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March 2022

INDIAN HEALTH SERVICE

Information on Third-Party Collections and Processes to Procure Supplies and Services

GAO-22-104742

GAO Highlights

Highlights of GAO-22-104742, a report to congressional requesters

March 2022

INDIAN HEALTH SERVICE

Information on Third-Party Collections and Processes to Procure Supplies and Services

Why GAO Did This Study

IHS provides care to American Indians and Alaska Natives (AI/AN) through a system of federally and tribally operated facilities. In addition to receiving appropriated funds, IHS relies on funding from third-party collections to procure services, supplies, and pharmaceuticals needed for its operations. Ensuring AI/ANs have access to quality health care requires IHS to effectively manage its resources such as third-party collections and procurement processes, including those procurements made under the Buy Indian Act.

GAO was asked to review IHS's oversight of third-party collections and its procurements. Among other things, this report examines recent trends in, and IHS's processes to oversee, third-party collections and the extent to which IHS uses the Buy Indian Act when procuring services and products, such as medical supplies. GAO reviewed agency documents, including policies, and interviewed IHS officials from headquarters and the nine area offices with two or more federally operated facilities—area offices are responsible for monitoring federally operated facilities' operations and finances. GAO also reviewed data on third-party collections at IHS federally operated facilities for fiscal years 2015 through 2021 and analyzed contracting data from the Federal Procurement Data System for fiscal years 2015 through 2020, the most recent data available at the time GAO began its review.

View GAO-22-104742. For more information, contact Michelle B. Rosenberg at (202) 512-7114 or RosenbergM@gao.gov.

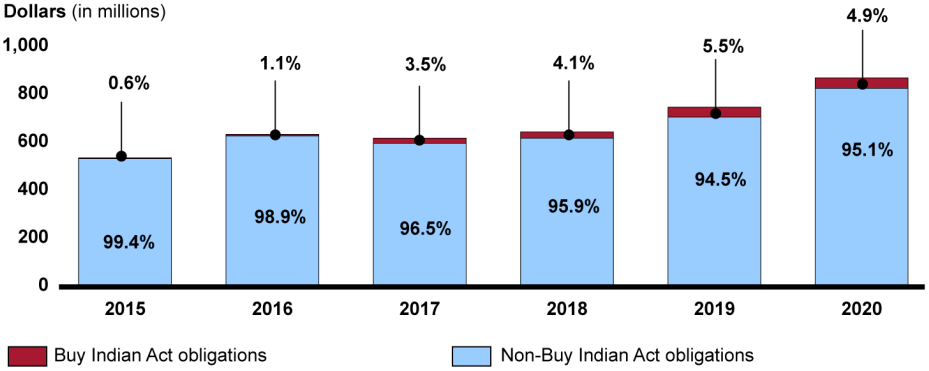
What GAO Found

The Indian Health Service's (IHS) third-party collections—that is, payments for patients' medical care received from public programs such as Medicaid and Medicare or from private insurers—increased from about $943 million in fiscal year 2015 to about $1.15 billion in fiscal year 2019 at its federal facilities. In fiscal year 2020—which included the beginning of the COVID-19 pandemic—collections decreased by about 4 percent to $1.10 billion, but they rebounded to about $1.26 billion in fiscal year 2021. According to IHS, these collections are increasingly important, as they represent a significant portion of facilities' health care delivery budgets. As a result, even a modest decline can affect facility operations.

While IHS headquarters conducts some oversight of third-party collections—including reviewing facilities' biannual data submissions—the agency has delegated much of the responsibility for this oversight to its area offices. Area office officials told GAO they oversee these funds by (1) taking steps to ensure facilities determine and verify whether a patient has or is eligible for insurance from a third-party payer at each patient visit, (2) regularly communicating with and providing training to facility staff, and (3) regularly reviewing facility information, including facilities' biannual data submissions before they were sent to headquarters. IHS headquarters officials used these data submissions to identify any concerns that need to be addressed by facilities in a corrective action plan—such as a backlog in billing. GAO's review of the two most recent submissions showed all facilities within the nine area offices submitted these data to headquarters.

When procuring products and services needed for its operations, IHS may use the Buy Indian Act to give priority to Indian-owned and -controlled businesses without using a competitive contracting process. IHS's use of the Act has increased since fiscal year 2015 but generally comprises less than 5 percent of annual non-pharmaceutical contract obligations. (See figure.) IHS officials described actions they have taken that may have contributed to this increase, including creating lists of known Indian-owned businesses to which IHS staff can refer when searching for a product or service.

Indian Health Service Non-Pharmaceutical Contract Obligations, Fiscal Years 2015–2020



Source: GAO analysis of Federal Procurement Data System data. | GAO-22-104742

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Abbreviations

AI/AN	American Indian and Alaska Native
COVID-19	Coronavirus Disease 2019
FPDS	Federal Procurement Data System
HHS	Department of Health and Human Services
IHS	Indian Health Service
MSPV	medical/surgical prime vendor
NSSC	National Supply Service Center
PPV	pharmaceutical prime vendor
VA	Department of Veterans Affairs

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Congressional Requesters

The Indian Health Service (IHS), an agency in the Department of Health and Human Services (HHS), is responsible for providing health care for over 2 million American Indians and Alaska Natives (AI/AN) who are members or descendants of federally recognized tribes.[1] According to IHS, its mission is to raise the physical, mental, social, and spiritual health of AI/ANs to the highest level. IHS provides health care services to AI/ANs either directly through a system of federally operated IHS facilities or indirectly through facilities that are operated by tribes or others. As of November 2021, IHS, tribes, and tribal organizations operated 45 hospitals and 368 health centers—of which 23 hospitals and 50 health centers were federally operated IHS facilities. Federally operated facilities provide mostly primary and emergency care services and are located in 10 of IHS's 12 areas.[2]

Like most federal agencies, IHS receives funding through annual appropriations, which it uses to fund federally and tribally operated facilities throughout the country. These facilities may also bill public programs such as Medicaid, Medicare, and the Department of Veterans Affairs (VA)—as well as private insurance—for care provided to patients.[3] The facilities are allowed to retain collections from these payers—referred

[1]Federally recognized tribes have a government-to-government relationship with the U.S. and are eligible to receive certain protections, services, and benefits by virtue of their status as Indian tribes. The Secretary of the Interior publishes annually in the Federal Register a list of all tribal entities that the Secretary recognizes as Indian tribes. As of January 2022, there were 574 federally recognized tribes. See 87 Fed. Reg. 4636 (Jan. 28, 2022).

[2]The 12 IHS areas are Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson. The two areas without federally operated facilities are Alaska and Tucson.

[3]25 U.S.C. §§ 1621e(a), 1621f(a). Medicaid is the federal-state health insurance program for certain low-income individuals. Medicare is the federal health insurance program for persons age 65 and over as well as certain others. The Department of Veterans Affairs provides health care for veterans. See, for example, 25 U.S.C. § 1645 and 42 U.S.C. §§ 1395qq and 1396j.

to as third-party collections—without an offset to any other appropriations made to IHS.[4]

IHS increasingly relies on funding from third-party collections for its operations, including to procure medical supplies, pharmaceuticals, and health care services.[5] Third-party collections represent a significant portion of IHS facilities' health care delivery budgets. For example, IHS's fiscal year 2021 budget justification noted that some IHS health care facilities reported that 60 percent or more of their annual budgets rely on revenue collected from third-party payers. IHS is responsible for overseeing third-party collections to help ensure the agency maximizes the funding available to provide AI/AN with quality health care. When procuring products and services, including those used to provide care for AI/ANs, IHS may use the Buy Indian Act to give preference to Indian-owned firms through set-aside contract awards.[6]

You asked us to review IHS's oversight of third-party collections and its processes for procuring medical supplies, pharmaceuticals, and health care services, including contracts awarded under the Buy Indian Act. In this report, we

1. examine recent trends in third-party collections and IHS's processes to oversee such collections;
2. describe IHS's processes to procure medical supplies, pharmaceuticals, and health care services; and
3. describe the extent to which IHS has entered into procurement contracts under the Buy Indian Act.

