for over 72 hours	File reviews to assess the quality of medical care at the facility
	ICE Health Service Corps (IHSC) Quality Improvement Audits	Quarterly	IHSC-staffed medical clinics in detention facilities	File reviews to assess the quality of medical care at the facility
Supplemental Oversight ¹⁹	Office of Detention Oversight (ODO) Inspections	Annual	Facilities with an ADP greater than 10, which house detainees for over 72 hours	Checklist inspection against a core set of detention standards, including medical care
	Detention Service Managers (DSM)	Daily	Assigned facilities with an ADP greater than 10, and all family residential facilities	Informal, on-the-spot guidance for corrections of minor deficiencies

Source: GAO analysis of ICE information. | GAO-16-231

^aEach detainee present at midnight per day equals one midnight count man-day for that facility.

^bFamily Residential Inspections are the responsibility of the Juvenile and Family Residential Management Unit within the Custody Management Division.

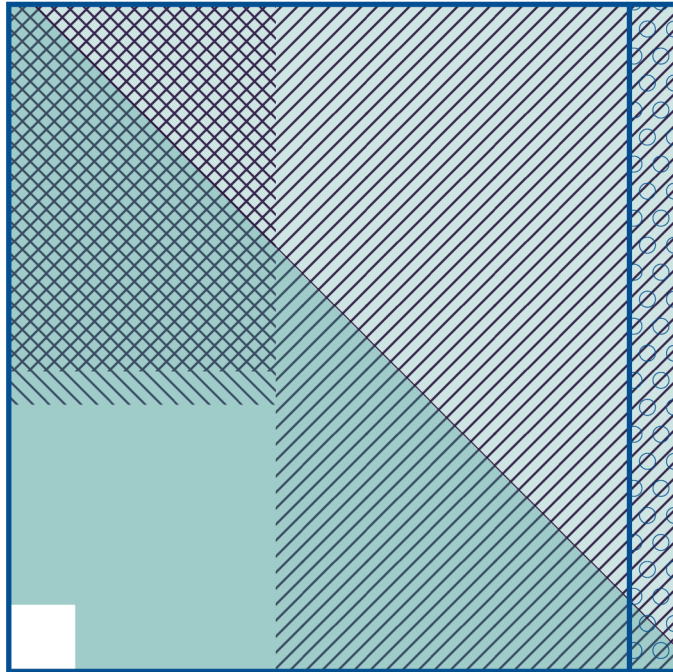
The use of these oversight mechanisms helps to ensure that more than 99 percent of the over-72-hour ADP is annually subject to at least two forms of medical care oversight—typically a detention standards inspection and a medical inspection. Small facilities, those with an ADP of fewer than 10 detainees, are to complete an annual Operational Review Self-Assessment (ORSA), and FMCs may visit the facilities approximately every six months for medical care inspections. The remaining adult and family residential facilities also are to have periodic checklist inspections, and IHSC staff are to conduct either FMC site visits or quality improvement audits for medical care. DSMs assess compliance at larger

facilities in an effort to use their limited resources to oversee the conditions of confinement for more detainees than they could at small facilities, according to CMD officials. ODO prioritizes inspection sites based on facility risk factors, such as number and type of allegations, previous inspection deficiencies, and ADP, according to officials

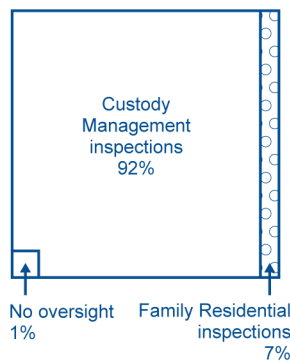
Figure 5 shows the percentage of ADP covered by the various ICE oversight mechanisms in fiscal year 2015 and how those mechanisms overlapped. As seen in the figure, more than 99 percent of the fiscal year 2015 ADP was covered by two or more oversight mechanisms. Approximately 65 percent of the ADP was covered by a detention standards inspection, a medical care inspection, and a third mechanism, either ODO inspection or DSM presence. An additional 22 percent of the ADP was covered by four mechanisms—detention standards inspection, medical care inspection, ODO inspection, and DSM presence—so that approximately 87 percent of the ADP was covered by three or four different oversight mechanisms during fiscal year 2015.

Figure 5: U.S. Immigration and Customs Enforcement (ICE) Oversight Mechanism Coverage of Average Daily Population (ADP), Fiscal Year 2015

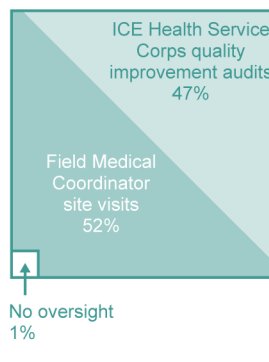
Overlap of oversight mechanisms



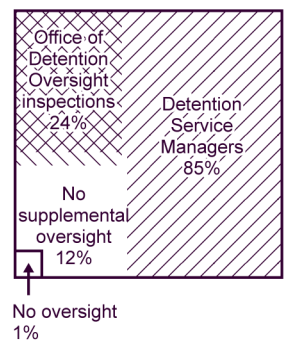
Core oversight



Targeted medical oversight



Supplemental oversight



Source: GAO analysis of ICE information. | GAO-16-231

Note: Less than 1 percent of the fiscal year 2015 ADP was covered by one oversight mechanism or by no oversight mechanism.

ICE can gain a comprehensive view of the conditions of confinement at individual facilities, including the provision of detainee medical care, by examining the combined results of multiple oversight mechanisms,

according to CMD officials. For example, ODO inspectors use weekly DSM reports to gain a situational awareness of facility conditions before an inspection. Similarly, DSMs collaborate with FMCs at intergovernmental service agreement facilities to resolve medical-related issues because DSMs are not medical experts, and DSMs may review FMC site visit results to better understand the medical care issues at a facility. At IHSC-staffed facilities, DSMs collaborate with health service administrators to resolve medical-related issues. When medical care deficiencies are found through CMD or ODO inspections, action plans to resolve those deficiencies are to be sent to IHSC to help ensure that the action plan will sufficiently address the issue. In this way, IHSC may know of the medical care deficiencies found through other oversight mechanisms. Rather than using the results of oversight mechanisms in a punitive manner, ICE offers facilities opportunities to resolve deficiencies before the issuance of results or reports. For instance, inspectors at the family residential facilities can offer technical guidance to facilities for on-the-spot corrections to deficiencies. Similarly, ODO is to share its preliminary results with the facility at the conclusion of each inspection so that corrections can be initiated before the issuance of the final report. IHSC's quarterly quality improvement audits identify local issues at the facility level, and IHSC can use the results to coach individual facilities about ways to improve their medical care. In these ways, facilities can resolve issues and improve the conditions of confinement for detainees in a timely manner.

ICE Conducts Some Analysis of Oversight Data across Facilities, but Could Benefit from Expanded Analysis

ICE collects medical care compliance data through its various oversight mechanisms; however, ICE does not utilize this information in a way that facilitates decision-making across all detention facilities. ODO and the IHSC Medical Quality Management Unit both conduct analyses across facilities to identify systemic issues or leading practices, but their analyses do not cover all facilities. ODO inspects select facilities and IHSC conducts quality improvement audits only in the 19 IHSC-staffed facilities; these inspections and audits covered approximately 57 percent of the ADP in fiscal year 2015. ODO provides ICE leadership with narrative annual reports that describe trends in deficiencies and identify leading practices that may assist in the decision-making process regarding facilities. Decisions made using ODO reports could include contractual issues, as well as additional training for ICE officers or facility staff, according to ODO officials. ODO reports trends in deficiencies by detention standards, by facility type, and over time. IHSC conducts analyses of quality improvement audit results across the 19 IHSC-staffed facilities in order to identify levels of low compliance among clinics. If

compliance rates fall below 90 percent across the 19 clinics, each clinic is required to conduct a study about the issue. These studies help IHSC determine whether a specific administrative process change or medical care intervention could improve the quality of care at clinics.

According to ICE officials, ICE uses its oversight mechanisms to help obtain a more complete picture of compliance at individual facilities at a given point in time, but ICE has not fully assessed the results of these oversight mechanisms across facilities. For instance, FMC site visit inspection results are stored and tracked, but FMCs' numerous responsibilities limit their ability to perform overarching analyses of the data, and the Medical Case Management Unit of IHSC, which manages the FMC program, does not have the resources necessary to perform additional analyses of the data, according to an IHSC official. The official also noted that FMCs are more focused on resolving local, facility-specific medical care issues than looking at issues across facilities. Similarly, CMD officials stated that their priority has been to address issues at individual facilities rather than to conduct analyses of data across facilities. The officials acknowledged the benefit of conducting such analyses, and stated that they planned to explore the possibility of doing so in future inspection cycles but did not have any specific plans for analysis.

Moreover, ICE has not assessed ORSA and DSM compliance results across facility types. Though small facilities began conducting annual ORSAs in 2012, ICE has not used the information gathered to conduct an analysis of results over time or across facilities. For example, unlike inspection results for larger adult facilities, ORSA results are not stored in a database, and staff members do not conduct additional analysis or follow-up after a corrective action plan is completed for deficiencies, according to CMD officials. That is, ORSA inspection worksheets are scanned and stored electronically, but the format does not facilitate tracking or analysis. Additionally, the ORSA form contains sections in which the inspector can identify any repeat findings from previous years, but CMD officials stated that they do not currently track any repeat findings noted on ORSA forms. CMD officials did not provide specific plans to improve the tracking of ORSA results. Similarly, CMD officials noted that DSMs had difficulty documenting their daily oversight interactions with facility staff because they happen so frequently, though

efforts to do so began in fiscal year 2016.²¹ Standards for Internal Control in the Federal Government calls for the assessment of agency performance over time, but without tracking the results of its oversight, ICE cannot conduct analyses of information over time or across facilities.²² Without such analysis, ICE management is not well-positioned to assess the medical care performance of facilities over time, by contracted standards, or by facility type; thereby, limiting ICE's ability to plan and manage overarching changes to detainee medical care. Expanding analysis of oversight data across facilities would strengthen ICE's ability to manage and oversee the provision of medical care across facility types.

