



Department of Homeland Security Office of Inspector General

The U.S. Immigration and Customs Enforcement Process for Authorizing Medical Care for Immigration Detainees





Homeland
Security

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Preface

The Department of Homeland Security (DHS) Office of Inspector General (OIG) was established by the *Homeland Security Act of 2002* (Public Law 107-296) by amendment to the *Inspector General Act of 1978*. This is one of a series of audit, inspection, and special reports prepared as part of our oversight responsibilities to promote economy, efficiency, and effectiveness within the department.

This report addresses the strengths and weaknesses of the Treatment Authorization Request process that U.S. Immigration and Customs Enforcement uses to arrange and pay for the medical care of immigration detainees. We based the report on interviews with employees and officials of relevant agencies and institutions, direct observations, and a review of applicable documents.

The recommendations herein have been developed to the best knowledge available to our office, and have been discussed in draft with those responsible for implementation. We trust this report will result in more effective, efficient, and economical operations. We express our appreciation to all of those who contributed to the preparation of this report.

A handwritten signature in cursive script that reads "Richard L. Skinner".

Richard L. Skinner
Inspector General

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Abbreviations

DIHS	Division of Immigration Health Services
DRO	Office of Detention and Removal Operations
FSC	Financial Services Center
ICE	Immigration and Customs Enforcement
MCC	Managed Care Coordinator
OIG	Office of Inspector General
OPLA	Office of Principal Legal Advisor
TAR	Treatment Authorization Request

OIG

*Department of Homeland Security
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Executive Summary

United States Immigration and Customs Enforcement must provide or arrange for the medical care of immigration detainees. For nonemergency care, facilities are required to submit a Treatment Authorization Request when detainees need health services. Managed care coordinators evaluate these requests based on existing coverage policy. We evaluated the effectiveness of the process used to authorize care for immigration detainees.

The managed care coordinators expressed concern regarding insufficient staffing to meet the workload. From October 2006 through March 2009, Immigration and Customs Enforcement received more than 110,000 requests for offsite medical care. We identified a variety of limitations that hinder the processing of requests, such as administrative burdens and incomplete submissions.

We determined that the existing medical treatment request process can be improved through a reduction in the amount of pre-authorization review, expansion of case management functions, and improvement in relationships with outside medical providers who deliver care to immigration detainees. We are making 10 recommendations to improve the process for authorizing medical care for immigration detainees.

Background

ICE Required to Provide Health Care

U.S. Immigration and Customs Enforcement (ICE) is responsible for protecting national security by enforcing customs and immigration laws. The *Immigration and Nationality Act* authorizes ICE to arrest, detain, and remove certain aliens.¹ ICE detains more than 32,000 aliens on an average day. Within ICE, the Office of Detention and Removal Operations (DRO) ensures safe and humane conditions of confinement. This includes an obligation to provide adequate health care for detainees.

Although the government must act with deliberate indifference to the serious medical needs of a detainee in order for any defect in the provision of medical care to rise to the level of a constitutional violation,² ICE's Office of the Principal Legal Advisor (OPLA), attempts to ensure that detention facilities exceed constitutional standards when providing medical care. Further, although defects in care resulting from either medical malpractice or negligent conduct do not necessarily meet the "deliberate indifference" standard for a constitutional violation, such conduct could potentially give rise to liability under the *Federal Tort Claims Act*, which allows the government to be sued "under circumstances where the United States, if a private person, would be liable to the claimant."³

The Division of Immigration Health Services (DIHS) is the ICE medical authority. In an October 2007 agreement between ICE and the Department of Health and Human Services, DIHS clinicians were detailed to ICE. They provide care at ICE-owned Service Processing Centers and Contract Detention Facilities that private organizations manage. County facilities that detain immigrants may use DIHS personnel, but usually provide onsite care to detainees through contracted medical providers or county health department staff.

The health program for ICE detainees employs a managed care model. As part of this model, DIHS adopted a Covered Services Package to outline general medical coverage policies.⁴ The package was implemented in 2005, before DIHS became a part of ICE. OPLA believes that the Covered Services Package allows sufficient discretion for providers and physicians to obtain medically necessary treatment, even for services not

¹ 8 USC § 1226, 1227, 1229, and 1357.

² *Despaigne v. Crolew*, 89 F.Supp.2d 582, 585-6 (E.D. Pa. 2000).

³ 28 U.S.C. § 1346(b)

⁴ <http://www.icehealth.org/ManagedCare/Combined%20Benefit%20Package%202005.doc>.

specifically covered. Some cases of delayed authorization have occurred, prompting interest groups to allege that ICE has difficulty providing necessary care to immigration detainees.