To examine recent trends in third-party collections and IHS's processes to oversee such collections, we collected data on third-party collections at

[4]See, for example, 25 U.S.C. §§1621(b), 1621f and 1641.

[5]The procurement of health care services may include contracting with providers, such as nurses or doctors, to provide patient care.

[6]Section 23 of the Act of June 25, 1910, 36 Stat. 861, commonly known as the Buy Indian Act, authorizes IHS to restrict the competition for procurements to qualified Indian-owned firms. Specifically, the Buy Indian Act and implementing regulations authorize the Department of the Interior's Bureau of Indian Affairs and the HHS's IHS to set aside, or reserve, a particular procurement for competition among Indian-owned firms, which helps promote the growth and development of Indian industries. See 25 U.S.C. § 47; 48 C.F.R. Subpart 326.5 (2020).

federally operated facilities from fiscal years 2015 through 2021 to identify trends in collections, including potential changes during the Coronavirus Disease 2019 (COVID-19) pandemic. To assess the reliability of these data, we (1) reviewed our assessment of these data from a 2019 report,[7] (2) reviewed IHS's Revenue Operations Manual, and (3) interviewed IHS officials about data collection processes, including any changes since our prior report. We determined that the data were sufficiently reliable for the purposes of our reporting objective.

In addition, we reviewed IHS policies related to third-party collections, such as the Indian Health Manual, which includes a section on oversight activities related to third-party collections, and the IHS Revenue Operations Manual.[8] We also reviewed documentation that IHS uses as part of its efforts to oversee third-party collections. For example, we reviewed training materials used to educate staff on various components of collections, including their roles and responsibilities; information and data reviewed regularly by the area offices, such as data on total collections and billing information; and IHS's online tool that was developed to monitor collections and identify any potential issues. In addition, we interviewed agency officials from IHS headquarters and the nine area offices with two or more federally operated facilities about policies and procedures as well as their responsibilities in overseeing collections.[9] As part of our review, we examined documentation from the two most recent online tools to determine if the area offices had completed their review of and addressed any issues identified in the tools submitted by facilities, as required in policy.

To describe IHS's processes to procure medical supplies, pharmaceuticals, and health care services, we reviewed procurement

[7]GAO, *Indian Health Service: Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections,* GAO-19-612 (Washington, D.C.: Sept. 3, 2019).

[8]Indian Health Service, "Part 5, Chapter 1: Third-Party Revenue Accounts Management And Internal Controls," in *Indian Health Manual* (Rockville, Md.: Feb. 6, 2015); and *Revenue Operations Manual Version 2.0* (Rockville, Md.: March 2019).

[9]As of fiscal year 2020, nine of the agency's 12 areas had two or more federally operated IHS facilities. These areas are: Albuquerque, Bemidji, Billings, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, and Portland. The California area had one federally operated IHS facility and the Alaska and Tucson areas had no federally operated IHS facilities. For the purposes of this report, we interviewed officials from the nine area offices that had two or more federally operated IHS facilities.

processes, including those established by HHS and IHS.[10] For example, we reviewed relevant parts of the HHS Acquisition Regulation, which establish uniform HHS acquisition policies and procedures that implement and supplement the Federal Acquisition Regulation. We also reviewed the Indian Health Manual, which includes a section on IHS's policies and procedures for acquisition management.[11] Additionally, we interviewed IHS officials from the agency's headquarters and its central contracting office—the Division of Acquisition Policy—the National Supply Service Center (NSSC), and the nine area offices noted above; during the interviews, we (1) discussed the agency's processes, including any factors that affect procurement of medical supplies, pharmaceuticals, and health care services; and (2) identified any variation across the area offices.[12] Lastly, we asked the nine area offices to estimate their use of various procurement options for fiscal years 2015 through 2020. We used these self-reported estimates to show the variation in the use of procurement options by the nine areas.

To describe the extent to which IHS has entered into procurement contracts under the Buy Indian Act, we analyzed data on contract obligations under the Buy Indian Act from fiscal years 2015 through 2020—the 6 most recent years available at the time we began our analysis—from the Federal Procurement Data System (FPDS).[13] To provide perspective on contracts awarded to Indian-owned firms more broadly, we also analyzed the FPDS data on contracts awarded to Indian-

[10]While procuring health care services may include contracting for providers, we did not include services purchased for patients through IHS's Purchased/Referred Care Program. In certain circumstances when needed health care services are not available at federally operated or tribally operated facilities, care may be obtained from private providers and paid for through IHS's Purchased/Referred Care program. For more information on this program, see GAO-19-612.

[11]Indian Health Service, "Part 5, Chapter 5: Acquisition Management," in *Indian Health Manual* (Rockville, Md.: June 13, 1996).

[12]NSSC is a national IHS program administratively structured under the agency's Oklahoma City Area Office. NSSC manages a supply of pharmaceuticals, medical, and other items related to health care that IHS, tribal, and urban Indian organization health care facilities can purchase.

[13]FPDS is the government's central repository for contracting data. To obtain the data, we performed an ad hoc query of the FPDS data through sam.gov, which is the authoritative source for FPDS contract data reports. We identified Buy Indian Act obligations using two data elements: "Type of Set Aside" and "IDV Type of Set Aside." Specifically, we included obligations under the Buy Indian Act if one of those two data elements contained "Buy Indian," "Indian Economic Enterprise," or "Indian Small Business Economic Enterprise."

owned firms outside the Buy Indian Act authority during the same 6-year period.[14] The data used in our analysis reflect non-pharmaceutical contract obligations from IHS headquarters, its 12 area offices, and the two IHS Division of Engineering Services offices.[15] We excluded contract obligations for pharmaceuticals because of an August 2019 change in how data on these purchases were reported to FPDS.[16] To assess the reliability of FPDS data, we discussed the data with officials at IHS who are knowledgeable about the source information upon which FPDS is based. Additionally, we discussed the accuracy of the data we retrieved from FPDS with IHS officials. We determined that the data were sufficiently reliable for the purposes of our reporting objective. Lastly, we interviewed procurement officials from IHS's headquarters and the nine area offices to understand how the agency uses the Buy Indian Act and any challenges faced by area offices in using the Act.

We conducted this performance audit from January 2021 to March 2022 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

IHS was established within the Public Health Service in 1955 to provide health services to federally recognized AI/AN tribes primarily in rural areas on or near reservations. IHS oversees its provision of health care

[14]For purposes of this analysis, when we refer to Indian-owned, we are referring to AI/AN entities. These are defined in the System for Award Management Non-Federal User Guide (the official U.S. government system that consolidated government-wide acquisition and award support systems into one system). They include Alaskan Native Corporation owned firm, Native American owned, Native Hawaiian Organization owned firm, tribally owned firm, American Indian owned, or an Indian Tribe (federally recognized). This information on Indian-owned status is self-reported by the firms.

[15]Obligations are not adjusted for inflation. IHS's Division of Engineering Services provides professional architectural, engineering, project management, and acquisition services to support IHS's program to construct new health care facilities.

[16]According to IHS officials, in August 2019, there was a change in how certain tribal pharmaceutical purchases were reported to FPDS. Thus, in order to ensure consistency in the type of information we were comparing over time, we excluded contract obligations with a pharmaceutical product or service code (6505). Obligations for pharmaceuticals ranged from about 24 to 28 percent of total obligations between fiscal years 2015 and 2019. There were no Buy Indian Act pharmaceutical obligations under the Buy Indian Act in fiscal years 2015, 2016, 2017, 2019, and 2020. Pharmaceutical obligations represented less than 1 percent of Buy Indian Act obligations—or about $60,000—in fiscal year 2018.

services through a decentralized system of 12 area offices, which are led by area directors and located in 12 geographic areas. These areas are further subdivided into service units, which are administrative entities that may contain one or more federally operated facilities. IHS's headquarters office is responsible for setting national health care policy, ensuring the delivery of quality comprehensive health services, and advocating for the health needs and concerns of AI/AN people. The area offices are responsible for monitoring federally operated facilities' operations and finances, and providing guidance and technical assistance. The types of services offered by these facilities vary but most commonly include primary care, emergency care, and some ancillary and specialty services.