DHS Headquarter Offices and ICE Detention Facilities Have Various Processes to Obtain and Address Medical Care Complaints; However, DHS Has Limited Oversight over the Universe of Complaints

DHS provides detainees with multiple avenues for filing medical care complaints related to immigration detention.²³ First, detainees can file complaints directly at immigration detention facilities. ICE detention standards call for detention facilities to have both informal and formal processes for obtaining and addressing detainee complaints and for complaints to be addressed at the lowest level possible. ICE and facility officials we spoke with told us that detainees are informed of the complaint processes through detainee handbooks and orientation sessions. In addition, ICE Detention and Reporting Information Line (DRIL) helpline and OIG hotline information posters provide contact information for reporting concerns. ICE detention standards and guidance call for informal resolution of detainee complaints through oral communication with ICE facility or contractor staff or medical personnel as appropriate. ICE detention standards further state that detainees may be able to more expediently resolve complaints through informal procedures. Unlike formal complaints, informal complaints do not require detainees be provided a written response, as they are typically resolved

²¹To help resolve this issue, CMD conducted a feasibility study in August 2015 to determine if a new DSM reporting system could better facilitate reporting and analysis of information at and across facilities. In a September 2015 update, CMD officials noted that the results of the study indicated that they can transition from manual to automatic reporting of findings, and that they will determine how to effectively manage, store, report, and analyze data gathered in an automated fashion. At the start of fiscal year 2016, DSMs began tracking key metrics from weekly narrative reports, according to a CMD official.

²²GAO/AIMD-00-21.3.1.

²³According to ICE officials, medical complaints can be filed by detainees, detainee family members, attorneys, and non-governmental organization representatives, among others.

immediately; if not satisfied with an informal response, detainees can submit formal, written complaints to facility officials. ICE detention standards call for facilities to maintain grievance logs to document complaints filed and their resolution—both formal and informal—and inspectors are to review these grievance logs during facility inspections.

CMD and ODO help oversee the complaint processes at the facility level by conducting inspections and determining whether processes are in place and functioning as intended. Our analysis of CMD inspection data showed that during fiscal years 2011 through 2014, approximately 12 percent of CMD over-72-hour facility inspections (58 of 496) identified 76 detainee grievance standard deficiencies.²⁴ However, in fiscal year 2014, two detainee grievance standard deficiencies were noted in the 96 inspections conducted. In addition, of the 32 inspections conducted by ODO during fiscal year 2014, 22 facilities had a total of 48 grievance standard deficiencies. In calendar year 2014, 31 over-72-hour facilities completed ORSA inspections, which resulted in two detainee grievance standard deficiencies reported at two ORSA facilities. Similar to medical standard deficiencies, grievance standard deficiencies found through CMD and ODO inspections may go through a corrective action plan process to help insure that deficiencies are corrected.

Second, detainees can file complaints through various DHS entities including CRCL, JIC, the OIG hotline, and the DRIL helpline. Complaints can be submitted by phone, e-mail, mail, or fax. Each DHS entity has a different focus and process for obtaining and addressing the complaints. For example, the OIG's responsibility is to investigate DHS employee and contractor misconduct, including civil rights abuses, while the DRIL helpline's focus is on addressing immigration detention related questions and concerns, including conditions of confinement. According to DHS officials, complaints can be reported through any of these entities, and the same complaint can be reported through the various options. Medical complaints obtained by each DHS entity in fiscal year 2014 ranged from about 100 by CRCL to approximately 550 by OIG.²⁵ Examples of

²⁴CMD inspection data included both annual and biennial inspections, as well as pre-occupancy inspections for potential facilities.

²⁵OIG's complaint count includes complaints forwarded from CRCL and JIC. OIG reviews and determines whether or not it will investigate these complaints; then returns to CRCL and JIC, any complaints it does not investigate.

complaints obtained by the different entities include medical treatment not timely; request for medical care refused; scheduled for but not taken to doctor visit; and inadequate dental care, among others. Table 6 shows the different DHS entities through which detainees and others can file complaints, including their primary focus, process for obtaining and addressing complaints, and medical complaints obtained and addressed in fiscal year 2014.

Table 6: Department of Homeland Security (DHS) Processes for Obtaining and Addressing Complaints

DHS entity	Primary focus and process for obtaining and addressing complaints	Database for maintaining and tracking complaints	Approximate number of complaints obtained in fiscal year 2014 ^a	Complaints addressed in fiscal year 2014
Office of Inspector General (OIG)	Reviews allegations of criminal and non-criminal misconduct by DHS employees and contractors. Obtains complaints related to immigration detention from detainees, third parties, and DHS components. Decides whether to investigate, return to referring component, or forward to affected agency. Investigation focus is generally on misconduct allegations and not medical complaints.	Complaints are housed in a complaints repository maintained by OIG. ^b There is no additional oversight or tracking after complaints are forwarded or returned to DHS components.	Immigration Detention Complaints Total: 2,400 Medical: 550	No medical complaints investigated.
Office for Civil Rights and Civil Liberties (CRCL)	Reviews and assesses allegations of civil rights and civil liberties violations and abuses, including violations of rights while in immigration detention, by DHS personnel and contractors. Obtains complaints from detainees, the public, other DHS components and federal agencies, and Non-Governmental Organizations, among others. Generally refers medical complaints to ICE Health Service Corps (IHSC), via the ICE Office of Diversity and Civil Rights, for review and investigation; and tracks and receives IHSC's reports on its findings. ^c	Complaints are maintained in a CRCL complaints data and information repository. ^d	Immigration Detention Complaints ^e Total: 200 Medical: 100	Total medical related complaints closed: approximately 90

DHS entity	Primary focus and process for obtaining and addressing complaints	Database for maintaining and tracking complaints	Approximate number of complaints obtained in fiscal year 2014 ^a	Complaints addressed in fiscal year 2014
Office of Professional Responsibility Joint Intake Center (JIC) ^f	Reviews allegations of criminal and non-criminal misconduct by DHS ICE and Customs and Border Protection employees and contractors. Obtains complaints from detainees and third parties. Generally does not investigate medical complaints, but forwards to IHSC for review and assessment via ERO Administrative Inquiry Unit.	Complaints are maintained in a system that manages and tracks OPR functions including investigations. ^g	Immigration Detention complaints Total: 3,600 Medical: 300	Medical complaints are forwarded to IHSC to be addressed.
ICE Detention and Reporting Information Line (DRIL)	Provides information to detainees and other agency stakeholders who have been unable to resolve concerns through traditional channels. Obtains and refers calls concerning immigration detention to appropriate ICE offices. Medical calls are forwarded to Detention/Deportation officers and the officers forward to IHSC to be addressed.	Complaints are maintained in a phone call tasking system. ^h	Immigration Detention Calls Total Calls: 47,500 Medical: 400	Medical calls are forwarded to IHSC to be addressed.
ICE Health Service Corps (IHSC)	Reviews and investigates medical care complaints related to immigration detention. Field Medical Coordinators and Health Services Administrators are typically tasked with investigating the medical care complaints.	Complaints received are maintained in a Microsoft Outlook mailbox and recorded in the IHSC Tasking Master Spreadsheet (Excel).	IHSC does not have a comprehensive list of all complaints addressed by IHSC in 2014 DRIL complaints were not tracked by IHSC in fiscal year 2014. ⁱ	IHSC addresses medical care related complaints obtained from CRCL, DRIL, JIC, and OIG hotline, via other ICE entities.

Source: GAO analysis of DHS complaint data and information. | GAO-16-231

^aThese data on total number of immigration detention and medical complaints or calls were derived from the respective entities' data repositories or published reports as indicated in the preceding column.

^bOIG maintains a complaint repository, called the Enterprise Data System (EDS), which houses information on all complaints received by OIG including medical complaints from CRCL and JIC. DHS protocol requires that CRCL and JIC send complaints they receive to OIG for a "first look" to see if any warrant OIG investigation.

^cODCR, created in 2013, coordinates IHSC's responses to CRCL complaints tasked to IHSC.

^dCRCL maintains a repository, called Entellitrack, which houses CRCL complaint data, including medical complaints.

^eThe totals represent total ICE and total ICE medical complaints opened by CRCL in fiscal year 2014. These data came from the DHS Office for Civil Rights and Civil Liberties Annual Report to Congress, Fiscal Year 2014. According to CRCL officials, annual report data is derived from CRCL's Entellitrack repository.

^fThe Joint Intake Center is operated by ICE OPR and U.S. Customs and Border Protection Internal Affairs.

^gComplaints filed with JIC are maintained in ICE OPR's Joint Integrity Case Management System (JICMS). JICMS is used to log, track, and manage OPR functions including investigations. According to an ICE OPR official, the JIC complaint data in this table was derived from JICMS.

