DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

JAN 31 2014

Ms. Carolyn Lerner
The Special Counsel
U.S. Office of Special Counsel
1730 M Street, N.W., Suite 300
Washington, DC 20036-4505

Dear Ms. Lerner:

I am responding to your November 8, 2013, letter to Department of Health and Human Services (HHS) Secretary, Kathleen Sebelius, disclosing a whistleblower's allegation that Contract Health Service (CHS) funds are expended improperly by the Indian Health Service (IHS) Portland Area CHS program.

The Secretary of HHS has delegated me the authority to sign this report and to take actions necessary under 5 U.S.C. § 1213(d)(5). Enclosed you will find a report of the investigation. As set forth in the report, HHS has identified no violation of federal law. HHS has concluded, however, that IHS policy does not specifically authorize Area Offices and Service Units to use contract medical care funds to purchase drugs through the Department of Veteran's Affairs Pharmaceutical Prime Vendor Program.

I respectfully submit the enclosed report of findings for OSC File Number DI-13-3495. Please contact me at (301) 443-1083 if you have questions.

Sincerely,

Yvette Roubideaux

Yvette Roubideaux, M.D., M.P.H.
Acting Director

Enclosure

U.S. Office of Special Counsel (OSC)

OSC File No. DI-13-3495

U.S. Department of Health and Human Services
Office of the Secretary

Indian Health Service (IHS)

Submitted by: Yvette Roubideaux, M.D., M.P.H., Acting Director, IHS

Yvette Roubideaux

Report of Findings

Re: OSC File No. DI-13-3495

The U.S. Office of Special Counsel received a whistleblower's allegation that Contract Health Service (CHS) funds are expended improperly by the Indian Health Service (IHS) Portland Area CHS program. As set forth below, HHS has identified no violation of Federal law. HHS has concluded, however, that IHS policy does not specifically authorize Area Offices and Service Units to use contract medical care funds to purchase drugs through the Department of Veterans Affairs (VA) Pharmaceutical Prime Vendor Program (VA PPV).

Allegations

Two specific allegations are made: 1) that the Portland Area uses CHS funds to pay Federal salaries; and 2) that the Portland Area uses CHS funds to procure medical and pharmaceutical supplies through the VA PPV. It is asserted that these uses of CHS funding violate both agency policy and the "purpose statute" (31 U.S.C. 1301(a)) which prohibits Federal officials from using appropriated funds for purposes other than those for which the funds were appropriated.

Legal and Policy Background

In order to respond to these allegations fully, it is necessary to set forth the legal and policy framework under which IHS obtains contract medical care. The principal authority for the health services provided by IHS, including purchased medical care, is the Snyder Act, which authorizes IHS to "expend such moneys as Congress may from time to time appropriate" for the "conservation of health" of Indians. *See* 25 U.S.C. § 13 (providing that the Bureau of Indian Affairs (BIA) will expend funds as appropriated for, among other things, the "conservation of health" of Indians); 42 U.S.C. § 2001(a) (transferring the responsibility for Indian health care from BIA to IHS). Under this authority, the IHS and tribes typically pay for medical care provided to IHS beneficiaries by public or private providers under CHS. Payment may be authorized under the CHS program for emergency and non-emergency care. For non-emergency care, an advance referral from the program is usually required and, for emergency care, timely notification is required. Payment for CHS covered services is subject to the availability of funding and the exhaustion of alternative resources.

Prior to 1976, eligibility for CHS, including residency requirements, was informally established by IHS Area Offices. As a result, the configuration of such areas and the eligibility for contract care were neither uniform nor consistent. This lack of uniformity was noted by the court in *Lewis v. Weinberger*, 415 F. Supp. 652, 661(D N.M. 1976), when it determined that IHS CHS policies had "no effect for lack of publication in the Federal Register and for lack of issuance in accord with A.P.A. rulemaking procedures." In 1978, in response to the ruling, IHS promulgated rules for the establishment of "contract health service delivery areas, and of eligibility and related requirements for the provision of contract health services within such areas." 41 Fed. Reg. 46792 (October 22, 1976).