The Process of Providing Health Care to Immigration Detainees

Although the ICE detainee population differs from enrollees in commercial managed care organizations, DIHS management views the managed care model as necessary for immigration detainees. ICE detainees generally have poor health status; many have not had access to regular care for years, if ever.⁵ A managed care approach allows for some level of case management that can track an individual's care, ensure proper follow-up, and improve overall health status.

The medical clinics that are part of immigration detention facilities can provide different kinds of care to detainees. Onsite medical personnel conduct a detainee's intake medical exam and the physical exam that is required within 14 days of a detainee's arrival at the detention facility.

Pursuant to ICE detention standards, facilities must provide detainees an "unrestricted opportunity to freely request health services."⁶ This ongoing period for detainees to request care is referred to as sick call. A detainee may request health care that onsite clinicians can provide without further review from DIHS headquarters in Washington, D.C. However, when the sick call process identifies a need for care that exceeds the capability of the onsite clinic, the facility submits a Treatment Authorization Request (TAR) via an online system called TARWeb. The system is used to authorize payment for detainees' offsite medical care.

TARs serve two important purposes: They limit nonemergency offsite medical treatment to that within the Covered Services Package, and they guarantee eventual payment to the offsite medical service provider. Emergency care does not require prior authorization. In emergencies, the TAR is submitted as soon as possible after treatment, to facilitate subsequent payment to the health care provider.

Managed care coordinators (MCCs), nurses assigned to DIHS headquarters, review TARs to ensure that the requested care is within the scope of the Covered Services Package. When a TAR submission is incomplete, the MCC will deny it. However, the detention facility can amend and resubmit the request. When the TAR is complete and appears

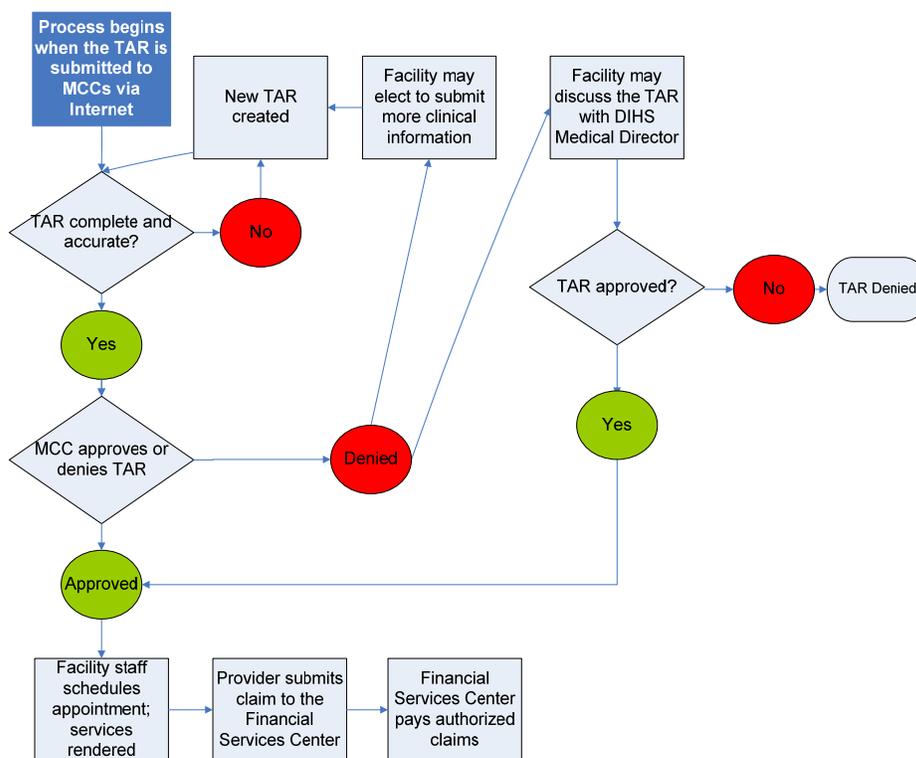
⁵ ICE testimony from Congressional hearing on "Medical Care and Treatment of Immigration Detainees and Deaths in DRO Custody," March 3, 2009.

⁶ *ICE/DRO Detention Standard: Medical Care*, page 16.
http://www.ice.gov/doclib/PBNDS/pdf/medical_care.pdf.

to be within the Covered Services Package, an MCC will approve the request. When the TAR is complete, but the requested treatment appears to be outside the Covered Services Package, the MCC will deny the request. When this happens, the facility can resubmit the request with more medical justification, or discuss the request with the DIHS Medical Director; in either case, the TAR might then be approved.