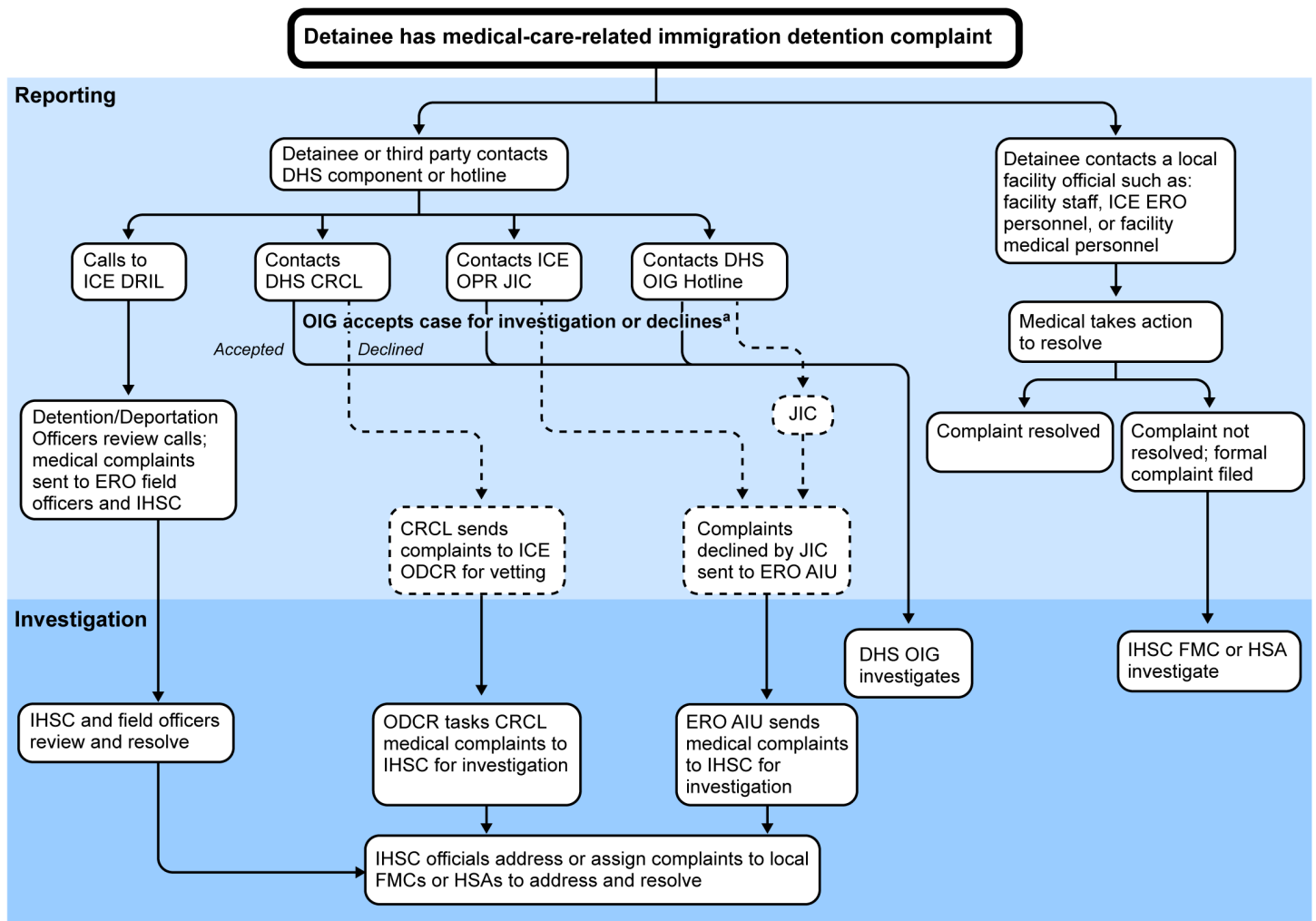
^hDRIL calls first go through a phone tree for dissemination of general information. If a caller needs additional assistance, an operator takes the call and if it is a medical complaint, the call is forwarded to a Detention/Deportation officer for review. The officer forwards the caller information to the appropriate field office, and the field office sends complaint to IHSC to be addressed.

ⁱIHSC began including DRIL complaints in its tasking system in fiscal year 2015.

As shown in figure 6, various DHS entities obtain complaints, and IHSC ultimately receives and is responsible for addressing medical complaints obtained by those entities. DRIL sends medical-care-related complaints it obtains to field deportation officers and the officers forward the complaints to IHSC to be addressed. CRCL, JIC, and Hotline complaints declined for review by OIG are forwarded to IHSC through other ICE units. CRCL forwards medical-care-related immigration detention complaints to ICE's Office of Diversity and Civil Rights for vetting, which assigns a tier level to help prioritize complaints by level of urgency—from emergent (Tier 1) to important but less urgent (Tier 3).²⁶ JIC, and Hotline complaints involving ICE that are passed through JIC, are sent to ERO's Administrative Inquiry Unit. This unit vets and submits medical-care-related complaints to IHSC for review and resolution.

²⁶ICE's Office of Diversity and Civil Rights uses a three-tiered complaint prioritization system to classify CRCL referred medical complaints by level of urgency—Tier 1 being emergent, with immediate need to be addressed and expected initial response within 24 hours; Tier 2 is urgent concern that calls for an initial response within 72 hours; and Tier 3 is important, but not urgent and requires an initial response within 7 days.

Figure 6: Process for Reporting and Investigating Medical-Care-Related Immigration Detention Complaints



Legend

- | | | | | | |
|------|---|------|-------------------------------------|------|---------------------------------------|
| AIU | Administrative Inquiry Unit | FMC | Field Medical Coordinators | ODCR | Office of Diversity and Civil Rights |
| CRCL | Office for Civil Rights and Civil Liberties | HSA | Health Services Administrators | OIG | Office of the Inspector General |
| DHS | Department of Homeland Security | ICE | Immigration and Customs Enforcement | OPR | Office of Professional Responsibility |
| DRIL | Detention Reporting and Information Line | IHSC | ICE Health Service Corps | | |
| ERO | Enforcement and Removal Operations | JIC | Joint Intake Center | | |

Source: GAO. | GAO-16-231

^aAlthough OIG can accept medical complaints, its focus is generally on misconduct allegations.

CRCL, DRIL, and JIC maintain complaint data in their respective data systems; however the data, in most cases, is not tracked or analyzed for trending purposes. Only CRCL is required to review and report on the

number of complaints it receives and their disposition. For example, CRCL tracks data in its data management system and can report on the number of complaints it obtains, including medical care complaints related to immigration detention.²⁷ DRIL and JIC maintain their data in a SharePoint System and automated case management system, respectively.²⁸ Both can determine the number of medical complaints received and forwarded to IHSC for resolution. A JIC official told us that the system is not designed for trend analysis. While the DRIL system can be used to perform trend analysis, ICE officials do not currently use DRIL to analyze medical care complaints because these complaints represent a small number of the total DRIL complaints received each year. OIG's database includes CRCL and JIC complaints that are passed through OIG for a determination of whether or not to investigate. Consequently, OIG's database contains numerous complaints, including medical-related complaints. The OIG database, however, is essentially a repository of data and is not designed for tracking medical care related complaints. Further, it would be difficult to readily identify medical complaints from among all the types of complaints OIG receives because, according to OIG officials, complaint descriptions are captured in narrative format. To identify possible medical complaints, a key word search of the complaint narratives' medical related terms would be needed. Such searches are typically done on request by officials. While OIG maintains a database that collects complaint data, according to OIG officials it is difficult to use the database for determining the volume of medical complaints and conducting analysis of complaint data.

According to IHSC officials, IHSC employs a tasking system to document receipt of medical care related immigration complaints obtained from other entities and the tasking of those complaints to IHSC personnel for review and resolution. IHSC officials stated that, by practice, these entities that receive complaints—DHS OIG, JIC, and CRCL—do not send complaints directly to IHSC, but notify IHSC, through ERO or another ICE entity, of medical care-related immigration complaints. IHSC maintains records of these notifications in an IHSC tasking e-mail inbox, and the

²⁷ CRCL tasks to IHSC for review and resolution, medical complaints involving detainees still in custody. CRCL tracks IHSC's reports on its findings.

²⁸ SharePoint is a software system that allows users, such as DRIL operators and Detention and Deportation officers, to share information via access to a designated SharePoint drive. Detention/Deportation officers are responsible for reviewing and forwarding complaints to the appropriate field office point of contact and IHSC staff.

notifications are saved in specific folders. IHSC officials told us that all complaints received are processed through this tasking system. IHSC officials also told us that in fiscal year 2014, their tasking system included CRCL and JIC complaints, but not DRIL complaints; however, in fiscal year 2015, IHSC began including DRIL complaints in the tasking process.²⁹

As the entity ultimately responsible for addressing medical-care-related complaints, IHSC officials acknowledged the need to have a more robust task management system and to maintain more comprehensive data on complaints. IHSC officials also told us that in cases when a count of complaints received is needed, IHSC tasking staff transfer the notifications maintained in the e-mail folders located in the tasking mailbox to an Excel spreadsheet and generate a count or list of the complaints. While IHSC officials can generate a count of complaints, they told us it is very cumbersome to review all message notifications to generate such counts. IHSC officials told us that this process for maintaining data on medical-care-related complaints is not comprehensive. They further told us that they are uncertain how many complaints come from different sources, such as NGOs, attorneys, detainees, and others, without going through complaint message notifications to determine the sources.

IHSC officials acknowledged that having the ability to identify information such as complaint volume and source, among other complaint information, would be useful for conducting various analyses. ERO and IHSC officials informed us they plan to have a new tasking system in place in 2016 and expect the new system will allow IHSC to monitor tasks, such as addressing CRCL, DRIL, and JIC complaints, and maintain a history of IHSC responses to the tasks. Further, they told us that the task management system intends to help streamline, centralize, and organize the current tasking system, including complaint resolution. IHSC officials provided us with a draft operations memorandum that discusses the planned system. Specifically, the draft memorandum lays out policies and procedures for receiving, initiating, and responding to tasks—from task origination to task closure. The memorandum also states that maintaining tasks in the new system would allow IHSC management to

²⁹According to ERO and IHSC officials, OIG hotline complaints are routed through JIC, then ERO Administrative Inquiry Unit before being forwarded to IHSC for review and investigation.

monitor compliance with tasking due dates, have visibility over tasking workloads, and provide the ability to obtain task status reports. The system is currently being piloted in an ICE ERO area of responsibility and a guide for system use is being developed.

While changes to IHSC's current tasking process should provide greater tasking management capabilities, including keeping track of its complete tasking workload, the operations memorandum for the new management system has not been finalized, a user guide is still in development, and the pilot program is underway. It is therefore too early to tell the extent to which this task management system will provide all of the desired tasking capabilities. The draft memorandum also does not specify whether all complaints obtained by IHSC will be included in the new tasking system, such as those that do not require action by IHSC. Further, it does not state whether a comprehensive set of complaint data will be systematically captured in the system, such as volume of complaints obtained and addressed, sources of complaints, and facilities where complaints originate. This information could enable ICE to conduct broad analyses of medical care complaints and potentially inform operational decision making. However, the draft memorandum and IHSC officials did not indicate that data in the new task management system would be used for such analyses. Rather, the planned task system would function primarily as a tool for assigning and monitoring the progress of internally generated tasks, including medical complaints requiring IHSC action.