Third-Party Collections

As mentioned previously, IHS facilities can collect revenue by billing third parties—public and private health insurance programs and the VA—for services provided to patients. The third-party collections revenue cycle at federally operated IHS facilities consists of several key steps. (See table 1.) These key steps are intended to help ensure facilities maximize their third-party collections. For example, IHS requires facilities to verify whether a patient is eligible for or has coverage through a third-party payer, such as Medicare, Medicaid, VA, or a private payer. This process is part of patient registration. Accounts management, another key step of the third-party collections revenue cycle, includes ensuring that claims are sent to third-party payers in a timely manner and that accounts receivable staff follow up on claims that have not been paid for more than 30 days.

Table 1: Steps of the Indian Health Service Revenue Cycle for Third-Party Collections

Step	Description
Patient registration	Patient registration staff at the facility updates or verifies patient demographic and third-party payer information at each patient encounter. Third-party payers include Medicare, Medicaid, Department of Veterans Affairs, and private insurers.
Benefits coordination	Benefits coordinator at the facility (1) identifies patients who are eligible for alternative resources, including Medicare, Medicaid, Department of Veterans Affairs, and private insurers; and (2) assists them in obtaining access to those resources.
Coding and data entry	Coding specialist reviews clinical documentation created by the provider and assigns the most appropriate medical code to reflect the medical services provided. The medical codes describe the diagnoses, services, and procedures provided to the patient. Reimbursement of hospital and provider claims are based on these medical codes.
Billing	Billing staff validates coding, ensures codes are correctly billed, and creates the claim. Once the claim is approved the biller will forward to the third-party payer for processing.
Accounts management	Staff manages an account once a claim is approved and accounts receivable is established. This includes following up on aging accounts (e.g., claims that have not been paid in over 30 days), managing denied claims, and posting payments. Staff responsible for overseeing this process may be from the facility's Patient Account Services or from its Business Office.

Source: Indian Health Service Revenue Operations Manual. | GAO-22-104742

IHS Procurement

As we previously noted, IHS procures, or awards contracts for, various medical supplies, pharmaceuticals, and health care services to meet agency needs. IHS procurements are guided by the Federal Acquisition Regulation, the HHS Acquisition Regulation, and the Indian Health Manual, among other policies. IHS's central contracting office—the Division of Acquisition Policy—sets policies and oversees contracting efforts across the agency to ensure the timely delivery of quality goods and services. Each area has its own contracting office, which is responsible for awarding and administering contracts in that area.[17] The Division of Acquisition Policy may also award agency-wide contracts, according to IHS officials. Additionally, IHS service units may have contracting staff that have the authority to procure products and services. Only authorized personnel that undergo training and maintain their certifications can procure products and services for IHS. IHS personnel can also use a government purchase card to purchase certain products

[17]In addition to the Senior Contracting Officer, who serves as the Chief Contracting Officer, each area is supported by an acquisition staff composed of contracting officers, Small Business Technical Advisors, contract specialists, purchasing agents, procurement analysts, cost/price analysts, procurements assistants, and clerical support staff, according to agency policy.

and services, but the purchase card holders must be delegated the authority to do so.

IHS also procures medical supplies and pharmaceuticals through an IHS national program and interagency agreements. Specifically, IHS has a national program—NSSC—that coordinates and manages the purchase and distribution of pharmaceuticals, medical, and other supplies related to health care for any federally operated IHS facility.[18] See table 2 for more information on IHS's contracting programs and offices. IHS also maintains an interagency agreement with the VA to acquire medical supplies and pharmaceuticals under the VA's medical/surgical prime vendor (MSPV) and pharmaceutical prime vendor (PPV) programs' existing contracts. In general, IHS policy is to use the most efficient and cost-effective procurement, contracting method, and procedures to achieve its acquisition objectives in furtherance of the overall Indian health care mission of IHS.[19]

Table 2: Contracting Responsibilities within the Indian Health Service (IHS)

IHS component	Contracting responsibilities
Division of Acquisition Policy (headquarters)	• Provide management direction and agency-wide leadership and expertise in the area of acquisition • Set agency-wide policies • Promote partnerships with contractors and the general public by ensuring the transparency of IHS's procurement processes • Solicit and award agency-wide contracts, as needed
Area offices	• Distribute funds to service units and tribes/tribal organizations • Disseminate and implement agency-wide policy • Conduct oversight of area procurement operations through its Chief Contracting Officer • Assist service units with procurements, and award new area-wide contracts, as needed
Service units[a]	• Implement agency-wide and area office policy • Identify facility needs, and prepare acquisition plans for needed products and services • Work with area contracting office to procure necessary products and services • Procure and award contracts within the service unit contracting professional's delegated authority
IHS supply service centers, including the National Supply Service Center (NSSC)[b]	• Coordinate and manage the purchase and distribution of medical supplies, pharmaceuticals, and other supplies that are related to health care • Fulfill medical supply and pharmaceutical orders for IHS service units

Sources: GAO review of IHS documentation and interviews with agency officials. | GAO-22-104742

[18]The NSSC also coordinates the purchase and distribution of such items for certain tribally operated facilities and urban Indian organizations.

[19]Indian Health Service, "Part 5, Chapter 5: Acquisition Management."

[a]Service units are administrative entities that contain one or more federally operated facilities.

[b]According to IHS officials, IHS supply service centers include NSSC, the Gallup Regional Supply Service Center in the Navajo area, and a supply warehouse in the Nashville area.

Buy Indian Act

The Buy Indian Act, as amended, authorizes the Secretaries of the Interior and HHS to employ Indian labor and to purchase the products of Indian-owned and -controlled firms in the open market without using a competitive process.[20] As a result, IHS may, but is not required to, use the Buy Indian Act to carry out its health care responsibilities. IHS may use the Act to give preference to Indian-owned firms through set-aside contract awards when acquiring products and services whenever the use of that authority is reasonable and practicable. The agency has broad discretion over whether and how to use the Buy Indian Act and has issued agency regulations governing the use of the authority.[21]

IHS Uses Several Approaches to Oversee Increasing Third-Party Collections

Third-Party Collections Have Generally Increased Since Fiscal Year 2015 but Declined During the Beginning of the COVID-19 Pandemic

Our analysis of IHS data shows that while IHS third-party collections at federally operated facilities have generally increased since fiscal year 2015, these collections declined during fiscal year 2020. Specifically, third-party collections increased from about $943.57 million in fiscal year 2015 to about $1.15 billion in fiscal year 2019. In fiscal year 2020—which includes the beginning of the COVID-19 pandemic—collections decreased by about 4 percent to $1.10 billion. Collections then increased to about $1.26 billion in fiscal year 2021. (See table 3.)

[20]The Buy Indian Act, ch. 431, § 23, 36 Stat. 861 (1910) (classified at 25 U.S.C. § 47).

[21]48 C.F.R. Part 1480 (2020). We previously recommended that IHS should clarify and codify their policies related to the priority for use of the Buy Indian Act, including whether the Buy Indian Act should be used before other set-aside programs. IHS agreed with this recommendation. As of October 2021, IHS has not implemented this recommendation. GAO, *Buy Indian Act: Bureau of Indian Affairs and Indian Health Service Need Greater Insight into Implementation at Regional Offices*, GAO-15-588 (Washington, D.C.: July 9, 2015).

Table 3: Indian Health Service Third-Party Collections at Federally Operated Facilities, Fiscal Years 2015–2021

Fiscal year	Third-party collections (billions of dollars)
2015	0.944
2016	0.971
2017	1.027
2018	1.088
2019	1.147
2020	1.096
2021	1.259

Source: Indian Health Service Unified Financial Management System. | GAO-22-104742

Note: Data are as of January 5, 2022.

