



September 2018

# INDIAN HEALTH SERVICE

## Considerations Related to Providing Advance Appropriation Authority

# GAO Highlights

Highlights of [GAO-18-652](#), a report to congressional committees

## Why GAO Did This Study

IHS, an agency within the Department of Health and Human Services (HHS), receives an annual appropriation from Congress to provide health care services to over 2 million American Indians and Alaska Natives (AI/AN) who are members of 573 tribes. IHS generally provides services through direct care at facilities such as hospitals and health centers. Some tribes receive IHS funding to operate their own health care facilities. Tribal representatives have sought legislative approval to provide IHS advance appropriation authority stating that it would facilitate planning and more efficient spending. Experts have reported that agencies can use the authority to prevent funding gaps, and avoid uncertainties associated with receiving funds through CRs.

House Report 114-632 included a provision for GAO to review the use of advance appropriations authority and applications to IHS. Among other things, this report (1) describes advance appropriation authority considerations identified by stakeholders for providing IHS-funded health care services, and (2) identifies other considerations for policymakers related to providing the authority to IHS. GAO reviewed its prior reports related to IHS, VA, government shutdowns, and CRs, and interviewed officials from IHS, several tribes and other organizations representing AI/AN interests, the Office of Management and Budget, VA and other experts.

GAO provided a draft of this report to HHS, which had no comments; to VA, which provided general comments; and to tribal representatives, which provided technical comments that were incorporated as appropriate.

View [GAO-18-652](#). For more information, contact Jessica Farb at (202) 512-7114 or [farbj@gao.gov](mailto:farbj@gao.gov).

September 2018

## INDIAN HEALTH SERVICE

### Considerations Related to Providing Advance Appropriation Authority

## What GAO Found

The Indian Health Service (IHS), like most federal agencies, must use appropriations in the year for which they are enacted. However, there has been interest in providing IHS with advance appropriation authority, which would give the agency authority to spend a specific amount 1 or more fiscal years after the fiscal year for which the appropriation providing it is enacted. Currently, the Department of Veterans Affairs (VA) is the only federal provider of health care services to have such authority.

Stakeholders interviewed by GAO, including IHS officials and tribal representatives, identified effects of budget uncertainty on the provision of IHS-funded health care as considerations for providing IHS with advance appropriation authority. Budget uncertainty arises during continuing resolutions (CR)—temporary funding periods during which the federal government has not passed a budget—and during government shutdowns. Officials said that advance appropriation authority could mitigate the effects of this uncertainty. IHS officials and tribal representatives specifically described several effects of budget uncertainty on their health care programs and operations, including the following:

- **Provider recruitment and retention.** Existing challenges related to the recruitment and retention of health care providers—such as difficulty recruiting providers in rural locations—are exacerbated by funding uncertainty. For example, CRs and government shutdowns can disrupt recruitment activities like application reviews and interviews.
- **Administrative burden and costs.** Both IHS and tribes incur additional administrative burden and costs as IHS staff calculate proportional allocations for each tribally operated health care program and modify hundreds of tribal contracts each time a new CR is enacted by Congress to conform to limits on available funding.
- **Financial effects on tribes.** Funding uncertainty resulting from recurring CRs and from government shutdowns has led to adverse financial effects on tribes and their health care programs. For instance, one tribe incurred higher interest on loans when the uncertainty of the availability of federal funds led to a downgraded credit rating, as it was financing construction of a health care facility.

GAO identified various considerations for policymakers to take into account for any proposal to change the availability of the appropriations that IHS receives. These considerations include operational considerations, such as what proportion of the agency's budget would be provided in the advance appropriation and under what conditions changes to the funding provided through advance appropriations would be permitted in the following year. Additionally, congressional flexibility considerations arise because advance appropriation authority reduces what is left for the overall budget for the rest of the government. Another consideration is agency capacity and leadership, including whether IHS has the processes in place to develop and manage an advance appropriation. GAO has reported that proposals to change the availability of appropriations deserve careful scrutiny, an issue underscored by concerns raised when GAO added IHS to its High-Risk List in 2017.

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## Abbreviations

AI/AN	American Indian and Alaska Native
CR	continuing resolution
HHS	Department of Health and Human Services
IHS	Indian Health Service
OMB	Office of Management and Budget
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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September 13, 2018

The Honorable Lisa Murkowski  
Chairman  
The Honorable Tom Udall  
Ranking Member  
Subcommittee on Interior, Environment, and Related Agencies  
Committee on Appropriations  
United States Senate

The Honorable Ken Calvert  
Chairman  
The Honorable Betty McCollum  
Ranking Member  
Subcommittee on Interior, Environment, and Related Agencies  
Committee on Appropriations  
House of Representatives

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), receives an annual appropriation from Congress to provide certain health care services to over 2 million American Indians and Alaska Natives (AI/AN) who are members of federally recognized tribes.<sup>1</sup> IHS services are generally provided through direct care at IHS facilities such as hospitals and health centers, and when services are unavailable at these facilities, the facilities may pay for patients to obtain services, including specialty care, from external providers. In addition to federally operated IHS facilities, some federally recognized tribes choose to operate their own health care facilities, for which they receive at least partial support through IHS funding.

IHS, like most federal agencies, receives appropriations through annual appropriations acts and the appropriations become available upon enactment, not at some future date. However, there has been interest in providing IHS with advance appropriation authority—an appropriation of

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<sup>1</sup>Federally recognized tribes have a government-to-government relationship with the United States 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. See, e.g., 83 Fed. Reg. 4235 (Jan. 30, 2018). There are currently 573 federally recognized tribes.

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new budget authority that becomes available one or more fiscal years after the fiscal year for which the appropriation providing it is enacted.<sup>2</sup> Organizations representing AI/AN people have advocated for Congress to provide IHS with advance appropriation authority, stating that advance appropriations would allow for greater planning, more efficient spending, and higher quality of care for AI/AN individuals. Although not commonly provided for federal programs, experts have reported that advance appropriations have implications for agencies' ability to manage during periods of budget uncertainty, in terms of preventing funding gaps, and avoiding issues associated with receiving short-term funds through continuing resolutions (CR).<sup>3</sup> The Department of Veterans Affairs (VA) is the only federal agency that currently receives advance appropriations for its health care program, which is administered by its Veterans Health Administration (VHA).