Standards for Internal Control in the Federal Government calls for there to be procedures in place to monitor performance of regular operations over time and that there be clearly defined roles and responsibilities for carrying out operating activities as well as effective communication within and across agencies to help ensure appropriate decisions are made. Developing and implementing a mechanism to consolidate and maintain complete data on medical complaints received by DHS entities, including volume of complaints, sources of and top reasons for complaints, could better position DHS to analyze trends and assess the overall process for obtaining and addressing complaints; information that could be useful for management. While DHS provides various avenues for detainees to file complaints, DHS does not have a mechanism to readily determine the overall volume of complaints it receives, their status, or outcome. Developing a system that would allow IHSC to have data readily available to conduct trend analyses, including analysis of complaint volume, facilities where complaints are filed, and differences across facility type, and one that can monitor IHSC responses, and amount of time to resolve complaints, could be useful for management decision making.

Conclusions

Ensuring that the tens of thousands of men, women, and children that are held in ICE detention facilities are provided with appropriate and timely medical care is an important responsibility of ICE. Because of this importance, DHS and ICE have implemented multiple levels of oversight as well as mechanisms for detainees and others to report medical grievances. In addition, ICE has established processes to provide detainees with medical treatment outside the detention facilities, such as in cases of emergencies or when specialty treatment is needed. Regarding these areas—off-site medical care, oversight mechanisms, and complaint mechanisms—ICE collects data and other information. However, ICE does not systematically utilize these data to analyze larger trends. For example, ICE has a data system that allows officials to review and approve requests for off-site care, but the system does not allow officials to track the number of requests and approvals or denials by procedure type. Furthermore, the authorizations for off-site care in this data system are not fully linked to claims paid to off-site providers. In terms of oversight, ICE uses seven different mechanisms that employ a variety of techniques to help ensure medical policies are followed and detention standards are met. Although these different mechanisms are effective for addressing specific medical issues at individual facilities, ICE does not systematically connect and use oversight results to examine any overarching medical issues over time and across all facilities. Similarly, there are multiple avenues for detainees or others to file medical complaints, such as toll-free telephone hotlines or formal written complaints, and all medical complaints eventually are received by IHSC for resolution. However, IHSC has limited oversight and tracking capability over the universe of complaints, making it difficult for DHS to analyze trends in medical care complaints and assess the extent to which changes to medical care may be needed across facilities. Taking additional actions in accordance with federal internal control standards to facilitate better analysis of off-site care, oversight, and complaint information would enhance ICE’s ability to make more effective clinical and business decisions across immigration detention facilities.

Recommendations for Executive Action

To enhance Department of Homeland Security’s (DHS) U.S. Immigration and Customs Enforcement’s (ICE) ability to make more effective business decisions across immigration detention facilities with respect to the provision of medical care, we recommend that the Secretary of Homeland Security direct ICE to take the following actions:

- develop and implement a mechanism to identify and assess trends in off-site medical care procedures across types of procedures and

facilities;

- develop and implement a mechanism to ensure that payments for off-site care are supported by the appropriate authorizations; and
- track inspection results and conduct analyses of oversight data over time, by standards, and by facility type.

Additionally, we recommend that the Secretary of Homeland Security ensure that IHSC's planned new tasking system includes all medical-care-related complaints received by DHS entities, and that this system facilitates the tracking and analysis of complaints over time and across facilities.

Agency Comments and Our Evaluation

We provided a draft of this report to DHS and the Department of Justice for their review and comment. The Department of Justice indicated that it did not have any comments on the draft report in a February 9, 2016 email from the department's Audit Liaison. DHS provided written comments, which are noted below and reproduced in full in appendix V, and technical comments, which we incorporated as appropriate.

DHS concurred with all four recommendations in the report and described actions underway or planned to address them. With regard to the first two recommendations related to the provision of off-site medical care, DHS concurred and stated that ICE will collaborate on actions with the Veterans Affairs entity that is responsible for handling ICE detainee medical claims. For example, DHS stated that ICE will work with Veterans Affairs to determine if trends in off-site medical care procedures can be incorporated into an existing medical claims database, and will review processes and develop routine reports to help ensure that claims paid correspond to appropriate authorizations. With regard to the third recommendation that ICE track facility inspection results and conduct analyses of oversight data, DHS concurred and stated that ICE has begun to summarize facility site visit findings that will enable trending and analysis over time and across facilities. With regard to the fourth recommendation that IHSC track and analyze medical-care related complaints received by DHS entities, DHS concurred and stated that IHSC has already commenced building a limited tracking system and will work to build as robust a system as resources will allow. DHS also stated that IHSC will request DHS entities involved in all medical complaints related to ICE detainees ensure that IHSC receives the complaint information for entry into its database, even for complaints that IHSC

does not handle. These planned actions, if fully implemented, should address the intent of the four recommendations contained in this report.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Homeland Security, the Attorney General of the United States, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions, please contact me at (202) 512-8777 or gablerr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made significant contributions to this report are listed in appendix VI.

Sincerely yours,



Rebecca Gambler
Director
Homeland Security and Justice

Appendix I: Objectives, Scope, and Methodology

This report addresses to what extent does the Department of Homeland Security (DHS):

1. have processes for administering medical care to immigration detainees and maintaining information on costs associated with care,
2. assess and monitor compliance with medical care standards at detention facilities, and
3. oversee processes to obtain and address complaints about medical care in immigration detention facilities?

To address these questions, we assessed DHS's cost maintenance, oversight, and grievance processes at 165 facilities used by U.S. Immigration and Customs Enforcement (ICE) to hold detainees for periods longer than 72 hours in fiscal year 2015. We visited a purposive, non-generalizable sample of 12 detention facilities in Arizona, California, Illinois, Maryland, Missouri, Texas, and Wisconsin. We selected these facilities to reflect a range of several factors, including facility type, detention standards governing the facility, the ICE Field Office Area of Responsibility, average daily population (ADP) of detainees, and recommendations made by DHS and organizations that work with immigration detainees. Data regarding facility type, detention standards, and ADP were obtained from ICE. To determine the reliability of these data, we reviewed ICE documentation and interviewed agency officials about the data systems, and determined that the data were sufficiently reliable for our purposes. For our site visits, we selected detention facilities in five Areas of Responsibility (AOR) that provided diversity across facility types, standards in use, and ADP. We interviewed ICE Enforcement and Removal Operations (ERO) field office officials, ICE Health Service Corps (IHSC) Field Medical Coordinators (FMC), facility administrators, medical personnel, and detainees about medical care at facilities. We interviewed a non-generalizable sample of 120 detainees to determine their perception of medical care at each facility and their knowledge of filing medical care grievances, among other things. We randomly selected detainees to interview at each of the 12 facilities, and we interviewed between 6 and 12 detainees per visit depending on the time allotted for interviews. Since detainees speak various languages, and not all are proficient in English, we interviewed detainees in both English and Spanish, and we used a translation service for interviews conducted in other languages, such as Punjabi or Burmese. We also observed facilities' practices regarding medical care and grievance systems, such as the posting of required DHS hotline information, the placement of grievance boxes, and the layout of medical care areas. The

information we obtained from our facility visits cannot be generalized to all facilities or detainees, but offers insight into the operational settings at facilities, such as how medical care standards are applied and assessed and the management of medical care grievance processes. Prior to each site visit, we spoke with at least one local or non-governmental organization in each ICE Field Office Area of Responsibility to understand their impressions of detainee medical care at each facility that we visited. We identified these organizations through recommendations provided by two national organizations—the American Civil Liberties Union and the National Immigrant Justice Center. While not generalizable, this sample of organizations provided us with helpful insights into the perspectives of local detainee advocacy groups regarding medical care at detention facilities.

To determine the processes of administering medical care to detainees, we reviewed ICE documents, including the IHSC Policy Manual, a July 2015 IHSC Operational Memorandum, and other documentation related to its mission of overseeing and providing medical care to detainees. In addition, we interviewed relevant ICE headquarters and regional officials, as well as ICE and detention facility officials associated with visits to 12 facilities about the processes of providing medical care. To determine the extent to which DHS maintains information on the costs associated with medical care, we reviewed information about authorizations and payments for off-site care for over-72-hour facilities operating in fiscal years 2012 through 2014. To determine the reliability of medical claims and expenditure data, we reviewed documentation and a prior GAO report, and interviewed agency officials. We determined that some of these data were sufficiently reliable to provide a general indication of approximate costs for some, but not all, medical care expenditures. We assessed ICE practices for administering off-site medical care and the agency efforts to track and utilize cost data against *Standards for Internal Control in the Federal Government*.¹

To determine the extent to which DHS monitors compliance with medical care standards, we analyzed the percentage of ADP covered by each of ICE's oversight mechanisms in 2015, the year for which the most recent data was available. Specifically, we analyzed the extent to which ICE

¹GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington D.C.: Nov. 1999).

utilized the following oversight mechanisms at over-72-hour detention facilities:

- Custody Management Division (CMD) Inspections,
- Operational Review Self-Assessments (ORSA),
- Family Residential Inspections,
- Field Medical Coordinator (FMC) Site Visits,
- IHSC Quality Improvement Audits,
- Office of Detention Oversight (ODO) Inspections, and
- Detention Service Managers (DSM).