The extent of decline in collections during fiscal year 2020 varied across area offices as well as among the federally operated facilities within the areas, according to interviews with agency officials. Eight of the nine area offices we interviewed described declines in their third-party collections as a result of COVID-19, ranging from about 4 to 10 percent. The other area office told us it saw an increase in collections during fiscal year 2020. Of the eight area offices experiencing declines in collections, officials from four area offices also noted that the extent of decline varied among federally operated facilities within their area. For example, officials from one area office told us that third-party collections at most of their facilities decreased by less than 10 percent. However, one facility in their area saw a decrease of about 13 percent, another saw a decrease of 24 percent, and another increased their collections by about 3 percent.

IHS headquarters and area office officials reported several factors that affected third-party collections at federally operated facilities during fiscal year 2020. For example, IHS headquarters and eight area offices reported that the decrease in collections was due, in part, to fewer patient visits or changes in services being provided, such as halting some services, during the initial months of the pandemic. Officials from two area offices noted that federal funding in response to COVID-19 helped to offset the decline.[22] Officials from the area office that did not see any decline in revenue said they were able to provide face-to-face care throughout the pandemic, and their smaller facilities were more easily

[22]Examples of federal funding include funds from the Coronavirus Aid, Relief, and Economic Security Act and the American Rescue Plan Act of 2021. See Pub. L. No. 116-136, Div. B, tit. VII, 134 Stat. 281, 550-51 (2020); Pub. L. No. 117-2, tit. XI, § 11001, 135 Stat. 4, 240-41 (2021).

able to shift their services to telehealth, which could have contributed to an increase in their collections. While collections at federally operated facilities increased in fiscal year 2021, officials from IHS headquarters told us collections were not as high as expected. Specifically, officials told us that the average increase of third-party collections has historically been around 6 percent per year, thus they would have expected collections to be about $1.27 billion in fiscal year 2021.

IHS Takes Steps to Ensure Facilities Verify Patient Eligibility, Holds Trainings, and Reviews Facility Information to Oversee Third-Party Collections

Our review of agency documentation and interviews found that IHS headquarters conducts some oversight of third-party collections—such as reviewing federally operated facilities' biannual data submissions—but the agency has delegated much of the responsibility for overseeing federally operated facilities' third-party collections to the area offices.[23] Area office officials told us that their oversight generally includes (1) taking steps to ensure federally operated facilities determine and verify third-party coverage and eligibility, (2) holding trainings for and communicating with staff at federally operated facilities, and (3) regularly reviewing information from federally operated facilities on third-party collections, including information submitted to headquarters.

Taking steps to ensure federally operated facilities determine and verify third-party coverage and eligibility. Officials from all nine area offices told us they take steps to ensure federally operated facilities determine and verify third-party coverage and patient eligibility for third-party coverage at each patient visit, as required in the Indian Health Manual.[24] Verifying third-party coverage and patient eligibility, which occurs during the patient registration and benefits coordination steps of the third-party collection revenue cycle, helps facilities to identify opportunities to collect revenue from a third-party payer. Officials from four area offices told us they provide training to facility staff on patient registration to ensure they understand policy and processes. These trainings include information on how to communicate effectively when registering patients, how to determine patient eligibility for third-party coverage, how to use patient registration data, and staff roles and responsibilities in the process, among other things. Some of these area offices provide these trainings on a regular basis, such as weekly or

[23]In addition to reviewing facilities' biannual data submissions, IHS headquarters officials told us they also provide training to staff on third-party collections policies, including through a 3-day conference with staff from the Centers for Medicare & Medicaid Services, tribes, and other agencies.

[24]Indian Health Service, "Part 5, Chapter 1: Third-Party Revenue Accounts Management And Internal Controls."

annually, while others provide them as needed, according to officials. Officials from two other area offices told us they have a contract for a system that allows the federally operated facilities across the area to verify patient eligibility for third-party coverage in real-time. These areas also discuss any issues that facility staff may have with determining coverage and eligibility as part of ad-hoc or routine meetings with the staff, according to area office officials. In addition, officials from two area offices told us they have overseen patient education efforts related to third-party collections. For example, officials from one area office told us they provide education to patients and the community using radio and brochures. Officials told us the purpose of these efforts was to help patients understand the importance of third-party collections to IHS.

Communicating with and holding training for staff at federally operated facilities on third-party collections. Officials from all nine area offices told us they ensure federally operated facilities understand IHS policy and processes for third-party collections, including coding, billing, and accounts management, by communicating with or holding trainings for facility staff. According to area officials, they generally communicate with facility staff about third-party collections through regular meetings. For example, officials from five area offices told us they hold monthly meetings with the federally operated facilities during which they discuss issues related to third-party collections. Officials from one of these area offices said that the area office's Executive Officer holds monthly budget meetings with facility leadership, and third-party collections are a standing agenda item. One of these area offices also has a scheduled time every quarter during which the business office team is available to facility staff should they need to discuss anything related to collections. According to area office officials, their meetings cover a range of management issues that could affect third-party collections at their federally operated facilities, including updates on Medicaid and Medicare billing practices.

In addition to regular communication, officials from seven area offices told us they hold trainings for staff at their federally operated facilities related to third-party collections operations, including coding, billing, and accounts management, in addition to the trainings provided by IHS headquarters. Some of these area offices offer trainings on a regular basis, such as quarterly or annually, while others offer training as needed, according to officials. The content of these trainings vary across area offices. For example, in addition to the trainings on patient registration noted above, one area office provides training on third-party payer

policies while another provides training to facilities that provides step-by-step instructions for how to submit data to area offices for review.

Regularly reviewing information from federally operated facilities on third-party collections. Officials from all nine area offices told us that to help oversee collections they regularly review information on third-party collections submitted by their federally operated facilities. Specifically, officials told us they review information on third-party collections that facilities are required to submit to IHS headquarters. Twice a year, federally operated facilities are required to complete an online tool—the Third-Party Internal Controls Online Tool Self-Assessment—that collects various information on third-party collections.[25] For example, the tool requires facilities to report information related to each of the key steps of the third-party collections cycle described above, including patient registration, benefits coordination, coding and data entry, billing, and accounts management, among other things. See table 4 for examples of information submitted through the tool.

Table 4: Examples of Information Facilities Are Required to Submit through the Indian Health Service (IHS) Third-Party Internal Controls Online Tool Self-Assessment

Section of tool	Examples of information in the tool
Facility specific procedures	Information on whether the facility has written policies and procedures for patient registration, coding/data entry, billing, and claims processing.
Patient registration	Information showing that third-party eligibility was verified at each patient visit for a random selection of patients.
Benefits coordination	Information on whether the facility reviews a regular report on productivity and information.
Coding/data entry	Data on the average number of visits that are coded each month, information on whether coding is being completed within 4 days of the date of service for all visits, and information on whether a quarterly review of all coding/data entries is being done by an independent, certified coder.
Billing	Data on billable claims and information on whether outpatient claims are being billed within 6 business days from the date of service and whether the service unit's chief executive officer is reviewing data on billing every month.
Account review and follow-up	A copy of the facility's report summarizing aged accounts and information on whether all aging accounts have been reviewed and researched within 45 days.

Source: GAO review of IHS documentation. | GAO-22-104742

Note: The tool also includes information on information technology systems, collections and deposits, and chief executive officer responsibilities, among other things.

Federally operated facilities are required to send these completed tools to headquarters for review and approval. The facilities submit the tool to the

[25]Indian Health Service, "Part 5, Chapter 1: Third-Party Revenue Accounts Management And Internal Controls."