Despite the establishment of eligibility regulations for CHS, IHS has never limited the use of funds requested and allocated for contract medical care to individuals eligible under IHS CHS eligibility rules. Nor has it limited the use of such funds to obtain services and supplies outside of IHS facilities. In annual budget justifications to Congress, IHS has described the use of such funds more broadly:

> The CHS program includes the purchase of hospital care including physician and ancillary services, ambulatory activities including outpatient physician care, laboratory, dental, radiology, and pharmacy services. Ambulance and limited patient and escort travel services are also provided. *Other costs support the delivery of direct care, such as medical referrals, diagnostic services, and required special consultants that serve to enhance the care of patients in existing IHS hospitals.*

See, e.g. Indian Health, Justification of Appropriation Estimates for Committee on Appropriations, Fiscal Year 1992 at 133 (emphasis added).

Historically, Congress has appropriated funding for contract medical care as part of IHS' health services appropriation. Although it has long been an identified category in IHS' budget justification, Congress generally did not identify the contract medical care allocation as a line item in the appropriation. For the fiscal year (FY) 1992 appropriation and thereafter, however, Congress has identified an allocation for contract medical care, typically making such funds available for a longer period than the remainder of the services appropriation. *See, e.g. Department of the Interior and Related Agencies Appropriations Act, 1991,* Pub. L. No. 102-154 ("That $301,311,000 for contract medical care shall remain available for expenditure until September 30, 1993"). More recently, funds appropriated for contract medical care remain available until expended. *See, e.g, Interior Department and Further Continuing Appropriations 2010,* Pub. L. No. 111-88.

Congress may use earmarks like it did for contract medical care to vary the period of availability for a portion of a lump sum appropriation. The statutory language that is commonly used for an availability earmark sets forth an amount that "shall remain available" for an extended period of time. In an opinion involving the National Forest Service (NFS), the Comptroller General (CG) analyzed language in the NFS' lump sum FY 1987 appropriation that states "$1,158,294,000, of which $263,323,000 for reforestation and timber stand improvement, cooperative law enforcement, firefighting, and maintenance of forest development roads and trails shall remain available for obligation until September 30, 1988." The CG concluded that the "shall remain available for obligation until September 30, 1988" establishes a limit only on the amount of funds available for two, rather than one, fiscal year and does not set a maximum on the amount of funds available out of the lump sum for the stated purpose. Accordingly, both unrestricted annual year lump sum funds as well as the specified amount of two year funds could be used for the stated purpose. Matter of: Forest Service-Appropriations for Fighting Forest Fires, Comp. Gen., B-231711 (1989).

Although the line item for "contract medical care" has been understood by IHS to refer to the funding for the CHS program, it has never been viewed by IHS as limiting such funds for CHS

expenditures. Indeed, even after the addition of the line item, IHS continued to submit justifications to Congress that reflected that IHS would expend such funds through contracts that support direct care. *See, e.g., Indian Health, Justification of Appropriation Estimates for Committee on Appropriations, Fiscal Year 1993,* at 71. Although the contract medical care line item is available to fund contracts for medical care, in accordance with B-231711, it is not the only funding available for contract expenditures.

IHS policy continues to recognize that IHS may use funds appropriated for contract medical care to support direct care. IHS refers to this practice as Contract Health Services to Support Direct Care and defines these activities as "medical services provided in an IHS facility when the patient is under direct supervision of an IHS physician or a contract physician practicing under the auspices (or authority) of an IHS facility." Indian Health Manual, Part 2, Ch. 3 Contract Health Services. According to the Indian Health Manual:

> Contract Health Service funds may be expended for services to support individuals receiving direct care in an IHS or Tribal facility to the extent that the individual is eligible for direct services. However, hospital and clinic funds shall be used to support direct care whenever possible. Payment for services contracted to support direct care (e.g., prenatal, podiatry, or orthopedic care) provided within the facility are permitted when patients are under the direct supervision of an IHS or Tribal physician or a contract physician practicing under the auspices of IHS or Tribal facility medical staff rules or regulations. Most services in a non-IHS or non-tribally operated facility are not included unless the patient meets CHS eligibility criteria of Title 42 CFR §136.23, "Persons to whom Contract Health Services will be provided."

As noted in your letter of November 8, IHS has also issued further guidance on the permissible use of Contract Health Services to Support Direct Care. *See* IHS Deputy Director's memorandum of February 23, 1993, "Use of Contract Health Services Funds for Direct Services;" and IHS Acting Director's memorandum of February 2, 1994, "Use of Contract Health Services Funds for Direct Care Services".