We determined which of 165 over-72-hour facilities utilized the various oversight mechanisms and calculated each facility's ADP as a percentage of ICE's total fiscal year 2015 ADP using ICE population data. To determine the reliability of ICE's ADP and population data, we reviewed ICE documentation and interviewed officials knowledgeable about the creation, use, and storage of the data. We determined that these data were sufficiently reliable for our purposes. We also identified overlapping oversight mechanisms to determine the percentage of ADP covered by multiple forms of oversight. We reviewed ICE documents and interviewed agency officials to determine how each oversight mechanism is intended to function. We also analyzed recent results for the various oversight mechanisms, from years 2011 through 2015, depending on the availability of inspection results and data. To determine the extent to which DHS assesses medical care compliance at facilities, we reviewed ICE documents and interviewed agency officials to determine use of inspection results, and assessed whether DHS uses results in accordance with *Standards for Internal Control in the Federal Government*.²

To determine the extent to which DHS oversees immigration detention medical care complaint mechanisms, we analyzed and compared Office

²[GAO/AIMD-00-21.3.1.](#)

for Civil Rights and Civil Liberties (CRCL), Detention and Reporting Information Line (DRIL), IHSC, Joint Intake Center (JIC), and Office of the Inspector General (OIG) processes for obtaining and addressing complaints; analyzed fiscal year 2014 complaint data maintained by these DHS entities' data systems; and reviewed ICE detention and family residential standards that govern facility grievance systems. We also reviewed and analyzed CMD, ODO, and ORSA grievance standard inspection data for calendar and fiscal year 2014—the most recent data available at the time of our review—to assess the extent to which inspections found deficiencies in grievance standards. To determine the reliability of the complaint and inspection results data, we reviewed documentation, interviewed agency officials, and conducted testing. Based on our review of CRCL, DRIL, JIC, and OIG information and data, and CMD, ODO, and ORSA inspection data, as well as the officials' responses to our questions, we determined the data were sufficiently reliable for our purposes. We reviewed IHSC fiscal year 2014 data on complaints tasked to IHSC from other DHS entities for review and resolution; and reviewed official's responses to our questions. We chose not to use specific IHSC data on complaints in fiscal year 2014 because, according to agency officials, all complaints were not included. IHSC addressed, but did not include DRIL complaints in its tasking data system, and therefore these complaints were not included in the count of complaints addressed by IHSC in fiscal year 2014. IHSC began including DRIL complaints in its tasking system in fiscal year 2015. We also interviewed DHS, ICE, and facility officials about their guidance, procedures, and any complaint data maintained; and assessed processes against applicable detention standards and *Standards for Internal Control in the Federal Government*.³

We conducted this performance audit from October 2014 to February 2016 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.

³[GAO/AIMD-00-21.3.1](#).

Appendix II: Description of Changes to U.S. Immigration and Customs Enforcement (ICE) Detention Standards over Time

ICE's National Detention Standards (NDS) were first issued in 2000 as a means to facilitate consistent conditions of confinement, access to legal representation, and safe and secure operations across the immigration detention system. The standards include requirements for the provision of detainee medical care, access to legal representation, and grievance procedures, among other topics, to help ensure the safe and secure operation of detention facilities. The 2000 NDS were formed through a collaborative effort among former Immigration and Naturalization Service officials, Department of Justice officials, and representatives of non-governmental organizations, according to ICE documents that describe changes to detention standards over time. The standards were modelled after standards for detention facilities issued by the American Correctional Association.

In 2004, the American Correctional Association updated its standards and issued the 4th Edition *Performance-Based Standards for Adult Local Detention Facilities*. ICE then began to revise its own detention standards to more fully align with those of the American Correctional Association, according to ICE documents. The revision of ICE's standards continued through 2007 and resulted in the formulation of the 2008 Performance-Based National Detention Standards (PBNDS). The Division of Immigration Health Services, now the ICE Health Service Corps, contributed to the development of the medical care and other health-related standards. The draft PBNDS were reviewed by the Detention Standards Compliance Unit of ICE, Division of Immigration Health Services, Office of the Principal Legal Advisor. Those offices then finalized the draft PBNDS with input from the ICE Office of Detention Policy and Planning, and the Department of Homeland Security's Office of Civil Rights and Civil Liberties. Following this review of the new standards, ICE solicited input from interested non-governmental organizations, according to ICE documents.

In addition to requirements dictating how detention facilities should operate, the PBNDS outline expected outcomes, or results that the required procedures found in the standards are expected to accomplish. These expected outcomes align with outcome measures found on inspection worksheets, which guide and document facility inspections. According to ICE documents, the outcome measures indicate how well a facility is doing what the standards require and how well the facility is achieving the expected results found in the standards.

ICE further revised the PBNDS for a 2011 version to improve conditions of confinement, including the improvement of medical and mental health

services and the process for reporting and responding to detainee complaints, as stated in ICE documentation. In the 2000 NDS and the 2008 PBNDS, some requirements applied only to Contract Detention Facilities and Service Processing Centers. The 2011 PBNDS expanded those requirements to dedicated intergovernmental service agreement facilities to make conditions of confinement more uniform at facilities housing only ICE detainees. Non-dedicated intergovernmental service agreement facilities following the 2011 PBNDS must conform to the procedures required of dedicated facilities, or must adopt procedures that meet the intent of those requirements. In the 2011 PBNDS, ICE made some of those required standards of the 2008 PBNDS applicable to all facilities.

The 2011 PBNDS also added optimal provisions, which are non-mandatory, and which represent optimal levels of compliance with the standards. According to ICE documents, implementation of optimal provisions facilitates effective operation of a facility at the level intended by ICE under the 2011 standards. For example, under the 2011 PBNDS expected outcome that “Detainees shall have access to a continuum of health care services, including screening, prevention, health education, diagnosis and treatment,” the following optimal provision is stated:

“Medical facilities within the detention facility shall achieve and maintain current accreditation with the standards of the National Commission on Correctional Health Care, and shall maintain compliance with those standards.”

According to ICE documents, facilities following the 2011 standards are not required to maintain National Commission on Correctional Health Care accreditation, but ICE intends optimal medical care processes to follow practices for such accreditation, as this accreditation would help to ensure that facilities meet the expected outcome of providing a continuum of health care services.

In the 2011 standards, ICE included a medical care standard specifically for women in order to help facilities deliver appropriate and necessary medical and mental health services to female detainees. This standard outlines requirements for intake health assessments, use of restraints for pregnant detainees, abortion access, and mental health services for detainees who recently gave birth, miscarried, or terminated a pregnancy. Like the general medical care standard, the optimal provision suggests compliance with National Commission on Correctional Health Care standards, as follows:

**Appendix II: Description of Changes to U.S.
Immigration and Customs Enforcement (ICE)
Detention Standards over Time**

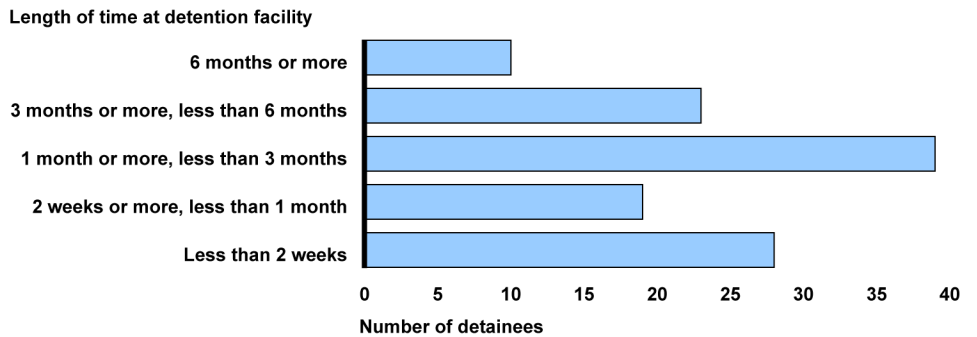
“The facility’s provision of gynecological and obstetrical health care shall be in compliance with standards set by the National Commission on Correctional Health Care.”

Appendix III: Analysis of Site Visit and Detainee Interview Data

We visited a purposive, non-generalizable sample of 12 over-72-hour detention facilities in Arizona, California, Illinois, Maryland, Missouri, Texas, and Wisconsin. We selected these facilities based on a mix of factors, such as facility type, detention standards governing the facility, the U.S. Immigration and Customs Enforcement (ICE) Field Office Area of Responsibility, average daily population (ADP) of detainees, and recommendations made by the DHS and organizations that work with immigration detainees. We interviewed a non-generalizable sample of 120 detainees to determine their perception of medical care at each facility and their knowledge of filing medical care complaints, among other things. We randomly selected detainees to interview at each of the 12 facilities, and we interviewed between 6 and 12 detainees per visit depending on the time allotted for interviews. Detainees spoke various languages, and some detainees were not proficient in English. We interviewed detainees in both English and Spanish, and we used a translation service for interviews conducted in other languages, such as Punjabi and Burmese. We did not require each detainee to answer every question during the interviews. We did not verify detainees' claims following interviews. For instance, we did not conduct reviews of detainees' medical files to determine whether they had received medical screenings upon arrival at a facility. The non-generalizable sample of detainees interviewed is not reflective of the current population of ICE detainees. We also observed facilities' practices regarding medical care and grievance systems, such as the posting of required DHS hotline information, the placement of grievance boxes, and the layout of medical care areas. The information we obtained from our facility visits cannot be generalized to all facilities or detainees, but offers insight into the operational settings at facilities, such as how medical care standards are applied and assessed and the management of medical care grievance processes.

The detainees that we interviewed reported that they had been in detention at the sample of facilities for varying amounts of time. Figure 7 shows the approximate length of time that the sample of detainees had been in detention at the time of our interviews. Of the 119 detainees who reported the length of their detention at each facility, 47—approximately 40 percent—said they had been in detention for less than 1 month, and 86—approximately 70 percent—said they had been in detention for less than 3 months at the time of the interviews. The remaining 33 detainees—approximately 30 percent—said they had been in detention for at least 3 months at the time of our interviews.

Figure 7: Length of Detention at Time of Interviews, Number of Detainees



Source: GAO analysis of interview responses. | GAO-16-231

Note: All detainees did not respond to every question during interviews. The number of detainees who responded to a question about their length of time in detention equaled 119.

ICE requires that, upon admission, facilities provide detainees with information regarding facility rules and procedures, as well as medical care services and the grievance system. When asked about materials received upon arrival at the detention facilities, 118 detainees responded whether they had or had not received written materials or participated in an orientation session that described medical care services. Of these detainees, 65 said that they did receive information regarding medical care services at the facility. Another 42 detainees said that they did not receive information about medical care, and 11 said that they received general facility information but did not recall whether or not it described medical care services.

When asked, 117 detainees responded about whether they knew how to file a complaint about medical care received at the detention facilities, and 50 stated that they knew how to report complaints about medical care at the facility, while the remaining 67 said that they did not know how to file complaints. Table 7 shows the number of respondents at facilities following ICE’s four different detention standards who said that they did or did not know how to file a medical care complaint. The table shows that detainees at facilities using the 2011 Performance-Based National Detention Standards (PBNDS) reported higher rates of knowledge of the complaint process than at facilities using any of ICE’s other detention standards.