Area Director for review and approval through the online system before it is submitted to IHS headquarters, according to headquarters officials. Once submitted, IHS headquarters officials review the online tool to determine if it is complete and to determine if there are any issues that need to be addressed. IHS headquarters officials may use the tool to identify general items of concern. The tool is also used by IHS headquarters officials to identify any red flags—e.g., information reported by the facility that is of critical concern—that must be addressed by facilities. IHS established six items that they look for as red flags. Examples of these items include identifying if a facility has a backlog of 30 days or more in billing for inpatient and outpatient services or if a facility is not transmitting approved claims within 1 business day.[26]

If a red flag is identified in the online tool, agency policy requires the Area Director to work with the facility to complete a corrective action plan, which outlines steps the facility will take to address the concern within a set period of time. The Area Director and service unit Chief Executive Officer must approve the corrective action plan before sending to headquarters for review. Our review of example corrective action plans from the nine area offices included red flags related to backlogs in coding and aging accounts (e.g., claims that have not yet been paid in over 45 days), among others.[27] For example, one facility experienced backlogs in aging accounts due to staff vacancies and turnover. The corrective action plan included steps, such as offering staff overtime to work on the backlogs as well as continued coordination with Human Resources to recruit new staff until vacancies are filled.

Officials from three area offices told us that they schedule periodic check-ins with the facilities that need to complete a corrective action plan to track the facilities' progress and provide assistance, as needed. IHS headquarters officials told us they have phone calls with the area offices to go over data from the online tool and to monitor progress in completing corrective action plans, if applicable. Based on our review of the two most recent reviews, all facilities within the nine area offices submitted their online tool to headquarters, and, if a red flag was identified, the area

[26]The remaining red flags are identifying if a facility has a backlog of 30 days or more in coding, is not reviewing aging accounts within 45 days, and has not recorded a claim in the billing system within 72 hours from the receipt of supporting documentation.

[27]Example corrective action plans were provided for fiscal years 2019, 2020, and 2021.

offices generally reviewed and approved any corrective action plans as required.[28]

In addition to the semiannual reviews of the online tool, officials from all nine area offices told us that their area business office or finance office staff also review information from federally operated facilities throughout the year to help oversee collections. For example, according to officials, all nine area offices conducted monthly reviews of various information, such as total collections, amounts billed, payment adjustments, and open or closed claims. Seven of these area offices also conducted monthly trend analyses of their total collections to see if facilities are meeting collections targets. In another example, officials from five area offices told us they conducted weekly reviews of information such as total collections, backlogs in billing, and aging accounts. Five area offices also reported reviewing daily logs that contain information, such as amounts billed and amounts collected. These reviews are in addition to weekly, monthly, and quarterly reviews conducted at the facility level, according to headquarters officials. Officials from the nine area offices told us they use these reviews to identify issues that could affect third-party collections, such as backlogs in aging accounts.

IHS Has Multiple Options to Procure Medical Supplies, Pharmaceuticals, and Health Care Services

Procurement Options Include Ordering through IHS Supply Service Centers, Using Existing Contracts, and Awarding New Contracts

Our review of the Indian Health Manual and interviews with agency officials show that IHS has several options to procure medical supplies, pharmaceuticals, and health care services to meet the needs of the

[28]IHS officials told us that one corrective action plan from the two most recent reviews was not approved by the Area Director in the online system. However, officials said the facility has addressed the identified concern, and the corrective action plan is closed.

facilities within each service unit.[29] The procurement process for each option begins when a service unit or other office identifies a need. Once a need is identified, IHS contracting and acquisition staff at the service unit generally procure the medical supply, pharmaceutical, or health care service through one of the following options depending on factors such as product availability.[30]

- **National Supply Service Center (NSSC).** IHS staff can use an internal system to order medical supplies and pharmaceuticals through NSSC—a national program that coordinates and manages the purchase and distribution of medical and other health care related supply items and pharmaceuticals across IHS.[31] NSSC maintains a stock supply of products in its warehouse. Service units pay the cost of the medical supply or pharmaceutical, plus a fee, which is added to recover only the necessary expenses required to operate the NSSC and to provide the services offered. In addition, NSSC serves as the point of contact and intermediary for access to medical supplies and pharmaceuticals between the service units and the VA MSPV and PPV programs.
- **VA medical/surgical prime vendor (MSPV) and pharmaceutical prime vendor (PPV) programs.** IHS staff can order medical supplies from the VA's MSPV program and pharmaceuticals from the VA's PPV program. The MSPV program is a collection of existing contracts for medical, surgical, dental, laboratory, and environmental medical supplies. Similarly, the PPV is a collection of existing contracts for drugs and other pharmaceuticals. According to officials, IHS staff can

[29]Service units are administrative entities that contain one or more federally operated facilities.

[30]IHS area offices and headquarters can also procure medical supplies, pharmaceuticals, or health care services. However, according to area office officials, the process typically starts at the service unit level because that is where care is being provided and the need is first identified. Service unit staff may ask their area office for assistance with more complex procurements or if the service unit does not have the appropriate staff.

[31]NSSC is administratively structured within IHS's Oklahoma City Area Office but is available for use by IHS facilities nationwide. According to IHS officials, IHS has two other regional supply service centers that serve specific areas—the Gallup Regional Supply Service Center in the Navajo area and a supply warehouse in the Nashville area. The Nashville supply warehouse was set up during the COVID-19 pandemic as another IHS supply point.

Overview of Indian Health Service's (IHS) Contract Solicitation and Award Process from the Open Market

For contracting needs that arise at the service unit level, service unit staff assemble an acquisition package with the product's or service's requirements, independent cost estimates, and the associated market research. If the service unit does not have a contracting officer on staff, it must submit the acquisition package to the area contracting office for procurement. IHS staff put out a solicitation for the product or service. The agency reviews the bids for their availability to meet IHS's requirements and for fair and reasonable pricing. For health care services, IHS staff confirm the contractors' credentials. IHS awards a contract to the winning bid and services commence.

Source: GAO review of IHS documentation and interviews with agency officials. | GAO-22-104742

either order products from these prime vendor programs through NSSC or directly from VA.[32]

- **Federal Supply Schedules.** IHS staff can order from the VA Federal Supply Schedules contracts for medical supplies, pharmaceuticals, and health care services via government purchase card or other payment method.[33] The Federal Supply Schedules are catalogs of related commercial products and services, from pre-approved vendors, which provide federal agencies with a simplified process for buying at prices associated with volume buying. Under delegated authority by the General Services Administration, the VA manages all supply schedules related to health care for the federal government.[34]
- **Open market.** IHS staff can buy medical supplies, pharmaceuticals, and health care services from the open market via government purchase card or by awarding a new contract.[35] When awarding new contracts, IHS must utilize contract set-asides to give preference to

[32]According to IHS officials, tribally operated facilities can utilize the VA MSPV and PPV programs' contracts; however, the order must be completed through IHS instead of directly from the tribally operated facility pursuant to the IHS and VA interagency agreement.

[33]The General Services Administration established SmartPay, the government's purchase card program in 1998, following the Federal Acquisition Streamlining Act of 1994 and Executive Order 12931, Federal Procurement Reform, which set forth requirements for federal agencies to establish programs for reducing administrative costs and other burdens that the acquisition function may impose on the federal government and the private sector. Government purchase cards can only be used for purchases that fall below the micro-purchase threshold, which was raised to $10,000 in August 2020. According to IHS officials, most IHS government purchase card holders are authorized to make purchases up to $3,500.

[34]Though the VA Federal Supply Schedules program, VA's MSPV program, and VA's PPV program are distinct programs, there is overlap in the products available from the programs. We previously reported on challenges facing VA's Federal Supply Schedules program, including duplication with the VA MSPV program. GAO, *VA Acquisition Management: Steps Needed to Ensure Healthcare Federal Supply Schedules Remain Useful*, GAO-20-132 (Washington, D.C.: Jan. 9, 2020).

[35]Contracting officers at the service unit, area office, or headquarters solicit and contract for the product or service. A contracting officer is a person who can bind the federal government to a contract. Contracting officers hold a warrant that allows them to negotiate on behalf of the federal government. Only contracting officers may execute, modify, or terminate a contract. Similarly, only IHS staff with delegated authority can be government purchase card holders.