House Report 114-632 included a provision for us to report on the use of advance appropriation authority for health care programs across the federal government, and applications to IHS.<sup>4</sup> This report

1. describes the advance appropriation authority that VA has for its health care program;
2. describes the advance appropriation authority considerations identified by stakeholders for providing IHS-funded health care services; and
3. identifies other considerations for policymakers related to providing advance appropriation authority to IHS.

To describe the advance appropriation authority that VA has for its health care program, we reviewed statutes related to VA's specific advance appropriation authority and interviewed VHA officials, including headquarters officials from the Office of Finance and the Office of Rural Health. In addition, we interviewed officials from the Office of Management and Budget (OMB) who work with VA in planning for

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<sup>2</sup>Legislation has been introduced in the House to provide IHS with such authority. See Indian Health Service Advance Appropriations Act of 2017, H.R. 235, 115<sup>th</sup> Cong. (2017).

<sup>3</sup>CRs provide temporary funding to allow agencies or programs to continue to obligate funds at a particular rate—such as the rate of operations for the previous fiscal year—for a specific period of time, which may range from a single day to an entire fiscal year.

<sup>4</sup>See Pub. L. No. 115-31, § 4, 131 Stat. 135, 137 (2017); 163 Cong. Rec. H3874 (daily ed. May 3, 2017); H.R. Rep. No. 114-632, at 89 (2016).

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advance appropriations. We also reviewed our prior reports examining VHA budget processes and experience with advance appropriations.

To describe the advance appropriation authority considerations identified by stakeholders for providing IHS-funded health care services, we reviewed our prior reports that examined the effects of CRs and government shutdowns on federal agencies, and interviewed IHS officials and tribal representatives. Specifically, we interviewed IHS officials and tribal representatives about their perceptions of the potential advantages or disadvantages of advance appropriations for IHS, including their perceptions of the effects of budget uncertainty on the provision of IHS-funded health care. IHS officials we interviewed included individuals from the Office of the Director, the Office of Finance and Accounting, the Office of Direct Service and Contracting Tribes, the Office of Tribal-Self Governance, and the Division of Acquisition Policy, among others.

Additionally, we interviewed tribal officials, including those who currently serve as co-chairs for IHS's National Tribal Budget Formulation Workgroup (who collectively represent multiple individual tribes and groups of tribes).<sup>5</sup> We selected tribal officials to interview to help ensure a range of experiences and different types of funding agreements with IHS. We also obtained information from representatives of several additional tribes and tribal organizations.<sup>6</sup> Our interviews and other information obtained from representatives of these tribes and tribal organizations are not generalizable to all federally recognized tribes. We also interviewed officials from associations representing tribal and AI/AN interests, including the National Indian Health Board and the National Council of Urban Indian Health.<sup>7</sup> For context, we also spoke with VA officials from two regional networks—Veterans Integrated Service Networks (VISN)—about their experience with advance appropriations; VA officials indicated

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<sup>5</sup>The National Tribal Budget Formulation Workgroup, which is a formal participant in IHS's budget formulation process and consists of two tribal representatives selected from each of the 12 IHS areas, meets annually and prepares the final set of tribal budget recommendations and presents these to the IHS Director and HHS senior officials.

<sup>6</sup>We supplemented our interviews with written materials submitted by tribal representatives in response to our request for input.

<sup>7</sup>In this report, we use the term "tribal representatives" to include tribal officials as well as officials from associations representing tribal and AI/AN interests.

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that these VISNs have extensive experience in serving rural populations, including AI/AN veterans.<sup>8</sup>

To identify other considerations for Congress and agency officials related to providing advance appropriation authority to IHS, we reviewed materials documenting past efforts to obtain advance appropriation authority for IHS—including proposed legislation and documents from advocacy groups such as the National Indian Health Board, as well as our prior work related to the consideration of advance appropriations for VA. For context, we also reviewed our past reports and those from the Congressional Research Service on various aspects of IHS—including budgeting processes. We interviewed IHS officials regarding their processes for budget planning and VA officials regarding their experiences planning for advance appropriations. In addition, we interviewed officials from OMB, the Congressional Research Service, and the Congressional Budget Office.

We conducted this performance audit from August 2017 to September 2018 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.

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## Background

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### IHS Health Care System and Tribal Health Care

IHS was established within the Public Health Service in 1955 to provide certain health services to members of federally recognized AI/AN tribes, primarily in rural areas on or near reservations. IHS provides services directly through a network of hospitals, clinics, and health stations

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<sup>8</sup>VISN offices provide management and oversight to the medical centers and clinics within their assigned geographic areas. Each VISN office is responsible for allocating funds to facilities, clinics, and programs within its region and coordinating the delivery of health care to veterans.

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operated by IHS, and also funds services provided at tribally operated facilities.<sup>9</sup>

As of October 2017, IHS, tribes, and tribal organizations operated 168 service units, 48 hospitals, and 560 ambulatory care centers—including health centers, school health centers, health stations, and Alaska village clinics.<sup>10</sup> See table 1.

**Table 1: Numbers of Federally Operated and Tribally Operated Indian Health Service (IHS) Facilities, as of October 2017**

Type of facility	Federally operated	Tribally operated	Total
Service units <sup>a</sup>	54	114	168
Hospitals	26	22	48
Ambulatory care centers	78	482	560

Source: IHS | GAO-18-652.

<sup>a</sup>IHS service units are administrative entities within a defined geographical area through which services are directly or indirectly provided to eligible Indians. A service unit may contain one or more health care facilities and may cover a number of small reservations, or, conversely, some large reservations may be covered by several service units.

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<sup>9</sup>When services are not available at federally operated or tribally operated facilities, IHS may pay for services provided through external providers through its Purchased/Referred Care program. IHS also provides funding to nonprofit, urban Native American organizations through the Urban Indian Health program to provide health care services to AI/AN people living in urban areas. See 25 U.S.C. § 1653.