After care is approved, facilities schedule medical appointments, generally with doctors or hospitals in surrounding communities. Figure 1 illustrates the TAR process.

Figure 1. The Treatment Authorization Request Process for Nonemergency Care



Source: Office of Inspector General, derived from multiple sources.

MCCs are critical to the interaction between ICE and offsite medical providers. MCCs can lessen problems that facilities and health care providers encounter, such as difficulty locating an appropriate specialist, difficulty obtaining a timely appointment, or slow payment of a claim.

Results of Review

Our review focused on the process to authorize offsite medical treatment, rather than an evaluation of the treatment provided. Since more than 97% of TARs are

currently approved, the TAR process should be changed to decrease the amount of pre-service review. In addition, the role of the MCC should be changed to ensure more case management for detainees and more support to detention facilities. ICE also must ensure that its medical claims processor receives needed funding more rapidly. This will decrease the amount of interest paid to providers for overdue medical claims and improve the relationships between ICE and the medical professionals who provide care to immigration detainees.

Strategic Redirection of the Authorization Process Is Needed

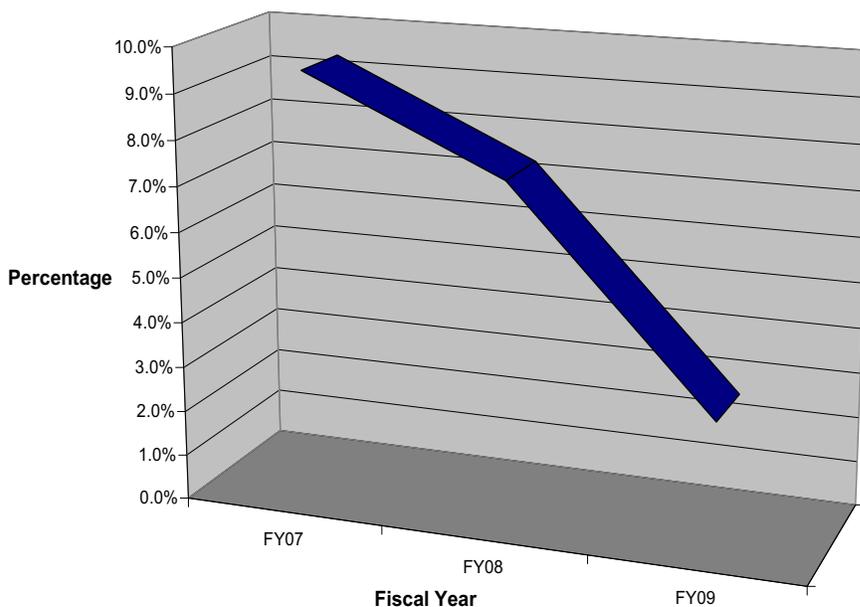
The Current Process Is Inefficient

The current TAR process places a great deal of pressure on the MCCs, for limited gain. Based on data for the 30 months from October 2006 through March 2009, detention facilities and Border Patrol stations submitted 110,538 TARs. This was an average of 850 TARs per week. Few of these requests were denied. Initially, MCCs denied only 8,106 (7.3%) of these TARs, but even this low rate significantly overstates the frequency of care denial.

Denied TARs frequently lacked information needed for processing, even though the requests for care were legitimate. ICE data demonstrated that thousands of TARs were denied initially because the facility did not include the detainee's Alien Number. MCCs said that facilities would resubmit denied TARs that did not include an Alien Number or other necessary information, such as greater detail about the detainee's medical needs. After the facilities provide additional information, the MCC often grants approval. Thus, at many facilities actual denials of care are very uncommon. No facility staff we interviewed expressed concern that the TAR process was denying medically necessary care.

The percentage of denied TARs has declined, as illustrated in figure 2.

Figure 2. Rate of TAR Denials, October 2006–March 2009



Source: DIHS.

In FY 2007, 4,584 TARs were denied, an average of 382 per month. In contrast, in the first half of FY 2009, only 589 were denied, fewer than 100 per month. We believe that the decrease is in part attributable to the training Border Patrol employees received in October 2008, which exposed them to the correct procedure for submitting TARs. This helped the Border Patrol reduce TAR denials. Additionally, facilities noted that MCCs no longer review TARs that a physician at the detention center has authorized.

Nonetheless, MCCs and facility staff offered examples of how the TAR process is burdensome. Some ambulance companies have expressed problems with payment because transportation often is not authorized before the services are rendered. This delays payment for legitimate services provided to support care that had already been approved through the TAR process. Also, additional TARs are required for follow-up care to complete a course of treatment that an MCC has authorized.