Table 7: Detainee Knowledge of Complaint Reporting Process by U.S. Immigration and Customs Enforcement (ICE) Detention Standards Used at Facility, Number of Detainees

ICE Detention Standard	Yes, detainee reported he/she knew how to file complaint	No, detainee reported he/she did not know how to file complaint	No response
2000 National Detention Standards (NDS), N=44	15	28	1
2008 Performance-Based National Detention Standards (PBNDS), N=17	3	14	0
2011 PBNDS, N=36	23	11	2
Family Residential Standards, N=23	9	13	1

Source: GAO analysis of interview responses. | GAO-16-231

Note: Not all detainees responded to every question during interviews.

One facility that we visited had been found deficient in a fiscal year 2014 inspection in the standard requiring facility handbooks to provide guidance regarding how detainees may appeal a grievance decision. When we spoke to detainees at this facility, eight of nine were generally unfamiliar with grievance processes, and said that they did not know how to file a complaint.

ICE detention standards require that detainees receive a medical screening within 12 hours of arrival at a detention facility. We asked detainees whether they had received a medical screening upon arrival and whether facility staff had provided an explanation for the screening. Of 108 detainees, 67 said that staff did explain the reasons for the screening, 34 stated that staff did not explain the reasons for the screening, and 7 could not recall if an explanation had been given. Table 8 shows the number of detainees at each facility type who reported receiving an initial medical screening within the same day of arrival, after the first day of arrival, or not at all. The table shows that detainees at facilities with intergovernmental service agreements (IGSA) reported more instances of receiving screenings after their first day at the facility or of not receiving medical screenings.

Table 8: Receipt and Timing of Detainee Medical Screenings by Facility Type as Reported by Detainees, Number of Detainees

Facility Type	Received medical screening within first day at facility	Received medical screening after first day at facility	Did not receive medical screening	Did not recall or did not respond to timing of medical screening	No response
Intergovernmental service agreement (IGSA) facility, N=32	18	9	4	0	1
Family residential facility, N=23	21	1	0	0	1
Contract detention facility, N=11	11	0	0	0	0
U.S. Marshals Service intergovernmental agreement or contract facility, N=30	22	3	1	1	3
Dedicated IGSA facility, N=12	11	0	0	1	0
Service processing center, N=12	9	2	0	0	1

Source: GAO analysis of interview responses. | GAO-16-231

Note: Not all detainees responded to every question during interviews.

One facility that we visited had been found deficient in the detention standard requiring medical screenings to occur within 12 hours of arrival during a fiscal year 2014 inspection. When we visited that facility, 11 of the 12 detainees we spoke with stated that they had received an initial screening within the same day of arrival. The twelfth respondent at this facility stated that he had received a screening but did not specify when.

During a fiscal year 2015 inspection of a family residential facility that we visited, inspectors noted that all medical files reviewed for residents indicated that medical screenings had been performed within the required 12-hour period after arrival at the facility. During our interviews with 12 residents at this facility, all 12 stated that they had received a medical screening on the same day as their arrival at the facility.

ICE detention standards also require facilities to conduct in-depth medical examinations of detainees within 14 days of arrival at a facility. We spoke with 96 detainees who reported whether or not they received an in-depth medical examination and who specified when that examination took place. Of 19 detainees who had been at the facility for 14 or fewer days, 18 had received a medical examination within that time and 1 was still awaiting his examination. Of the 77 detainees who had been at the facility for longer than 14 days, 48 stated that they had received a medical examination within 14 days. The remaining 29 detainees stated that they did not receive a medical examination within 14 days, either because they

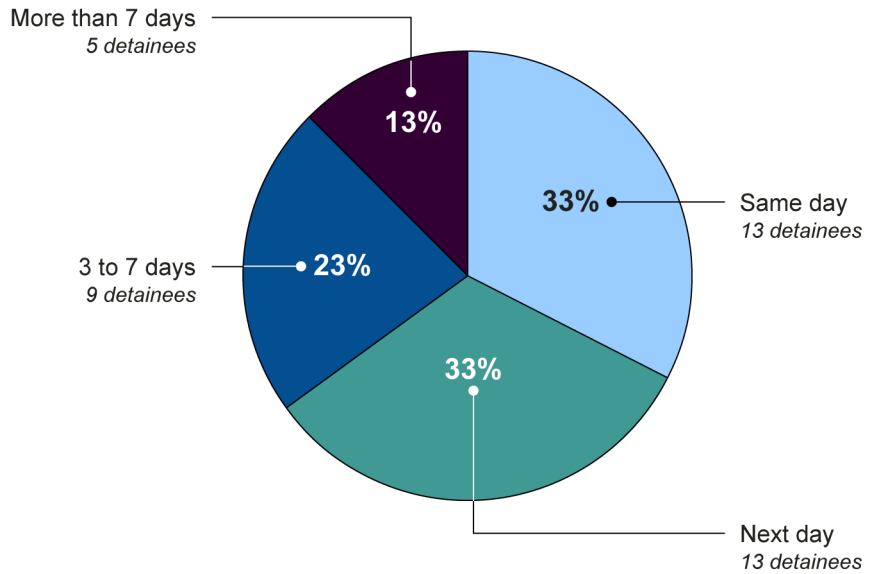
had received an examination after 14 days, or because they had never received a medical examination.

During a fiscal year 2015 inspection of a family residential facility that we visited, inspectors noted that all medical records reviewed for residents indicated that medical examinations had occurred within two working days of arrival.¹ When we spoke to residents at this facility about when they received a medical examination, all nine responded that they had received it within 14 days of arrival.

Our analysis of interview responses found that 50 detainees had requested additional medical care while at the detention facilities and that 25 had requested this care during medical clinic hours, known as sick call. Another 9 detainees visited the medical clinic during walk-in hours, 2 asked for care verbally, 4 used a kiosk system to request care, and 1 requested care during the medical examination. The remaining 9 detainees did not specify how they had requested additional medical care. Of the 50 detainees who had requested care, 9 reported having to wait an unspecified amount of time to receive care, while 1 detainee stated that he was still waiting for care. Figure 8 shows the amount of time that the other 40 detainees reported having to wait to receive care. The figure shows that more than half of detainees interviewed who requested medical care at a facility reported receiving that care by the following day.

¹According to ICE's Family Residential Standards, medical examinations are required within 7 days of arrival for adults and within 24 hours of arrival for minor residents.

Figure 8: Reported Receipt of Additional Medical Care at Facilities Following Requests for Care, Number of Detainees



Source: GAO analysis of interview responses. | GAO-16-231

Note: All detainees did not respond to every question during interviews. The number of detainees interviewed who provided an approximate wait time for requested medical care equaled 40.

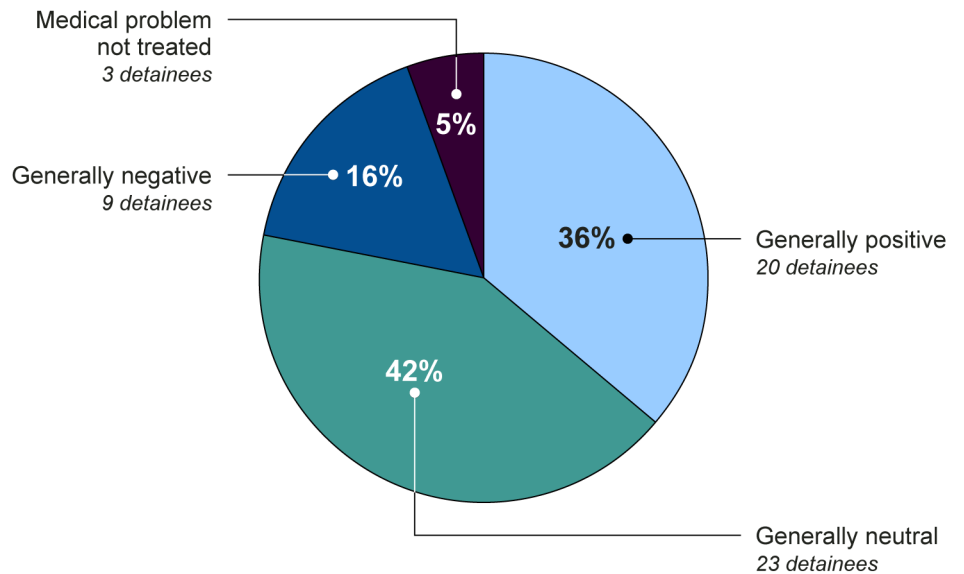
Of those who received additional medical care, 22 indicated that they were generally satisfied with the wait time or felt that the wait time was acceptable. Another 12 respondents indicated that they were unsatisfied with the amount of time it took to receive medical care. The remaining 15 respondents did not indicate their levels of satisfaction with their wait time.

One facility that we visited received a deficiency during a fiscal year 2015 inspection for the detention standard that requires detainees' medical information to remain protected. Inspectors found that detainees submitted medical care request slips to nursing or detention staff, which did not ensure patient privacy since the request slips contained medical information. During our site visit to this facility, we observed medical care request slips (i.e., "sick call" slips) inserted through door frames by detainees without a confidential envelope to protect the medical information present on the request slips.

Overall, the majority of detainees who expressed their opinions about medical care received at the facilities felt generally positive or neutral about their care. Of 55 detainees who expressed their views, 20 felt

generally positive about their medical care services, 9 felt generally negative, 23 felt neutral or “okay,” and 3 stated that their medical problems were not treated, as seen in Figure 9.

Figure 9: Perceptions about Medical Care Received at Detention Facilities, Number of Detainees



Source: GAO analysis of interview responses. | GAO-16-231

Note: All detainees did not respond to every question during interviews. The number of detainees interviewed who provided an opinion of medical care received at a facility equaled 55.

Table 9 shows detainees’ reported satisfaction with medical care received by facility population type (i.e., mixed adult, ICE-only adult, or ICE-only family populations). The table shows that detainees housed at ICE-only facilities reported fewer instances of negative perceptions of their medical care than detainees housed at facilities holding other detained individuals, such as state or county prisoners.