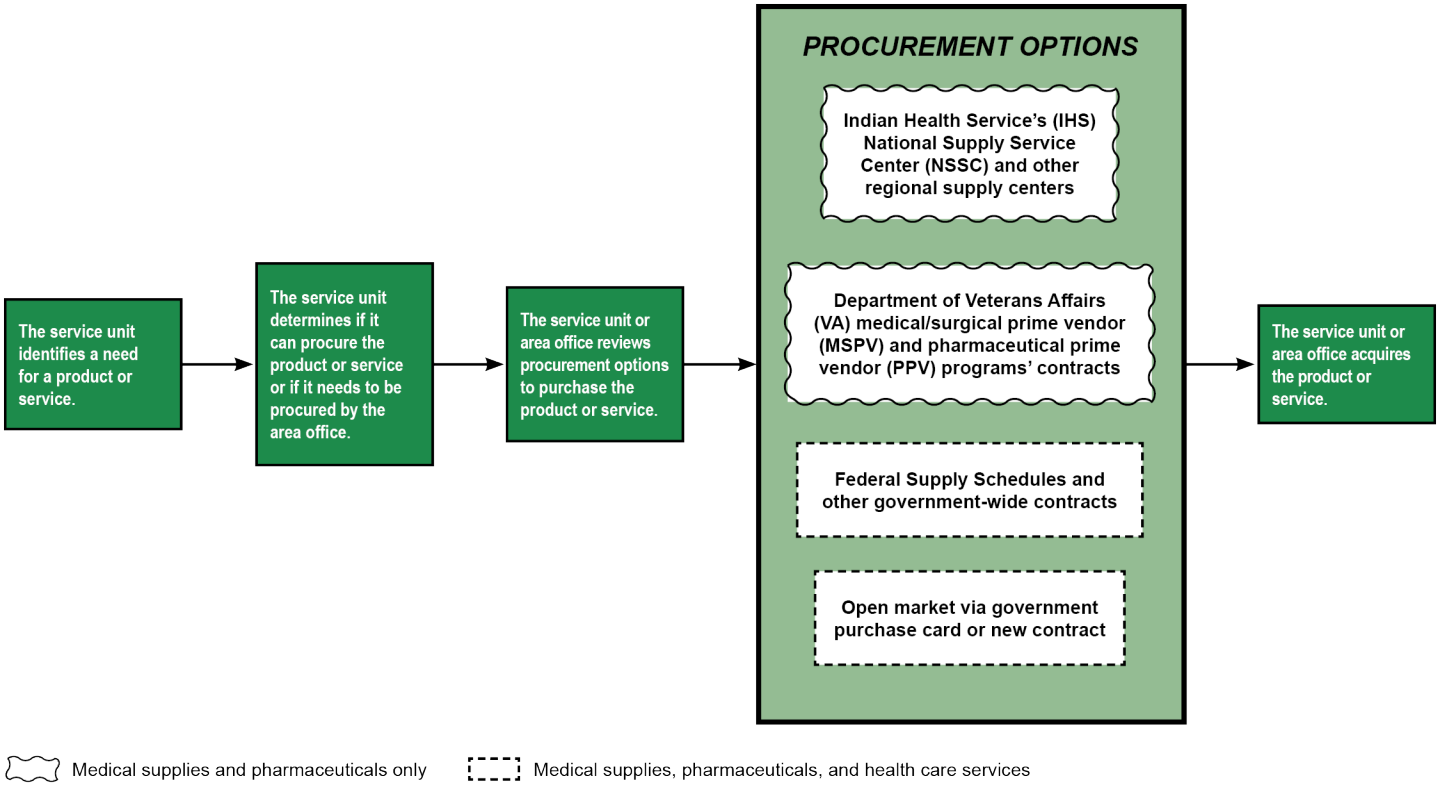
small businesses when a contract meets specific criteria.[36] In addition to these set-asides, IHS may also utilize contract set-asides to give preference to Indian-owned and -controlled businesses.[37]

See figure 1 for an overview of these procurement options.

[36]Federal set-asides include contracts for women-owned small businesses, small disadvantaged businesses and small businesses, Historically Underutilized Business Zones small businesses, and service-disabled veteran-owned small businesses. Federal agencies are generally required to reserve contracts that have an anticipated value greater than the micro-purchase threshold (currently $10,000), but not greater than the simplified acquisition threshold (currently $250,000) exclusively for small businesses, unless the contracting officer is unable to obtain offers from two or more small businesses that are competitive with market prices and the quality and delivery of the goods or services being purchased. 15 U.S.C. § 644(j)(1).

[37]IHS's guidance on the Buy Indian Act is contained in its Indian Health Manual and in the HHS Acquisition Regulation. IHS officials stated that updated procedures are contained in the agency's January 2022 Final Rule, which goes into effect on March 14, 2022. See Federal Acquisition Regulations for the Department of Health and Human Services, 87 Fed. Reg. 2067 (January 13, 2022) (to be codified at 48 C.F.R. Parts 326 and 352). IHS officials told us they are also updating the Buy Indian Act guidance in the Indian Health Manual.

Figure 1: Indian Health Service (IHS) General Process and Options for Procuring Medical Supplies, Pharmaceuticals, and Health Care Services



Sources: GAO review of IHS documentation and interviews with agency officials. | GAO-22-104742

Note: The process highlighted in the figure is the general process as described by the IHS area offices. This is not an exhaustive list of all the possible procurement options. In addition to the process highlighted in the graphic, according to officials, IHS headquarters can also procure products and services to meet the needs of the agency through a similar process. Awarding a new contract from the open market must be performed by an IHS contracting officer.

Area Offices and Their Service Units Use Various Procurement Options Depending on Their Staffing and Needs

The procurement options used by area offices and service units varied. Specifically, IHS officials we interviewed from the nine area offices described variation in the extent to which their areas, including service units, used NSSC, the VA MSPV and PPV programs, VA Federal Supply Schedules, or new contracts to procure medical supplies, pharmaceuticals, and health care services from fiscal years 2015 through 2020.[38]

[38]Area offices' use of procurement options are self-reported estimates by area office officials.

- **NSSC.** The nine area offices estimated that they procured between none to just over half of their medical supplies through NSSC, with three area offices estimating that they used NSSC for less than 10 percent of their medical supplies. Similar variation existed related to the procurement of pharmaceuticals. Specifically, eight of nine area offices estimated that they procured no more than 5 percent of their pharmaceuticals through NSSC, while the ninth procured half of their pharmaceuticals through NSSC. Officials from one area office indicated that there was similar variation in the use of NSSC among service units within their area. The area office officials told us that among their service units, the estimated percent of medical supply and pharmaceutical procurements made through NSSC ranged from 15 to 80 percent.
- **VA MSPV and PPV.** Four area offices reported that they did not procure any of their medical supplies through the VA MSPV program, while a fifth area office reported using the VA MSPV program to procure over half of its medical supplies. In comparison, most of the area offices with whom we spoke reported using the VA PPV program for the majority of their pharmaceutical procurements.
- **VA Federal Supply Schedules.** Two area offices reported that they did not order directly from the VA Federal Supply Schedules to procure medical supplies, while three area offices estimated that they procured from 35 to 50 percent of such supplies through the VA Federal Supply Schedules. Similarly, five area offices estimated that 60 percent or more of their contracted health care services were procured through the VA Federal Supply Schedules, while two areas reported that they did not order directly from the VA Federal Supply Schedules at all for their contracted health care services.
- **Open market.** Five area offices estimated that less than 25 percent of their medical supplies were procured through new contracts or purchase cards, while one area office estimated that over 90 percent of its medical supplies were procured through these methods. Similarly, three area offices estimated that 25 percent or less of their contracted health care services were procured through new contracts, while four area offices reported that over 50 percent of their contracted health care services were procured through new contracts. There were also some differences in whether new contracts were made by the service unit or the area office. For example, two areas estimated that over 70 percent of their contracted health care services were procured via new contracts through the area offices, while none were procured through a new contract or purchase card at the service unit. However, three areas estimated that they procured about 5 to 23

percent of their medical supplies through a new contract or government purchase card at the service unit, and none were procured through the area office.