Based on the needs of their communities, tribes and tribal organizations can choose to receive health care administered and operated by IHS, or assume responsibility for providing all or some health care services formerly administered and operated by IHS. Under the Indian Self-Determination and Education Assistance Act (ISDEAA), as amended, federally recognized Indian tribes can enter into self-determination contracts or self-governance compacts with the Secretary of HHS to take over administration of IHS programs for Indians previously administered by IHS on their behalf. Specifically, through self-determination contracts, Indian tribes can assume responsibility for administration of programs for the benefit of Indians because of their status as Indians that would otherwise be managed by IHS. Through self-governance compacts, Indian tribes can assume responsibility for administration of IHS programs that are otherwise available for tribes and Indians and also consolidate those programs. Pub. L. No. 93-638, 88 Stat. 2203 (1975) (codified as amended at 25 U.S.C. §§ 5301-5423). The provisions governing self-determination contracts are found in title I (25 U.S.C. §§ 5321-5332). The provisions governing self-governance compacts with IHS are in title V (25 U.S.C. §§ 5381-5399).

<sup>10</sup>IHS service units are administrative entities within a defined geographical area through which services are directly or indirectly provided to eligible Indians. A service unit may contain one or more health care facilities and may cover a number of small reservations, or, conversely, some large reservations may be covered by several service units.



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According to IHS officials, the agency provides services almost exclusively in locations designated as Health Professional Shortage Areas, with most locations identified as extreme shortage areas.<sup>11</sup> In addition, IHS data indicate that about 35 percent of certain IHS facilities, including four hospitals, were identified as isolated hardship posts in 2016.<sup>12</sup>

IHS oversees its health care facilities through a decentralized system of 12 area offices, which are led by area directors; 10 of these 12 IHS areas have federally operated IHS facilities. IHS's headquarters office is responsible for setting health care policy, helping to ensure the delivery of quality comprehensive health services, and advocating for the health needs and concerns of AI/AN people. The IHS area offices are responsible for distributing funds to the facilities in their areas, monitoring their operation, and providing guidance and technical assistance.

IHS's estimated budget authority for fiscal year 2018 is over \$5.6 billion, an increase of almost \$580 million from its enacted budget authority of just over \$5 billion in fiscal year 2017.<sup>13</sup> IHS has agreements with tribes and tribal organizations by which it transfers a substantial portion of its

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<sup>11</sup>HHS's Health Resources and Services Administration designates areas identified as having a shortage of primary care physicians as primary care Health Professional Shortage Areas. Primary care is defined as the specialties of family medicine, internal medicine, pediatrics, and obstetrics and gynecology. The agency also designates Health Professional Shortage Areas in dental health and mental health.

<sup>12</sup>Isolated hardship posts are described as "unusually difficult, which may present moderate to severe physical hardships for individuals assigned to that geographic location." According to IHS, physical hardships may include crime or violence, pollution, isolation, a harsh climate, scarcity of goods on the local market, and other problems.

In 2016, we reported that residents of tribal lands often lack basic infrastructure, such as water and sewer systems, and telecommunications services. See GAO, *Telecommunications: Additional Coordination and Performance Measurement Needed for High-Speed Internet Access Programs on Tribal Lands*, [GAO-16-222](#). (Washington, D.C.: Jan. 29, 2016.)

<sup>13</sup>The \$5.6 billion estimate for fiscal year 2018 includes the amounts enacted for Indian Health Services and Indian Health Facilities by the Consolidated Appropriations Act, 2018, plus an estimate for Contract Support Costs from the President's fiscal year 2019 budget justification, for which IHS receives an annual indefinite appropriation of "such sums as may be necessary." See Pub. L. No. 115-141, div. G, tit. III, 132 Stat. 348, 677-679 (2018). "Budget authority" refers to authority provided by federal law to enter into contracts or other financial obligations that will result in immediate or future expenditures (or outlays) involving federal government funds. Most appropriations are a form of budget authority that also provides the legal authority to make the subsequent payments from the Treasury.

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budget authority to tribes and tribal organizations. For example, in 2017, the agency transferred approximately 54 percent of its total budget authority to tribes and tribal organizations to operate part or all of their own health care programs through self-determination contracts and self-governance compacts.

- Self-determination contracts: IHS had 373 self-determination contracts in place with 220 tribes in 2017.
- Self-governance compacts: IHS had 98 self-governance compacts in place—including 124 funding agreements—with 360 tribes in 2017.<sup>14</sup> See figure 1 for the percentage of IHS's total budget authority transferred to tribes in fiscal year 2017.

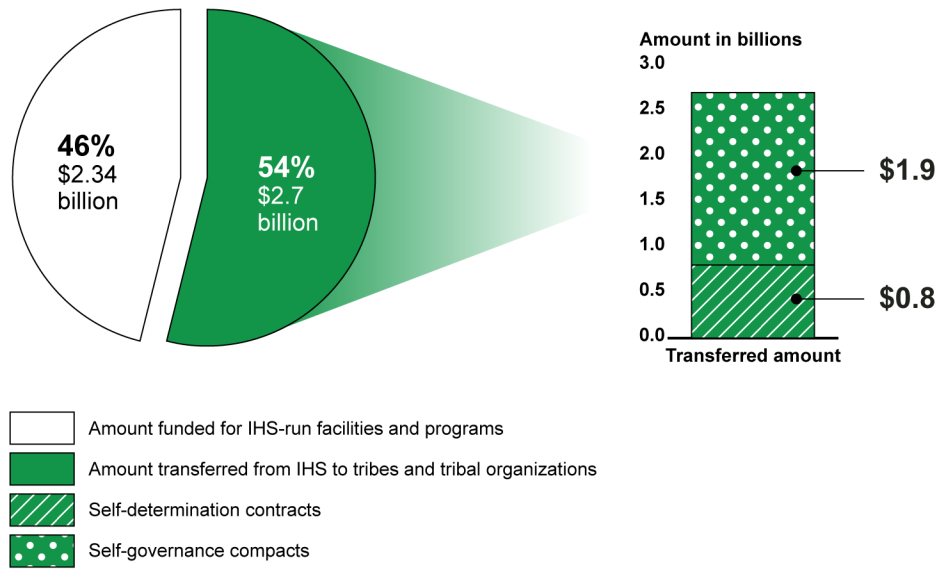
According to IHS officials, over the last few years an increasing number of tribes have sought to enter into contracts and compacts with IHS to assume responsibility for some or all of their health care programs, and thereby receive funding from IHS.