Although IHS has authorized certain types of non-CHS contract expenditures through guidance documents and the Indian Health Manual mentioned above, there is no relevant legal distinction between such expenditures and other non-CHS contract expenditures in the context of the "contract medical care" line item. IHS guidance, circulars and staff manuals are not substantive rules having the force of law. The Indian Health Manual and the guidance documents issued in the 1990's are essentially instructions to IHS staff. They serve to clarify the type of medical care that may be purchased by contract, and who may be served by those contracts. Thus, compliance with such polices is not determinative with respect to whether a violation of Federal law has occurred.

Findings with Respect to Allegations

The allegation that the Portland Area uses CHS funds to pay the Federal salaries of individuals providing services at the Omak Clinic in Omak, WA is factually incorrect. The Portland Area

does not use CHS funds to pay the salaries of Federal employees. Omak Clinic staff include both Federal employees, whose salaries and benefits are paid for out of Hospitals & Clinics (H&C) funds and Medicaid revenues, and health professionals working under personal services contracts (PSCs), including a physician, dentist, and nurse. Regardless of the source of funding, IHS is specifically authorized to employ personal services contractors through PSCs under 25 U.S.C. § 1638c. Funds appropriated for contract medical care are used to pay contract health professionals working under PSCs. Such funds are not used to pay the salaries of Federal employees.

Under existing IHS guidance, including the February 2, 1994, memorandum, the use of contract medical care funds allocated for CHS to procure physician provider services and non-physician medical care in support of direct care is permitted without regard to whether services are provided on a full time equivalent basis. Additionally, such expenditures are for contract medical care, and accordingly, the expenditures are consistent with the purpose for which HHS requests and Congress appropriates such funds.

According to your letter, the whistleblower alleges "...that the IHS clinic in Omak, Washington (Omak Clinic), part of the Colville Service Unit, was created around 2006 using entirely CHS funds." This is factually incorrect. No funds appropriated for contract medical care were used to fund these activities. The Confederated Tribes of the Colville Reservation (Tribe) financed and managed the construction of the existing Omak Clinic in 2003 due to lack of a Federal facility for this underserved community. In July 2003, to provide dental and pharmacy services, IHS began leasing 2,300 square feet of the building from the Tribe. In October 2010, under a re-negotiated lease, IHS increased its leased space to 4,905 square feet and began providing primary care services.

As to the allegation regarding the purchase of pharmaceuticals, the IHS Portland Area Office has confirmed that it uses CHS funds to procure medical and pharmaceutical supplies through the VA PPV. According to the IHS Portland Area Office, the CHS funds that are used to procure pharmaceutical supplies through the VA PPV for the Omak Clinic would otherwise be expended by individual CHS-eligible patients having their prescriptions filled elsewhere. IHS policy does not specifically authorize the purchase of PPV drugs using funds appropriated for contract medical care. Under current IHS policy, Service Units "may establish contracts with community pharmacies to provide pharmaceutical care for eligible patients." See Indian Health Manual Part 3 Ch. 7 -Pharmacy. Community pharmacy contracts are permitted where no direct services are available from the IHS, but Service Units are otherwise directed to minimize such practices, as they are not as cost-effective.

Contracting with a community pharmacy is usually not cost-effective because IHS is generally able to obtain discounted pharmaceuticals through other contract channels. Federal agencies, including IHS, use Federal Supply Schedules (FSS) to access commercial supplies and services at volume discount pricing. The General Services Administration (GSA) has authorized the VA to award and manage FSS contracts with pharmaceutical companies, which allows Federal agencies to obtain pharmaceuticals at prices associated with volume buying. Essentially, VA is directed to obtain prices that are equal to or better than the lowest price the manufacturers charge their favored non-federal customers under comparable terms and conditions.

In addition to negotiated FSS pricing, section 603 of the Veterans Health Care Act of 1992 (VHCA) established federal ceiling prices (FCPs) for pharmaceuticals procured by the four designated agencies covered in the Act: VA, Department of Defense (DoD), Coast Guard, and the Public Health Service/IHS. *See* 38 U.S.C. 8126(b). All drug manufacturers participating in Medicaid must agree to FCP pricing, and to list those drugs on the FSS. FCP pricing is often lower than the FSS price negotiated by VA for the same drug, allowing the four specified agencies to realize greater savings.