Area office officials told us that in addition to cost, there are a number of factors that are considered when determining which option to use for procurement, including staffing and service unit needs.[39]

- **Staffing.** Eight area offices reported that staff shortages, including shortages of staff with the proper credentials to conduct procurement activities, affect the procurement options available to the service units. Specifically, service units may not have staff qualified to use certain procurement options.[40] For example, one area office reported that they do not have staff at all of their service units who are qualified to procure from NSSC, VA MSPV, or VA PPV. Thus, they would have to use another procurement option or submit the request to the area office. In another example, five area offices reported that all new contract actions must go through the area offices because the service units in their area do not have contracting officers. Similarly, a contracting officer is required to award a procurement through the VA Federal Supply Schedules. As a result, if a service unit does not have a contracting officer on staff, the service unit would have to submit the request to the area office.
- **Service unit needs.** The nine area offices told us that service unit needs, such as delivery time frames and product availability, also affect their decisions about which procurement option to use. For example, three area offices cited delivery time frames as a factor they consider when deciding whether to use NSSC. More specifically, a service unit may choose not to use NSSC if they have an urgent need and NSSC cannot meet the delivery time frame. In addition, two area offices discussed that providers' preferences related to certain medical supplies, such as face masks and needles, influenced their decision on how they would procure the medical supply. For example, the IHS supply service centers may not have a certain brand that is

[39]According to IHS officials, IHS staff follow the Federal Acquisition Regulation, Part 8-Required Sources of Supplies and Services, while procuring medical supplies, pharmaceuticals, and health care services.

[40]According to IHS officials, the general federal acquisition method of having contracting officials centrally located within a procurement office, supervised and managed by a higher level contracting official is a best practice. They noted that most areas have contracting officers located in area contracting offices, and most service units do not have contracting officers at the service unit.

preferred by a service unit's providers; therefore, the service unit may opt to use another procurement option.

An Increasing but Small Percentage of IHS Funds Are Obligated for Products and Services through the Buy Indian Act

Use of Buy Indian Act Has Increased but Represents a Small Percentage of IHS's Contract Obligations

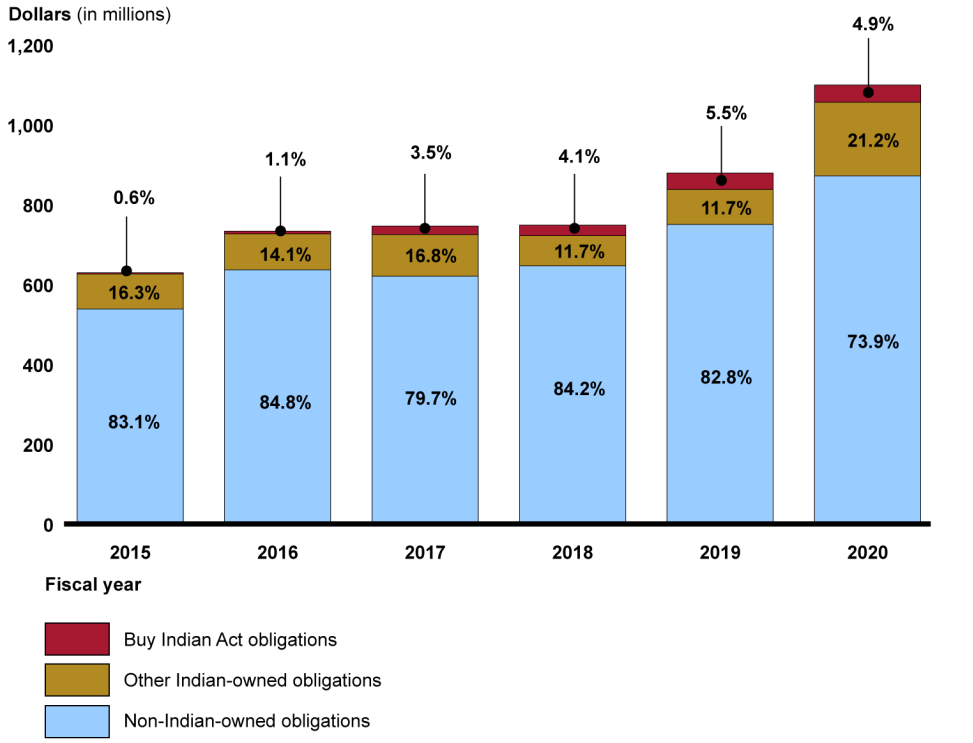
Our analysis of FPDS data shows that while IHS's use of the Buy Indian Act increased from fiscal years 2015 through 2020, Buy Indian Act non-pharmaceutical obligations comprised less than 5 percent of total non-pharmaceutical obligations in fiscal year 2020.[41] Specifically, in fiscal year 2015, IHS obligated about $3.2 million under the Buy Indian Act, or about 0.6 percent of its total non-pharmaceutical obligations. In fiscal year 2020, IHS's Buy Indian Act non-pharmaceutical obligations increased to about $43.1 million, or about 4.9 percent of its total non-pharmaceutical obligations.

Although Buy Indian Act obligations represent a small percentage of IHS non-pharmaceutical obligations, IHS has awarded an increased amount of non-pharmaceutical obligations to Indian-owned firms using authorities other than the Buy Indian Act since fiscal year 2015. Specifically, in fiscal year 2015, IHS obligated about $87.7 million—or about 16.3 percent of total non-pharmaceutical obligations—to Indian-owned firms using authorities other than the Buy Indian Act. In fiscal year 2020, IHS obligated about $184.7 million—or about 21.2 percent of total non-pharmaceutical obligations—to Indian-owned firms.

Figure 2 shows the amount and percentage of non-pharmaceutical obligations made under the Buy Indian Act, to Indian-owned firms through other procurement authorities, and to non-Indian-owned firms.

[41]Obligations include all non-pharmaceutical obligations awarded by IHS headquarters, two Division of Engineering Services offices, and 12 area offices.

Figure 2: Indian Health Service Non-Pharmaceutical Contract Obligations, Fiscal Years 2015–2020



Source: GAO analysis of Federal Procurement Data System data. | GAO-22-104742

Note: Total obligations include all non-pharmaceutical obligations awarded by the Indian Health Service's headquarters, its two Division of Engineering Services offices, and 12 area offices. We excluded pharmaceutical obligations because of a change in how data were reported to the Federal Procurement Data System in August 2019. Buy Indian Act obligations are not included in Indian-owned obligations. Dollars are not adjusted for inflation.

Our review of FPDS data also found that the number of contracts and individual firms that were awarded contracts under the Buy Indian Act increased during this time. In fiscal year 2015, IHS awarded 22 contracts under the Buy Indian Act to 19 firms for non-pharmaceutical products and services. This increased to 200 contracts awarded to 104 firms in fiscal year 2020.

As Buy Indian Act obligations increased from fiscal year 2015 through 2020, the IHS offices with the largest proportion of these obligations changed. For example, IHS headquarters through its Division of Acquisition Policy has awarded an increased percentage of IHS's Buy Indian Act non-pharmaceutical obligations since fiscal year 2015, going

from 0 percent to about 46.9 percent in fiscal year 2020. During the same time period, the percentage of IHS's Buy Indian Act non-pharmaceutical obligations awarded by the Navajo area office ranged from a high of about 43.8 percent in fiscal year 2017 to a low of about 6 percent in fiscal year 2020.

IHS area office and headquarters officials described actions they had taken that may have contributed to the increased use of the Buy Indian Act.