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<sup>14</sup>A funding agreement is an annual or multi-year agreement that generally identifies the programs and services to be assumed by the tribe, describes the financial terms of the agreement, and sets out the responsibilities of the HHS Secretary.

**Figure 1: Transfer of Funds from Indian Health Service (IHS) to Tribes and Tribal Organizations, Fiscal Year 2017**

**FY2017 total IHS budget authority provided by Congress: \$5.04 billion**



Source: GAO analysis of IHS data. | GAO-18-652

## Federal Budget Environment

Unless otherwise specified in law, funding included in annual appropriation acts is available for obligation during a single fiscal year, after which it expires. For this reason, the continuation of normal government operations depends upon the enactment each fiscal year of a new appropriations act. Any lapse in appropriations—a funding gap—causes most government functions to shut down.<sup>15</sup> To avert a government shutdown, Congress may enact one or more CRs. CRs are spending bills that provide funds to allow agencies to operate during a specified period of time while Congress works to pass an annual appropriations act. Relevant aspects of the federal budget environment include the following.

<sup>15</sup>There are certain exceptions to this requirement, such as a determination by the head of the agency that continued action is necessary because of an emergency involving the safety of human life or the protection of property.

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**Frequency of CRs and shutdowns.** In all but 4 of the last 40 fiscal years—including fiscal year 2018—Congress has enacted CRs.<sup>16</sup> Since fiscal year 1999, CRs have varied greatly in their number and duration—the number of CRs enacted in each year ranged from 2 to 21, and the duration of CRs has ranged from 1 to 187 days. Regarding lapses in appropriations that resulted in government shutdowns, in January 2018 the government partially shut down for 3 calendar days after the CR in place expired. Other shutdowns have lasted longer—16 calendar days in October 2013 and 21 calendar days in December 1995 through January 1996. We have previously reported on the effects of CRs and shutdowns for federal agencies.<sup>17</sup>

**Budget authority during a CR.** CRs provide “such amounts as may be necessary” to maintain operations consistent with the prior fiscal year’s appropriations and authorities. To control spending in this manner, CRs generally prohibit agencies from initiating new activities and projects for which appropriations, funds, or other authorities were not available in the prior fiscal year. They also require agencies to take the most limited funding actions necessary to maintain operations at the prior fiscal year’s level.

**Budget authority during a funding gap.** Certain federal health care programs have various budget authorities that can allow for continued operations during a funding gap. For example, VA’s advance appropriations authority for its health care programs allows operations to continue after one appropriation expires, using the previously enacted budget for the next year. Although IHS does not have this authority, Congress has enacted longer periods of availability for certain IHS appropriations that would allow the activities they support to continue during a funding gap, assuming the appropriation has not run out. For example, IHS’s appropriation for Indian health facilities remains available

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<sup>16</sup>CRs vary from year to year in their application to federal agencies and activities. We did not determine the number of years in which IHS received funding through CRs during this period.

<sup>17</sup>See, for example, GAO, *Budget Issues: Continuing Resolutions and Other Budget Uncertainties Present Management Challenges*, [GAO-18-368T](#) (Washington, D.C.: Feb. 6, 2018); GAO, *2013 Government Shutdown: Three Departments Reported Varying Degrees of Impacts on Operations, Grants, and Contracts*, [GAO-15-86](#) (Washington, D.C.: Oct. 15, 2014); and GAO, *Continuing Resolutions: Uncertainty Limited Management Options and Increased Workload in Selected Agencies*, [GAO-09-879](#) (Washington, D.C.: Sept. 24, 2009).

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until expended, in contrast to its appropriation for Indian health services, which is generally available for a single fiscal year.<sup>18</sup>

In this regard, funds for Indian health services that IHS transfers to tribes and tribal organizations during the 1-year period of availability are deemed to be obligated at the time of the award and thereafter remain available to the tribes to operate their own health care programs without fiscal year limitation.<sup>19</sup> Thus, to the extent sufficient funding remained available from federal or other sources during a lapse in appropriations, a tribe could continue to operate its own health care programs during a shutdown. To operate IHS's health care system on an emergency basis during a funding gap, IHS would need to determine what programs and activities qualified for an emergency exception under the law.<sup>20</sup>

**Contingency planning for government shutdowns.** Federal agencies must determine what activities and programs they are permitted or required to continue prior to a potential shutdown. This includes designating certain employees as "excepted" employees who would be expected to continue to work during the shutdown and who would be paid upon the enactment of an appropriation.<sup>21</sup> Employees who are not "excepted" would be subject to furlough.

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## Interest in Advance Appropriation Authority for IHS

Citing funding uncertainty associated with continued use of CRs, AI/AN advocacy groups such as the National Indian Health Board have requested that Congress grant IHS advance appropriation authority; legislation to provide IHS this authority has been introduced more than once. The most recent such legislation, H.R. 235, introduced in January 2017 (not enacted), would have provided IHS with 2-year fiscal budget authority for its Indian health services and Indian health facilities accounts, similar to the authority that VA currently has for its health care

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<sup>18</sup>See, e.g., Pub. L. No. 115-141, 132 Stat. 679.

<sup>19</sup>See, e.g., Pub. L. No. 115-141, 132 Stat. 677. Because AI/AN tribes and tribal organizations are sovereign entities, they are not subject to government shutdowns, though they could be adversely affected by the resulting funding gaps.

<sup>20</sup>To invoke this exception, the emergency must involve the safety of human life or protection of property. See 31 U.S.C. 1342.