Finally, VA has entered into a PPV arrangement through which it is able to obtain pharmaceuticals at prices lower than the applicable FSS or FCP rate. IHS is able to participate in the PPV arrangement by virtue of being included as an eligible entity in the contract between VA and the prime vendor contractor. VA often also uses competitive bids both regionally and nationally to obtain even lower prices from pharmaceutical manufacturers. IHS pharmacies access the VA PPV through the PPV national contract and interagency agreement with VA. The advantage in using the PPV contract as opposed to other contractual mechanisms, including community care pharmacies, is that the PPV offers access to high-quality pharmaceuticals with next day delivery, thereby increasing efficiency while decreasing overhead expenses and avoiding many of the costs associated with other acquisition and distribution systems.

Although pharmacy purchases from the VA PPV are usually funded through non-CHS sources of funding, such expenditures are contract acquisitions, and therefore may be viewed as expenditures for contract medical care consistent with the appropriation of funds by Congress for contract medical care. Accordingly, while it appears that the Service Unit did not expend its funds in accordance with established agency policy, no violation of the purpose statute has been committed.

Conclusion

While the Department has found no violation of law, the allegations received by your office do suggest that IHS practice governing the use and expenditure of funds appropriated for contract medical care is neither uniform nor entirely consistent with agency policy and guidance. Based on the Department's findings in this matter, the IHS will evaluate whether it must update or clarify permissible uses of funds appropriated for contract medical care This evaluation will include the need for Agency-wide training on any policy updates or clarification.

1) Summary of the Information Disclosed by the Whistleblower
   The whistleblower alleges that CHS funds are expended improperly by the IHS Portland Area program. Two specific allegations are made: 1) that Portland Area uses CHS funds to pay Federal salaries; and 2) that Portland Area uses CHS funds to procure medical and pharmaceutical supplies through the VA PPV. It is asserted that these uses of CHS funding violate both agency policy and the "purpose statute" (31 U.S.C. 1301(a)) which prohibits Federal officials from using appropriated funds for purposes other than those for which the funds were appropriated.

2) Description of the Conduct of the Investigation

Meeting periodically over a period of several days, select staff reviewed and discussed Portland Area CHS expenditures; CHS regulatory and policy documents; and the genesis and development of Indian healthcare services at Omak, WA. Data on Area CHS expenditures were extracted from the Agency's Resource and Patient Management System (RPMS) records. Among the regulatory and policy documents reviewed were 42 C.F.R. § 36.21 et seq.; IHS Circular No. 91-07, Contract Health Service Fund Control;" the IHS Deputy Director's memorandum of February 23, 1993, "Use of Contract Health Services Funds for Direct Services;" the IHS Acting Director's memorandum of February 2, 1994, "Use of Contract Health Services Funds for Direct Care Services;" Portland Area IHS Circular No. 95-03, Use of Contract Health Service Funds; and the Indian Health Manual Part 2, Chapter 3, "Contract Health Services." Records of personal services contracts identifying the Omak Clinic as the location of the delivery of services were retrieved. Records in the Area's Division of Health Facilities Construction helped illustrate the evolution of healthcare services for the Omak, WA American Indian/Alaska Native (AI/AN) community.

3) Summary of Evidence Obtained from the Investigation

The evidence consists of the data, records, and other documents that were collected and reviewed by the staff assembled to investigate the disclosures: Data and records on Area CHS expenditures pulled from RPMS; Federal regulatory and Agency and Area policy documents; records of personal services contracts; Health Facilities Construction records.

4) List of Violations or Apparent Violations of Law, Rule, or Regulation

None

5) Description of Action(s) Taken or Planned

A. Changes in Agency Rules, Regulations, or Practices

The IHS will evaluate whether it must update or clarify permissible uses of funds appropriated for contract medical care.

B. Restoration of Aggrieved Employee
NA

C. Disciplinary Action(s) Against Employee(s)
None

D. Referral to the Attorney General of Evidence of Criminal Violation
None

Yvette Roubideaux

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Acting Director
Indian Health Service

Addendum to OSC File No. DI-13-3495

The Indian Health Service (IHS) will evaluate whether it must update or clarify permissible uses of funds appropriated for contract medical care. A supplemental report will be developed by the end of this calendar year that will include the outcomes of this evaluation and a timeframe to make recommended changes.

The IHS is currently updating and revising Agency policy on the use of contract health funds in support of direct care. Upon completion of revisions to the *Indian Health Manual* (IHM) at Chapter 2, Section 3, Contract Health Services (CHS), this guidance will be provided to staff.