

Why GAO Did This Study

IHS provides health care to American Indians and Alaska Natives. When care at an IHS-funded facility is unavailable, IHS's CHS program pays for care from external providers. Hospitals are required to accept Medicare rates from federal and tribal CHS programs, while physicians and other nonhospital providers are paid at either billed charges or negotiated, reduced rates. The Patient Protection and Affordable Care Act requires GAO to compare CHS program payment rates with those of other public and private payers. GAO examined (1) how payments to physicians by IHS's federal CHS programs compare with what Medicare and private health insurers would have paid for the same services, (2) physicians' perspectives about how a cap on payment rates could affect them, (3) hospitals' perspectives about how the MLR requirement affected them, and (4) IHS and tribal officials' perspectives about the MLR requirement and a potential cap on nonhospital services. GAO compared 2010 physician claims data for federal CHS programs with the Medicare Physician Fee Schedule and claims from private insurers. GAO also spoke to a nongeneralizable sample of 10 physicians and 9 hospitals that interacted frequently with IHS and spoke to IHS and tribal officials where these providers practiced.

What GAO Recommends

Congress should consider capping CHS program payments for nonhospital services, including physician services, at rates comparable to other federal programs. Should Congress cap payments, we recommend HHS direct IHS to monitor access to care.

View [GAO-13-272](#). For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

INDIAN HEALTH SERVICE

Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services

What GAO Found

The Indian Health Service's (IHS) federal contract health services (CHS) programs primarily paid physicians at their billed charges, which were significantly higher than what Medicare and private insurers would have paid for the same services. IHS's policy states that federal CHS programs should purchase services from contracted providers at negotiated, reduced rates. However, of the almost \$63 million that the federal CHS programs paid for physician services provided in 2010, they paid about \$51 million (81 percent) to physicians at billed charges and about \$12 million (19 percent) to physicians at negotiated, reduced rates. Payments for other types of nonhospital services followed similar trends, with about \$40 million out of \$52 million (77 percent) paid at billed charges. GAO estimated that IHS's federal CHS programs paid two times as much as what Medicare would have paid and about one and a quarter times as much as what private insurers would have paid for the same physician services provided in 2010. If federal CHS programs had paid Medicare rates for these services, they could have used an estimated \$32 million in savings to pay for many of the services that IHS is unable to fund each year. Savings for the overall CHS program may be even higher, as this analysis does not include other types of nonhospital services or the CHS program funding that goes to tribal CHS programs, which the Department of Health and Human Services' (HHS) Office of Inspector General found also paid for nonhospital care above Medicare rates.

Although the 10 physicians GAO interviewed were among those most frequently paid by federal CHS programs, 8 said their CHS program payments constituted 10 percent or less of their total payments. Some physicians identified ways that capping CHS program payments for nonhospital services, including physician services, at Medicare rates could benefit the CHS program and physician practices. However, other physicians were concerned that reducing payment rates to Medicare levels could negatively affect their practices.

Seven of nine hospitals GAO interviewed said the Medicare-like rates (MLR) required by statute had little negative effect, generally because they already had contracts with the CHS program to be paid Medicare rates. While two hospitals previously paid by the CHS program at or near billed charges said they were financially affected by the MLR requirement, both said it had not affected their delivery of care to CHS program patients.

IHS and tribal officials GAO interviewed said the MLR requirement for hospital services generated savings that allowed CHS programs to expand access to health care. They said that a cap on nonhospital service payments, including physician services, could have benefits and challenges. Most IHS officials indicated that it was unlikely they could negotiate many more contracts. Some tribal officials said that some physicians might think Medicare rates were too low and decide to no longer accept tribal patients, although they agreed that a cap at these rates could save money. IHS officials noted, however, that they would not be able to implement a cap for nonhospital services, including physician services, unless the agency received explicit statutory authority to do so.

HHS stated in its comments that it concurred with GAO's conclusions and recommendation and added that imposing a cap at Medicare rates would allow IHS to fund additional services.