<sup>21</sup>Historically, Congress has also permitted the retroactive payment of employees who did not work during a shutdown. See, e.g., Pub. L. No. 115-120, § 2001, 132 Stat. 28, 29 (2018).

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appropriation accounts. HHS, on behalf of IHS, has not requested that IHS be granted advance appropriation authority during its annual budget submissions to Congress.

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## VA's Advance Appropriation Authority for Health Care

VA, through the VHA, operates one of the nation's largest health care systems, with 171 VA medical centers, more than 1,000 outpatient facilities, and total health care budget authority of about \$69 billion in fiscal year 2017. VA provided health care services to about 6.8 million veterans in fiscal year 2017, and the agency forecasts that demand for its services is expected to grow in the coming years.

VA was granted advance appropriation authority for specified medical care accounts in the Veterans Health Administration in 2009.<sup>22</sup> Currently, VA's annual appropriations for health care include advance appropriations that become available in the fiscal year after the fiscal year for which the appropriations act was enacted. Under this authority, VA receives advance appropriations for VHA's Medical Services, Medical Support and Compliance, Medical Facilities, and Medical Community Care appropriations accounts and is required to provide Congress with detailed estimates of funds needed to provide its health care services for the fiscal year for which advance appropriations are to be provided. According to VA officials, veterans service organizations were the primary advocates who sought advance appropriation authority for VA's health care program.

In its health care budget proposal each year, VA submits a request for the upcoming fiscal year, as well as an advance appropriation request for the following year. In early 2018, for example, VA submitted a request for fiscal year 2019, as well as a fiscal year 2020 advance appropriation request. According to VA, more than 90 percent of its budget request is developed using an actuarial model that is based in part on VA's actual health care utilization data from prior years; for example, the 2020

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<sup>22</sup>Pub. L. No. 111-81, 123 Stat. 2137 (2009) (codified as amended at 31 U.S.C. § 1105(a)(37) and 38 U.S.C. § 117). This authority took effect with the budget submissions for fiscal year 2011.

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advance appropriation request used fiscal year 2016 data.<sup>23</sup> VHA officials said that the agency calculates its advance appropriation request to fund needed care as estimated by its actuarial model, with less funding requested for other expenses (such as non-recurring maintenance) and officials told us this is consistent with direction provided by OMB. OMB officials told us that the amount provided in the advance appropriation is intended to provide VA with some assurances that it will be able to continue health care operations seamlessly across fiscal years.

In the subsequent year (the year during which the advance appropriation can be used), VA may request an adjustment to the amount previously provided through advance appropriations—referred to by agency officials as a “second bite”—an arrangement that is intended by design to help respond to more recent policy changes or significant events. For example, VA requested a “second bite” increase of \$2.65 billion for fiscal year 2018, to the \$66.4 billion initially provided to its VHA accounts through its advance appropriation. Both OMB and VHA officials said this “second bite” provides an opportunity to make an adjustment to VA’s advance appropriation using updated utilization data. VHA officials told us that changes in policy (such as determining which veterans or what health benefits can be covered) sometimes drive changes from the initial budget request. For example, policy changes can include adding an additional presumptive condition—such as health conditions associated with Agent Orange exposure—resulting in a new health benefit, or a costly new drug treatment, as in the case of the addition to the drug formulary of a new Hepatitis C drug treatment.<sup>24</sup>

Despite having advance appropriation authority, VA has faced challenges in budget formulation, in addition to the general management and

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<sup>23</sup>We have previously reported on this model—the Enrollee Health Care Projection Model—and other aspects of VA’s health care budget estimation process. See, for example, GAO, *Veterans’ Health Care: VA Uses a Projection Model to Develop Most of Its Health Care Budget Estimate to Inform the President’s Budget Request*, [GAO-11-205](#) (Washington, D.C.: Jan. 31, 2011); GAO, *Veterans’ Health Care Budget: Transparency and Reliability of Some Estimates Supporting President’s Request Could Be Improved*, [GAO-12-689](#) (Washington, D.C.: June 11, 2012); GAO, *Veterans’ Health Care Budget: Improvements Made, but Additional Actions Needed to Address Problems Related to Estimates Supporting President’s Request*, [GAO-13-715](#) (Washington, D.C.: Aug. 8, 2013); and GAO, *VA’s Health Care Budget: In Response to a Projected Funding Gap in Fiscal Year 2015, VA Has Made Efforts to Better Manage Future Budgets*, [GAO-16-584](#) (Washington, D.C.: June 3, 2016).

<sup>24</sup>See [GAO-16-584](#).

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oversight challenges we cited in adding VA to our High-Risk List in 2015.<sup>25</sup> Specifically, we reported in our 2017 update to the High-Risk List that VA faces challenges regarding the reliability, transparency, and consistency of its budget estimates for medical services, as well as weaknesses in tracking obligations for medical services and estimating budgetary needs for future years.<sup>26</sup> These challenges were evident in June 2015, when VA requested authority from Congress to move funds from another appropriation account because agency officials projected a fiscal year 2015 funding gap of about \$3 billion in its medical services appropriation account.<sup>27</sup>

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## Budget Uncertainty Effects on the Provision of IHS-Funded Health Care That Were Cited by Stakeholders

IHS officials, tribal representatives, and other stakeholders we spoke with described how budget uncertainty resulting from CRs and government shutdowns can have a variety of effects on the provision of IHS-funded health care services for AI/ANs.<sup>28</sup> The following summarizes these effects, along with the views of IHS officials, tribal representatives, and other stakeholders on how advance appropriation authority could mitigate them, and VA's related experiences:

**Provision of health care services.** IHS officials said that, in general, most health care services would be expected to continue at IHS-operated facilities during a shutdown, as health care providers would be deemed "excepted" personnel under the agency's contingency plan.<sup>29</sup> However, officials noted some health care procedures could be delayed, as determined on a case-by-case basis at the local level. IHS officials also acknowledged that tribal health care programs may not have access to

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<sup>25</sup>See GAO, *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015).