- Officials from three area offices told us they identified more Indian-owned firms through small business matchmaking sessions or by seeing Indian-owned firms partner with other enterprises to expand the number of products and services they could offer. For example, officials from one area office told us that prior to the COVID-19 pandemic, their area office staff attended matchmaking sessions hosted by their local Procurement Technical Assistance Center and collected capability statements from local businesses. The area office then uploaded the statements into a shared catalog, so all IHS staff could find information on new Indian-owned firms and share information with headquarters.
- Officials from four area offices also reported creating lists or databases of known Indian-owned firms to which they can refer when searching for a product or service to procure.[42]
- Officials from IHS headquarters also noted that, in recent years, they have increased communication with area office staff and made an effort to regularly encourage IHS contracting officers to use the Buy Indian Act, which could also contribute to area offices' increased use. On January 13, 2022, IHS issued a final rule providing implementation guidance for using the Buy Indian Act.[43] Several area offices told us that, when implemented, it may result in increased use of the Buy Indian Act.

While use of the Buy Indian Act increased, officials from IHS headquarters and all nine area offices that we interviewed reported that

[42]Two of these area offices reported that IHS headquarters also has a list of Indian-owned firms that they share with area offices.

[43]See Federal Acquisition Regulations for the Department of Health and Human Services, 87 Fed. Reg. 2067 (January 13, 2022) (to be codified at 48 C.F.R. Parts 326 and 352). The rule will go into effect on March 14, 2022. IHS is also updating the Buy Indian Act section of the Indian Health Manual (Chapter 5, Part 5, Section 6).

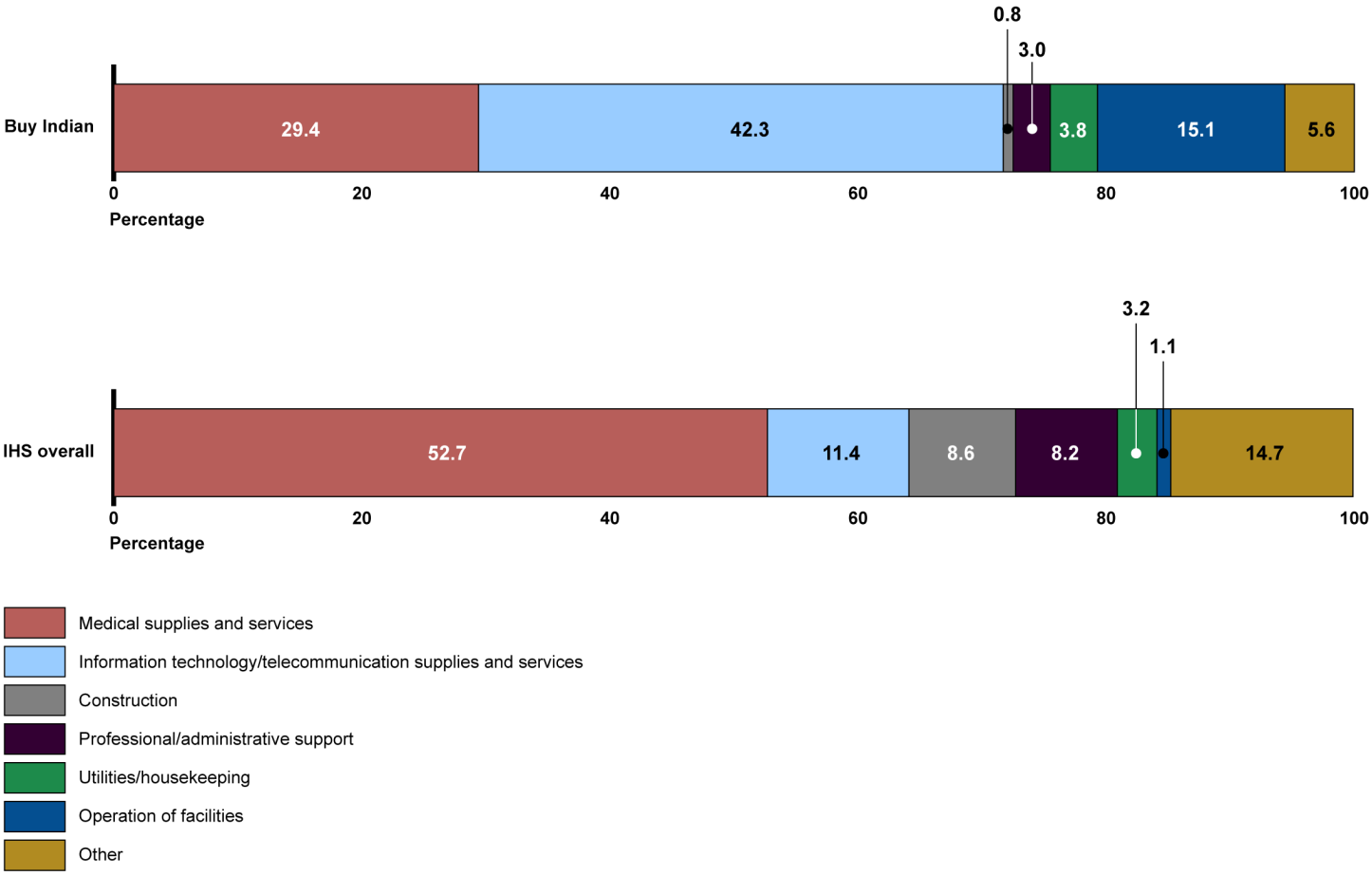
they face challenges in awarding contracts under the Buy Indian Act. For example, six area offices reported challenges in finding Indian-owned firms that offered their desired products or services. Six area offices also reported that, sometimes, Indian-owned firms have higher prices, which can deter area offices from awarding contracts to those firms because they can find more cost-effective prices elsewhere.

Types of Products and Services Purchased under the Buy Indian Act Vary

Our review of FPDS data found that IHS has used the Buy Indian Act to purchase a variety of products and services in categories such as telecommunications, medical, administrative support, and utilities and housekeeping. Specifically, from fiscal years 2015 through 2020, IHS primarily used the Buy Indian Act to purchase products and services in three main categories: information technology and telecommunication supplies and services; medical supplies and services; and operation of facilities. Examples of medical supplies purchased included surgical and dental instruments. Examples of medical services purchased included registered nurse services, emergency room physician services, and ground ambulance services.

From fiscal years 2015 through 2020, we also found that there were some instances in which the proportion of different types of products and services purchased under the Buy Indian Act varied from the proportions purchased by IHS overall. For example, obligations for information technology and telecommunications supplies and services made up about 42 percent of Buy Indian Act obligations, while comprising about 11 percent of total non-pharmaceutical IHS obligations. In contrast, medical supplies and services, including providers, made up about 53 percent of total non-pharmaceutical IHS obligations, while making up about 29.4 percent of obligations under the Buy Indian Act. See figure 3 for more detail on how the proportion of non-pharmaceutical products and services purchased by IHS overall varied from what IHS purchased under the Buy Indian Act.

Figure 3: Proportion of Non-Pharmaceutical Obligations Made Under the Buy Indian Act Compared to Overall Indian Health Service (IHS), by Type of Product or Service, Fiscal Years 2015–2020



Source: GAO analysis of Federal Procurement Data System data. | GAO-22-104742

Note: The "other" category includes electrical and electronic equipment, furniture, education/training, transportation, and other non-pharmaceutical products and services.

Agency Comments

We provided a draft of this report to HHS. HHS provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on GAO's website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at RosenbergM@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix I.

Michelle B. Rosenberg
Director, Health Care

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Appendix I: GAO Contact and Staff Acknowledgments

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In addition to the contact named above, Kristi Peterson (Assistant Director), Amy Leone (Analyst-in-Charge), Emily Bippus, and Jean Recklau made key contributions to this report. Zhi Boon, Gina Flacco, Suellen Foth, Jacquelyn Hamilton, Jeff Hartnett, Teague Lyons, Vikki Porter, and Caitlin Scoville also made important contributions.

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