Table 9: Perceptions about Medical Care Received at U.S. Immigration and Customs Enforcement (ICE) Detention Facilities by Facility Population, Number of Detainees

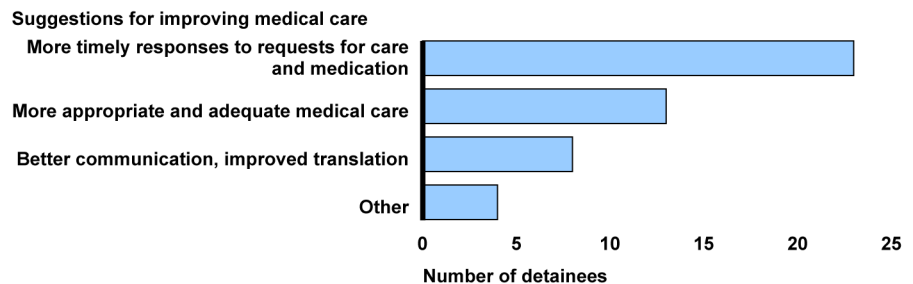
ICE detention facility population type	Generally positive	Generally neutral or “okay”	Generally negative	Medical problem not treated by facility	No response
Mixed adult population, N=74	10	11	7	3	43
ICE-only adult population, N=23	4	7	0	0	12
ICE-only family population, N=23	6	5	2	0	10

Source: GAO analysis of interview responses. | GAO-16-231

Note: Not all detainees responded to every question during interviews.

During our interviews with detainees, 42 respondents provided suggestions for improving medical care at detention facilities, as seen in figure 10. Approximately half of the detainee responses suggested that facilities could improve their timeliness of responses to requests for medical care and medication, as well as more regular check-ups to ensure that detainees remain healthy while in detention. Approximately one quarter of responses suggested more appropriate and adequate medical care. That is, the detainees suggested that facilities have more services available, as well as provide treatment that addresses detainees’ medical issues. The remainder of responses suggested improved communication from and among medical staff, as well as improved translation, better record keeping of treatments, and better coordination with outside providers. Of the detainees that we spoke to, 13 stated that language barriers exist for filing complaints and requesting medical care at facilities, specifically because guidance is provided to detainees in English rather than Spanish or other relevant languages.

Figure 10: Detainee Suggestions for Improving Medical Care at U.S. Immigration and Customs Enforcement (ICE) Detention Facilities, Number of Detainees



Source: GAO analysis of interview responses. | GAO-16-231

Note: All detainees did not respond to every question during interviews. The number of detainees interviewed who provided suggestions for improving medical care in ICE detention facilities equaled 42. Four respondents provided multiple suggestions for improving medical care services at detention facilities.

Appendix IV: Description of U.S. Immigration and Customs Enforcement (ICE) Medical Care Oversight Mechanisms

Based on our review of ICE policy, ICE uses the following seven oversight mechanisms to assess facility compliance with medical care detention standards and to inspect the quality of medical care at facilities:

- Custody Management Division (CMD) Inspections
- Operational Review Self-Assessments (ORSA)
- Family Residential Inspections
- Field Medical Coordinator (FMC) Site Visits
- ICE Health Service Corps (IHSC) Quality Improvement Audits
- Office of Detention Oversight (ODO) Inspections
- Detention Service Managers (DSM)

During fiscal year 2015, more than 99 percent of ICE's average daily population (ADP) was covered by two or more of these oversight mechanisms.

Custody Management Division Inspections

The Custody Management Division of ICE Enforcement and Removal Operations (ERO) employs a contractor to conduct inspections of detention facilities against the National Detention Standards (NDS) and Performance-Based National Detention Standards (PBNDS). The contractor utilizes a checklist inspection form to identify line item deficiencies at a facility. The form also provides space for the contractor to make notes about line items within a standard, allowing the contractor to clarify why an item is or is not deficient. Line items represent smaller parts of an overall standard, and facilities can receive deficiencies for individual line items without receiving a deficiency on the standard overall. Inspections are conducted annually or biennially at facilities that are authorized to house detainees for more than 72 hours, and that have an ADP of 10 or more detainees. After two consecutive years of overall passing ratings for annual inspections, those facilities with an ADP of fewer than 50 detainees may be moved to a biennial inspection schedule. Following the inspection, the contractor submits deficiencies to CMD for the development of uniform corrective action plans to help ensure that the

deficiencies are addressed, according to a CMD official, and CMD records the implementation of these action plans. In 2014, 90 over-72-hour facilities underwent inspections by CMD contractors.¹ Inspectors found 62 medical care line item deficiencies at 30 facilities. Table 10 shows the frequency of line item deficiencies found at over-72-hour facilities in 2014. Two-thirds of facilities had no medical care line item deficiencies that year. No facilities inspected in 2014 had overall deficient medical care standards.

Table 10: Frequency of Medical Care Line Item Deficiencies Found by Custody Management Division (CMD) Over-72-Hour Facility Inspections, 2014

Number of deficiencies	Number of facilities
0	60
1	9
2	15
3	3
4	1
5	2 ^a

Source: GAO analysis of ICE inspection results. | GAO-16-231

Notes: Inspections analyzed included annual and biennial CMD inspections, as well as pre-occupancy inspections of potential facilities. Not all facilities that received pre-occupancy inspections ultimately housed ICE detainees. Like deficiencies identified during annual CMD inspections, those identified during pre-occupancy inspections are also addressed through uniform corrective action plans.

^aOne facility received three line item deficiencies in the medical care standards and two deficiencies in the Medical Care (Women) standard.

Operational Review Self-Assessments

Over-72-hour facilities with an ADP of fewer than 10 detainees complete an annual ORSA. This inspection process began in 2012. Like the CMD inspections, ORSAs are checklist inspections that assess facility compliance against the NDS or a sub-set of the NDS. ORSAs are completed by ERO Field Office staff, facility staff, or both.² Deficiencies

¹Inspections analyzed included both annual facility inspections and pre-occupancy inspections for potential facilities. Not all facilities that received pre-occupancy inspections ultimately housed ICE detainees. Like deficiencies identified during annual inspections, those identified during pre-occupancy inspections are also addressed through uniform corrective action plans.

²Each ERO Field Office Director is responsible for the entire ORSA process, which includes the annual inspection, the uniform corrective action plan process, and the final approval to use the facility as an ORSA facility.

found also require action plans for resolution, and officials stated that they record the implementation of those action plans. Table 11 shows the number of over-72-hour facilities that conducted ORSAs from 2012 through 2014, as well as the number of medical care line item deficiencies found. In 2012, one facility had three line item medical care deficiencies, one facility had two deficiencies, and one facility had one deficiency.

Table 11: Operational Review Self-Assessment Medical Care Line Item Deficiencies at Over-72-Hour Facilities by Calendar Year

Calendar Year	Number of Facilities Inspected	Number of Line Item Deficiencies	Number of Facilities with Line Item Deficiencies
2012	20	6	3
2013	26	3	3
2014	31	4	4

Source: GAO analysis of ICE inspection results. | GAO-16-231

Family Residential Inspections

The Juvenile and Family Residential Management Unit within CMD oversees inspections of family residential facilities, and employs an inspections contractor other than that utilized for adult facility inspections. Family residential facilities receive monthly, semiannual, and annual inspections, which use a checklist to assess compliance against the 2007 Family Residential Standards.³ The family residential inspection process uses a checklist format, and also includes a narrative aspect to describe the substance of deficiencies. Juvenile and Family Residential Management officials stated that this narrative aspect allows for more in-depth analyses of results than those performed using only a compliance checklist. For instance, officials cited an example of a detention standard that requires a response to medical issues within 72 hours. Inspectors using only a checklist might validate whether there was any response regarding the issue within that 72-hour timeframe. The family residential inspections contractor, however, could use the narrative inspection fields to describe how the response was or was not substantially responsive to the issue, allowing for a more detailed validation of compliance, according to officials. Action plans for deficiencies found during inspections are developed and implemented by the Juvenile and Family Residential Management Unit. During inspections in February 2015 and September

³The Hutto facility is inspected on a semiannual basis and is not inspected monthly.

2014, respectively, two family residential facilities each had one medical care line item deficiency.

Field Medical Coordinator Site Visits

IHSC uses FMCs to conduct semiannual site visit inspections of medical care at facilities that house detainees for over 72 hours where IHSC does not directly provide care to detainees. During these inspections, FMCs assess a facility's compliance with medical care standards found in the NDS and the PBNDS. FMCs conduct reviews of detainees' medical records using a set of audit worksheets developed in conjunction with the Department of Homeland Security's Office for Civil Rights and Civil Liberties (CRCL).⁴ Compliance with an indicator requires that 90 percent of files reviewed for that indicator meet requirements set forth on the audit worksheet. FMCs conduct these inspections approximately every 6 months, visiting each over-72-hour facility within their respective geographical areas of responsibility during that period. FMCs visit a facility more frequently if the facility has many deficiencies regarding medical care. If numerous deficiencies are found at a facility, FMCs send their findings to ERO and request an action plan for resolution of each deficiency. Full results for fiscal year 2015 site visit inspections were not available at the time of this report's issuance, but IHSC provided an example of results for review. This example, while not inclusive or representative of all results, showed that IHSC intends to track site visits by date, noting overall compliance level with the medical care standard, as well as recommendations and facility actions to be taken.