<sup>26</sup>See GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, [GAO-17-317](#) (Washington, D.C.: Feb. 15, 2017).

<sup>27</sup>In our report examining that instance, we noted that that the majority of the projected funding gap was the result of higher-than-expected obligations for VHA's program providing care in the community through non-VA providers. See [GAO-16-584](#).

<sup>28</sup>For this report, leaders from individual AI/AN tribes as well as officials from advocacy organizations that work on behalf of tribes and AI/AN people are referred to, collectively, as tribal representatives.

<sup>29</sup>According to IHS, staff involved in the safety of human life and protection of property would continue to report for work and provide services under the agency's contingency plan, consistent with actual occurrences in the past.



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furloughed IHS staff who do not work during a shutdown, such as support staff at local IHS area offices, who may carry out administrative duties on their behalf. For example, tribal representatives told us that during a previous government shutdown, finance employees from the local IHS area offices were furloughed (and thus not permitted to work), which created challenges for tribal health care operations that depended on these IHS employees to process payments and agreements.

IHS officials stated they believe advance appropriations could help ensure continuity of health care services through certainty of funding. IHS officials also said that while lapses in appropriations do not halt patient care, they do create complications—such as the determination of excepted personnel as described above—that could be eliminated by funding provided through advance appropriations. Tribal representatives said the certainty of funding that would come with IHS having advance appropriations would create a sense of stability in tribal health care programs as well.

VA VISN officials we spoke to said having advance appropriations has improved their ability to manage resources for continuity of services and allowed them to avoid the substantial additional planning that occurs before a potential government shutdown when agencies are determining which providers and staff would be deemed excepted. According to the VISN officials, knowing that funding is coming—as opposed to having less certainty—would allow an agency to plan and prioritize its services more efficiently.

**Health care program planning.** Tribal representatives said operating health care programs with short-term funding provided through a series of CRs—and facing potential government shutdowns—rather than a full year's apportionment hinders their ability to plan for new programs and for improvements that need to be carried out across budget years or that require large up-front investments, such as an electronic medical records system or other significant information technology purchases. Tribal representatives said there are often plans that they have to set aside because they don't have enough funds to start a project during a CR, and—if there are multiple CRs—there is not enough time left in the budget year to start bigger projects once an annual appropriation is passed. Tribal representatives also told us that they believe that advance appropriations would help tribal health care programs plan for current and future needs. For example, one tribal official told us advance appropriations would allow tribes to plan for long-term health initiatives. The official's specific tribe has a gestational diabetes program in

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conjunction with a local university that the tribe could plan to take full responsibility for if they had more funding stability.<sup>30</sup>

VA VISN officials we interviewed provided several examples of how they believe advance appropriations facilitate their planning. For example, VISN officials told us advance appropriations allow them to plan strategically for equipment purchases: if they need to buy a CT scanner, they would plan to do site preparation in one year—for example, reconfiguring the space for the new equipment by moving walls, electrical rewiring, etc.—and buy the scanner in the next year. With advance appropriations, they know they are going to have funds for an expensive equipment purchase available the next year; without an advance appropriation, they would not be sure, and could spend funds on preparation and then ultimately not have the funds to make the equipment purchase. These officials also said having advance appropriations gave them confidence in making current plans to provide the new shingles vaccine for their over-50 population in 2019, including the ability to secure an adequate supply of the vaccine from the manufacturer.

**Provider recruitment and retention.** IHS officials and tribal representatives said existing challenges related to their recruitment and retention of health care providers—many of which are related to the rural and remote locations of many of IHS’s facilities—are exacerbated by funding uncertainty resulting from CRs or potential government shutdowns.<sup>31</sup> IHS officials said CRs and government shutdowns can disrupt recruitment activities such as IHS marketing efforts, job advertisements, application review, interviews, and candidate site visits. Additionally, when recruiting health care providers, IHS officials said CRs and potential government shutdowns create doubt about the stability of employment at IHS amongst potential candidates, which may result in reduced numbers of candidates or withdrawals from candidates during the pre-employment process. IHS officials said that many providers in rural and remote locations are the sole source of income for their families, and the potential for delays in pay resulting from a government shutdown

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<sup>30</sup>According to the Centers for Disease Control and Prevention, gestational diabetes is a type of diabetes that is first seen in a pregnant woman who did not have diabetes before she was pregnant.

<sup>31</sup>We have reported on challenges IHS faces in recruiting and retaining clinical staff, including the rural location of many IHS facilities and insufficient housing for providers. See GAO, *Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies*, [GAO-18-580](#) (Washington, D.C.: Aug. 15, 2018).

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can serve as a disincentive for employees considering public service in critical shortage areas that do not offer adequate spousal employment opportunities. Tribal representatives said CRs create challenges for tribes in funding planned pay increases—such as cost-of-living adjustments—for health care staff at their facilities, and they may, as a result, defer increases.

IHS officials and tribal representatives stated they believe advance appropriations could mitigate these challenges. For example, IHS officials said that with advance appropriations, recruitment and outreach activities could continue without disruption, and selected candidates could be brought on board as scheduled. One tribal representative stated that advance appropriations could help with recruitment by providing perceived job stability that is similar to VA or the private sector.

According to VA VISN officials, the agency's experience with advance appropriation authority suggests that advance appropriations can facilitate physician recruitment, including hiring. If, for example, they were far along in the hiring process at the end of a fiscal year, but could not finalize the hire before the end of the year, having advance appropriations for the next fiscal year provides the certainty that they will be able to make the hire in the new fiscal year.

**Commercial contracts and vendor negotiations.** IHS officials and tribal representatives said budget uncertainty can lead to vendor reluctance to provide services to IHS and tribally operated facilities. IHS officials said they have heard from vendors—who are typically Indian- or veteran-owned small businesses in the communities being served by IHS—that they lose trust in IHS and federally-funded tribal health care programs when they are affected by budget uncertainty. One tribal organization told us delays in receiving full funding because of CRs has inhibited its ability to pay invoices for pharmaceuticals in a timely manner, which has harmed its relationship with its vendors.

VISN officials told us that advance appropriations can provide an element of stability to agency funding that may serve to reassure potential vendors.<sup>32</sup> According to VISN officials, vendors can be hard to find in

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<sup>32</sup>We previously reported that agencies have delayed executing contracts while under a CR, which could increase costs. See GAO, *Budget Issues: Continuing Resolutions and Other Budget Uncertainties Present Management Challenges*, [GAO-18-368T](#) (Washington, D.C.: Feb. 6, 2018).

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remote and rural areas, and their perception of funding certainty can play a role in encouraging their participation as government contractors. As contracting with the federal government can be burdensome, particularly for smaller vendors, VISN officials said, any measures—such as advance appropriations—that could enhance the stability of agency contracting could make these vendors more likely to participate in government contracting.

**Administrative burden and costs.** IHS officials and tribal representatives said the agency and tribes incur additional administrative burden and costs when the government is funded through multiple CRs, due to the high proportion of IHS funding that is transferred to tribes through contracts and compacts.<sup>33</sup> Specifically, IHS officials said there is an additional administrative burden generated by each CR that results in the distribution of funds to tribes.<sup>34</sup> For each CR period, IHS headquarters staff generate proportional funding allotments, which they provide to individual area offices, which then also conduct processing activities to generate payments from these allotments to the tribes in their areas.<sup>35</sup> As part of this process, IHS officials said they modify hundreds of tribal contracts and make amendments to funding agreements associated with tribal compacts, and those efforts represent a significant administrative burden for IHS staff. Tribal representatives also described administrative burden associated with CRs. As one representative of a group representing several tribes told us, each CR requires the same processing and manpower for each partial payment as for a full apportionment, and moreover, CRs require tracking and reconciliation that is not necessary for a single, full apportionment. IHS officials and tribal representatives noted that time and money spent on these

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<sup>33</sup>We previously reported that agency officials said that managing within the constraints of a CR had created additional work, which potentially reduced productivity. In particular, shorter and more numerous CRs can lead to more repetitive work, including entering into shorter-term contracts or grants multiple times to reflect the duration of the CR. See [GAO-18-386T](#).

<sup>34</sup>Contracting tribes receive payments from IHS on a mutually-determined schedule that may vary (e.g., lump sum annual payment, quarterly payments, etc.), and compacting tribes generally receive annual lump sum payments. If tribal payments are due during a CR, then IHS makes payments in proportion to the term of the CR.

<sup>35</sup>IHS officials told us that it is not administratively feasible to distribute funds through the same process when Congress passes very short-term CRs (such as those lasting for a period of only 1 to 3 days). In such instances, IHS would generally not distribute the funds for such a brief period, but instead combine them with the next apportionment, assuming the next apportionment is for a longer CR or a full budget.

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additional administrative activities detract from other priorities, including patient care.

IHS officials said that advance appropriations would reduce this administrative burden, and added that having advance appropriations would allow for more efficiency in processing payments to tribes. IHS officials suggested that the agency would have to do less administrative work overall, because currently, under a single year appropriation (with recurrent CRs), they may modify or amend agreements 7 or 8 times within a fiscal year. Although acknowledging that advance appropriation authority would entail the additional burden of preparing budget requests for more than one fiscal year, they expect this administrative burden to be less than those under repeated CRs.

**Financial effects on tribes.** According to tribal representatives we spoke with, funding uncertainty from recurring CRs and from government shutdowns has led to particular adverse financial effects on tribes that operate their own health care programs with funding from IHS. For example, according to tribal representatives,

- Funding uncertainty surrounding a CR results in more expensive commercial loans (with higher interest rates) to finance construction of new health care facilities. Specifically, a tribal representative said the uncertainty of the availability of funds due to a CR resulted in a downgrading of the tribe's credit rating, and hence higher interest rates, as it was planning a clinic expansion.
- During a government shutdown, some tribes must redistribute funds from other budget categories to replace health care funding from IHS in order to continue providing health care services. Some tribes have economic development activities that provide additional funding and facilitate this redistribution, but others do not. For example, one tribal organization said that during the 2013 government shutdown, it had to take out loans and maintain a line of credit in order to pay for services and make payroll. Subsequently, that tribal organization had to pay interest on those loans, causing greater financial hardship.
- Tribes attempt to mitigate the challenge of not knowing their final annual payment from IHS under recurrent CRs by keeping extra funds in reserve for emergencies, which limits the remaining funds available for providing health care services.
- Short-term funding under CRs or delayed funding after a lapse in appropriations can limit the ability of tribes and tribal organizations to

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invest funds from IHS and generate interest that can be reinvested in tribal health care programs.

- CRs have affected the ability of tribes to reduce costs by planning for bulk purchases at favorable rates. For example, some tribes in Alaska prefer to make bulk purchases of heating oil during “barge season”—when waterways are still navigable and not frozen. If they do not have enough money for a bulk purchase because of a CR’s limited funding, they must purchase fuel in smaller quantities, which is ultimately significantly more expensive. Tribal representatives told us one beneficial financial effect of advance appropriations for tribes could be providing opportunities for longer term contracts with vendors, which could result in cost savings that could be used for tribal health care programs.

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## Considerations for Policymakers Related to Providing Advance Appropriation Authority to IHS

We identified three types of considerations for policymakers related to providing advanced appropriation authority to IHS—operational, congressional flexibility, and agency capacity and leadership considerations. We identified these considerations based on a review of our 2009 testimony that examined considerations for granting VA advance appropriation authority, in which we identified key questions that would be applicable to any agency being granted such authority, and our interviews with VA, IHS, and other officials.<sup>36</sup> In our 2009 testimony, we noted that proposals to change the availability of the appropriations for VA deserved careful scrutiny, given the challenges the agency faces in formulating its health care budget and the changing nature of health care.<sup>37</sup> Similar consideration would apply to IHS.