IHSC Quality Improvement Audits

IHSC conducts quarterly quality improvement audits at the approximately 20 IHSC-staffed medical clinics in detention facilities. These audits use worksheets similar to those used by FMCs, and Quality Improvement Coordinators conduct medical record file reviews to assess the quality of care at each clinic. Facilities are compliant in an indicator when 90 percent or more of the files reviewed satisfy the requirements of the respective audit worksheet. If an indicator falls below the established

⁴CRCL and IHSC developed a number of quality-of-care audit worksheets to help FMCs assess the quality of health care at each facility and to help ensure continuity and coordination of care for detainees with serious chronic care conditions, including diabetes, HIV, and mental health conditions. The audit worksheets dictate requirements of files reviewed and allow FMCs to record the answers to audit questions for each detainee file reviewed during the audit.

threshold for compliance, the facility is required to submit a corrective action plan and consider conducting a study about the issue, according to an IHSC official. In fiscal year 2014, IHSC identified nine indicators that fell below this 90 percent compliance threshold when viewed across all IHSC-staffed facilities. That is, the aggregated compliance across the total number of IHSC-staffed facilities, rather than compliance of individual facilities, fell below 90 percent for these nine indicators. Of these nine deficient indicators, the lowest compliance score was 73 percent. According to officials, IHSC also conducts random continuous quality improvement “spot check” audits via medical records reviews to help determine the accuracy of quarterly facility audits. These audits are conducted monthly at the headquarters level. The quarterly audits identify local issues at the facility level, and IHSC officials stated that they use the results to improve healthcare delivery by monitoring and identifying high-risk, high-volume, or problem-prone process or systemic issues and developing and implementing strategies for improvement. Results are shared internally at IHSC and are sent to ERO upon request for the development of a corrective action plan.

Office of Detention Oversight Inspections

ODO, within ICE’s Office of Professional Responsibility, conducts annual inspections at a risk-based sample of over-72-hour facilities with an ADP of more than 10 detainees, according to a senior ODO official and ODO documentation. ODO gives a risk score to each facility to reflect a facility’s risk and probability of being deficient with detention standards. Risk factors used in scoring facilities include the following:

- deficiencies found in CMD inspections;
- number of deficiencies found;
- number and type of complaints and allegations;
- record of significant incidents, such as detainee deaths, hunger strikes, or suicide attempts;
- facility population size;
- operation by ICE contractors;
- last date of ODO inspection; and

- last date of CMD inspection.

ODO conducts as many inspections per fiscal year as the budget allows, and the office prioritizes inspections by facility risk score, according to a senior ODO official. ODO's goal, starting in fiscal year 2016, is to modify its risk-based methodology and prioritize facilities for inspections based on their last ODO inspection date and to inspect all over-72-hour facilities with an ADP of more than 10 detainees within a three-year period. During these inspections, ODO assesses facility compliance with a core set of standards, including medical care. These standards are ones that, if found to be deficient, could have the greatest impact on detainee health, safety, and civil rights and civil liberties. ODO may inspect facilities against additional standards based on trends and areas of concern found in various sources, such as CMD inspection reports and previous ODO inspection findings. The inspections also include interviews with a representative sample of detainees. ODO staff lead all inspections, and they use contract subject matter experts as needed. Medical care subject matter experts accompany ODO staff on all facility inspections to conduct an inspection of the medical care-related detention standards. Deficiencies found are sent to ERO in the form of a narrative facility report. ERO is then responsible for the development and implementation of corrective action plans for each deficiency. Table 12 shows the frequency of deficiencies found at facilities inspected by ODO during fiscal years 2011 through 2014. In each year, the majority of facilities received two or fewer medical care line item deficiencies. In fiscal years 2012 and 2014, 67 and 53 percent of facilities inspected, respectively, received at most one medical care line item deficiency.

Table 12: Frequency of Medical Care Line Item Deficiencies Found in Office of Detention Oversight (ODO) Inspections, by Fiscal Year, 2011 to 2014

Number of deficiencies	Number of facilities, 2011	Number of facilities, 2012	Number of facilities, 2013	Number of facilities, 2014
0	5	24	16	9
1	4	13	3	8
2	10	10	12	6
3	8	4	5	3
4	0	3	0	3
5	2	1	2	2
6	4	0	0	1 ^a
7	1	0	2	0
Total facilities inspected	34	55^b	40	32

Source: GAO analysis of ICE inspection results. | GAO-16-231

^aThis facility received five deficiencies in the medical care standard and one deficiency in the medical care (Women) standard.

^bODO inspected 56 facilities in fiscal year 2012, and one facility was not inspected for medical care compliance.

Detention Service Managers

DSMs have a continuous presence at facilities to provide informal, on-the-spot guidance for corrections of minor deficiencies, that is, those deficiencies that are isolated or non-life-threatening. DSMs speak with detainees on a regular basis to help identify issues within a facility, and they collaborate with facility staff to identify and fix deficiencies. In fiscal year 2015, DSMs operated in 53 of the 165 over-72-hour facilities that we analyzed. Of these facilities, 42 had a permanent DSM, while 11 used a roving DSM that oversaw multiple facilities. The ADP of facilities with a DSM was generally over 50 detainees in fiscal year 2015; four facilities had an ADP of 39, 43, 45, and 49, according to ICE data. DSMs send their findings to regional management each week through a narrative report that offers a more formal description of the work done and deficiencies found by the DSM, and provides details of the conditions of confinement at a facility. DSMs may request corrective action plans for any severe deficiencies found in a facility. At the start of fiscal year 2016, DSMs began tracking key metrics from weekly narrative reports, such as the number of compliance monitoring deficiencies found and the number of on-the-spot corrective actions logged by facilities, according to a senior CMD official.

Appendix V: Comments from the Department of Homeland Security



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

**Homeland
Security**

February 18, 2016

Rebecca Gambler
Director, Homeland Security and Justice Team
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Re: Draft Report GAO-16-231, "IMMIGRATION DETENTION: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care"

Dear Ms. Gambler:

Thank you for the opportunity to review and comment on this draft report. The U.S. Department of Homeland Security (DHS) appreciates the U.S. Government Accountability Office's (GAO) work in planning and conducting its review and issuing this report.

The Department is pleased to note GAO's positive recognition of the U.S. Immigration and Customs Enforcement (ICE) efforts to provide appropriate and timely medical care to the tens of thousands of men, women, and children that are held in ICE detention facilities. This includes multiple levels of oversight and mechanisms that have been implemented for detainees and others to report medical grievances. During fiscal year 2015, more than 99 percent of the Average Daily Population of detainees were subject to at least two forms of medical care oversight and 87 percent had three or four forms of oversight. ICE has also established processes to provide detainees off-site medical treatment, including emergencies and specialty care, when needed.

The draft report contained four recommendations with which the Department concurs. Specifically, GAO recommended that the Secretary of Homeland Security direct ICE to:

Recommendation 1: Develop and implement a mechanism to identify and assess trends in off-site medical care procedures across types of procedures and facilities.

Response: Concur. ICE's Enforcement and Removal Operations (ERO) / ICE Health Service Corps (IHSC) will engage the Veterans Affairs Financial Services Center (VAFSC) in Austin, Texas, who is responsible for handling the medical claims for IHSC, to determine if they can incorporate trends in off-site medical care procedures, using their medical claims database. IHSC is currently engaged with a contractor in the process of

developing a new electronic system to handle outside medical care requests, which will incorporate coding for types of procedures, so that trending for types of procedures may be realized in the future. IHSC will work with the contractor to ensure that trending this across facilities through standardized reports is incorporated into the planning. Estimated Completion Date (ECD): February 28, 2017.

Recommendation 2: Develop and implement a mechanism to ensure that payments for off-site care are supported by the appropriate authorizations.

Response: Concur. The mechanism being recommended is already in place through the service level agreement with the VAFSC. The VAFSC adjudicates and pays claims on behalf of IHSC and each claim that is paid is matched to an authorization; either a MedPAR or a certification for payment by IHSC staff. IHSC will obtain and review a copy of the processes and business rules that the VAFSC follows in the adjudication and payment of the claims to achieve a reasonable assurance that each has the appropriate authorization. In addition, IHSC will work more closely with the VAFSC to develop routine reports and alerts to help ensure there are no gaps in the current practice. ECD: August 31, 2016.

Recommendation 3: Track inspection results and conduct analyses of oversight data over time, by standards, and by facility type.

Response: Concur. IHSC Health Operations Unit, in collaboration with Medical Quality Management Unit, tracks and maintains inspection results of the IHSC Health Systems Assessment Reviews. These assessments are conducted on an annual basis at all IHSC-staffed facility. IHSC policy states that the Medical Case Management Unit (MCMU) and Field Medical Coordinators (FMCs) conduct semi-annual site visits at the Intergovernmental Service Agreement (IGSA) facilities. These site visits are similar to the inspections conducted by IHSC Health Operation's Unit and are focused on meeting compliance of all applicable standards and quality of health care delivery. During this past year, the MCMU began summarizing FMC site visit findings to enable trending and analyses over time and across IGSA facilities. The IHSC will continue its current practices, as described above, and will look for solutions to provide the comprehensive system wide analysis that is being recommended. ECD: August 31, 2016.

Recommendation 4: Ensure that IHSC's planned new tasking system includes all medical-care related complaints received by DHS entities, and that this system facilitates the tracking and analysis of complaints over time and across facilities.


Response: Concur. IHSC will request that DHS entities involved in all medical complaints related to ICE detainees ensure that IHSC receives information related to these complaints for entry into IHSC database, even those IHSC does not handle. Currently, the DHS Office for Civil Rights and Civil Liberties (CRCL), ICE Office of

Professional Responsibility (OPR), DHS Office of Inspector General (OIG), and others decide which complaints are directed to IHSC for review and action. CRCL, OPR, OIG, and others would have access, if needed, to whatever tracking system IHSC and ERO build.

IHSC has already commenced building a limited tracking system with internal resources. The IHSC Task Management System is being developed with an intent to capture all tasks created internally and received from external sources. It is envisioned that this internally built system will contain enough data points to capture the information necessary to respond to this recommendation. This system, however, will be limited to the available functionality of ICE's SharePoint platform. IHSC will work with its partners in ERO and the ICE Office of Chief Information Officer to build as robust a system as resources will allow. ECD: February 28, 2017.

Again, thank you for the opportunity to review and comment on this draft report. Technical comments were previously provided under separate cover. Please feel free to contact me if you have any questions. We look forward to working with you in the future.

Sincerely,



Jim H. Crumpacker, CIA, CFE
Director
Departmental GAO-OIG Liaison Office

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Rebecca Gambler, at (202) 512-8777 or gablerr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Jeanette Espinola (Assistant Director), Alyssia Borsella, Carla Brown, Sarah Harvey, Eric Hauswirth, David Lutter, Robin Marion, Jon Najmi, Tovah Rom, and Cynthia Saunders made key contributions to this report.

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