**Operational considerations.** If Congress were to grant IHS advance appropriation authority, it would need to make operational decisions regarding what amount of IHS funding would be provided in advance appropriations, with input from OMB and IHS as appropriate. Specifically, Congress could consider the following questions:

- (1) What proportion of IHS’s estimated budget would be provided in the advance appropriation—the full amount, or less (as is the case for

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<sup>36</sup>See GAO, *VA Health Care: Challenges in Budget Formulation and Issues Surrounding the Proposal for Advance Appropriations*, [GAO-09-664T](#) (Washington, D.C.: Apr. 29, 2009).

<sup>37</sup>See [GAO-09-664T](#).

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VA)? Which appropriations accounts would be included? Further, would funds intended for transfer to tribes be handled differently?

(2) Under what conditions, if any, would there be changes to funding provided through advance appropriations during the next budget cycle? For example, would Congress expect to adjust the advance appropriation amount through a “second bite,” as is the case with VA?

**Congressional flexibility considerations.** We reported in 2009 that consideration of any proposal to change the availability of the appropriations VA receives for health care should take into account the impact of any change on congressional flexibility and oversight. These same considerations hold merit regarding potential changes to the appropriation status of any federal agency, including IHS. Specifically, advance appropriation authority reduces flexibility for congressional appropriators, because it reduces what is left for the overall budget for the rest of the government—meaning the total available for appropriations for a budget year is reduced by the amount of advance appropriations for that year, when budgets have caps.

**Agency capacity and leadership considerations.** IHS officials told us they believe the agency’s current budget planning processes would be adequate for estimating advance appropriation budget requests, because IHS begins planning for its budget request 3 years in advance. Officials added that IHS plans its budget so far in advance to have sufficient time to work with tribes in formulating recommendations for its budget request. IHS officials said that a downside to planning so far in advance is that they do not necessarily have the most current information while formulating the budget request. In addition, we noted prior to VA receiving advance appropriation authority that advance appropriation authority could potentially exacerbate existing challenges when developing or managing a budget, generally, due in part to the higher risk of uncertainty when developing estimates that are an additional 12 months out from the actual budget year (e.g., 30 months out instead of 18 months).<sup>38</sup>

We raised certain capacity and leadership concerns based on our previous work when we added IHS to our High-Risk List in 2017.<sup>39</sup> Further, in June 2018, we found that while IHS had taken some actions to

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<sup>38</sup>See [GAO-09-664T](#).

<sup>39</sup>See [GAO-17-317](#). In addition to IHS, we added other federal programs servicing tribes and their members to our High-Risk List, including education and energy programs run by the Department of the Interior.

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partially address these concerns, additional progress was needed to fully address these management weaknesses.<sup>40</sup> For example, IHS still does not have permanent leadership—including a Director of IHS—which is necessary for the agency to demonstrate its commitment to improvement. Additionally, while the agency has made some progress in demonstrating it has the capacity and resources necessary to address the program risks we identified in our reports, there are still vacancies in several key positions, including in the Office of Finance and Accounting. While not directly related to consideration of advance appropriations, IHS’s high-risk designation and continuing challenges in mitigating the deficiencies in its program point to questions about the agency’s capacity to implement such a change to its budget formulation process.

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## Agency Comments and Third-Party Views

We provided a draft of this report to HHS and VA for review and comment. HHS did not have any comments. We received general comments from VA that are reprinted in appendix I.

We also provided relevant draft portions of this report to NIHB, which represents tribal and AI/AN interests. NIHB provided technical comments, which we incorporated as appropriate.

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We are sending copies of this report to the Secretaries of the Department of Health and Human Services and the Department of Veterans Affairs, 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 about this report, please contact me at (202) 512-7114 or [farbj@gao.gov](mailto:farbj@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page

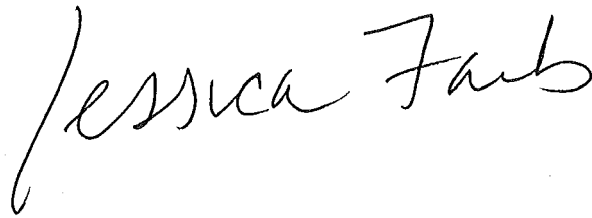
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<sup>40</sup>See GAO, *High Risk: Agencies Need to Continue Efforts to Address Management Weaknesses of Federal Programs Serving Indian Tribes*, [GAO-18-616T](#) (Washington, D.C.: June 13, 2018).



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of this report. GAO staff who made key contributions to this report are listed in appendix II.

A handwritten signature in black ink that reads "Jessica Farb". The signature is written in a cursive, flowing style.

Jessica Farb  
Director, Health Care

# Appendix I: Comments from the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS  
WASHINGTON

August 24, 2018

Ms. Jessica L. Farb  
Director  
Health Care  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Farb:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**INDIAN HEALTH SERVICE: Considerations Related to Providing Advance Appropriation Authority**" (GAO-18-652).

The enclosure provides our general comments. VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in cursive script that reads "Robert L. Wilkie".

Robert L. Wilkie

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to  
Government Accountability Office (GAO) Draft Report  
***“INDIAN HEALTH SERVICE: Considerations Related to Providing  
Advance Appropriation Authority”***  
(GAO-18-652)

**General Comments:**

The Veterans Health Administration (VHA) Office of Rural Health is responsible for administering the Veterans Affairs/Indian Health Service (IHS) Memorandum of Understanding (MOU), December 2010.

Under this MOU:

- VHA has concluded a VHA/IHS reimbursement agreement under which VHA reimburses IHS and tribal organizations for Native American Veteran health care;
- VHA and IHS created another agreement under which IHS and tribal health programs now use VHA mail order pharmacy to order medications for Native American Veterans who receive care in IHS and tribal facilities;
- VHA and IHS have initiated cultural awareness programs, telehealth connections, and educational content for continuing education credit for IHS and VHA providers.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

Jessica Farb, (202) 512-7114 or [farbj@gao.gov](mailto:farbj@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Kathleen M. King (Director), Karen Doran (Assistant Director), Julie T. Stewart (Analyst-in-Charge), Kristen J. Anderson, and Leonard S. Brown made key contributions to this report. Also contributing were Sam Amrhein, George Bogart, Christine Davis, and Vikki Porter.

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