Decreasing the number of TAR denials can help detention facilities and the MCCs. Some facility clinicians told us that the TAR process creates difficulties, especially when additional clinical information is deemed necessary before care can be authorized.

ICE has made an effort to decrease the administrative workload that the TAR process creates. Automatic approval of some TARs, for example, has lessened the work required for services that were not previously denied. Facility staff praised the decision to automatically approve TARs for chest x-rays to test for tuberculosis. Staff noted that such approvals decrease staff burden, especially when large numbers of detainees arrive at a facility on the same day. MCCs and some facility staff recommended that basic lab services also receive automatic approval.

Such a change is sensible. However, a more extensive shift in the TAR process is warranted. Because of the low level of TAR denials that actually lead to cost savings through rejection of payment for non-covered medical care, ICE should change the TAR process so that pre-authorization is required only for the most costly services. This could be accomplished through automatic approval of most services or elimination of the TAR submission for most services. A dramatic reduction in the pre-authorization burden would save resources currently used to deny a very small number of requests.

In 1999, United HealthCare, the Nation's second largest managed care company, ended pre-authorization for its managed care enrollees. The company, which served 14.5 million enrollees in 1999, determined that the pre-authorization process cost \$128 million to administer while denying less than 1% of requested care. Post care utilization reviews are conducted to ensure that providers are not delivering uncovered services and to track which providers are using an inordinate level of care.⁷ As previously stated, there are significant differences between the health care needs of enrollees in a commercial managed care company and immigration detainees, but this example and other studies demonstrate that pre-authorization can be an unnecessary burden on a managed care program.⁸

Managed care organizations that have elected to change pre-authorization policies can still use the practice in limited cases. Some companies maintain a pre-authorization requirement based on the frequency of service. Other companies maintain the

⁷ "Managed Retreat," *The Economist*, November 13, 1999; "How One Big HMO Capitulated," *Time*, November 22, 1999.

⁸ "Prior Authorization of Newer Insomnia Medications in Managed Care: Is It Cost Saving?" *J Clin Sleep Med*. 2007 June 15; 3(4): 393-398

requirement for the most costly services, such as inpatient hospital admissions.⁹

A challenge to the successful transition from the current TAR process is the wording of the Covered Services Package, which establishes coverage policy for detainee medical care. More precise coverage guidance would be necessary if care pre-authorizations were decreased or eliminated. An MCC informed us that a system with little or no pre-authorization must have more specific coverage guidance to prevent “creative” facilities or providers from arranging for or providing care that is not within the scope of coverage.

The Covered Services Package resembles the documents that managed care companies use to inform enrollees of their coverage options. For example, the document is organized around different types of health services, such as cardiology, general surgery, and hearing services. However, current coverage guidance is somewhat contradictory. For general surgery, for example, DIHS has established that “Scheduled, non-emergency surgical services are not a covered benefit. Requests will be reviewed on a case by case basis.” Similar guidance appears for various other services.

DIHS staff we interviewed said that the current Covered Services Package, finalized in 2005, is outdated. Revisions to the document should account for changes in technology and accepted medical practice.

We recommend that the Assistant Secretary, U.S. Immigration and Customs Enforcement:

Recommendation #1: End or greatly reduce the amount of pre-authorization required under the Treatment Authorization Request process.

Recommendation #2: Revise the Covered Services Package to provide more guidance on coverage policy for a process that minimizes pre-authorization of most services.

⁹ “Old Techniques Never Die, Nor Even Fade Away,” *Managed Care*, January 2006; “New Imaging Controls Strict, But May Be Easier On Doctors,” *Managed Care*, November 2007.

Managed Care Coordinators Face a Variety of Challenges

Staffing Limitations Hinder the Coordinator's Efficiency

All MCCs said that the volume of TAR submissions is overwhelming, resulting in a high turnover rate among MCCs. MCC staffing levels have declined dramatically since April 2006, when there were eight MCCs. Since 2006, four MCCs have handled the TAR workload. The decline in the number of MCCs is one reason for the strain on the remaining MCCs. At the conclusion of our fieldwork, we were informed that two of the four remaining MCCs would soon be taking other positions. Plans to replace the two departing MCCs and add two more were in development, but concern existed that the training and transition period for new MCCs would create new short-term burdens for the remaining MCCs.

The coordinators reported that the high number of TAR submissions caused a great deal of stress. If pre-authorization work could be reduced, MCCs could become more involved in care coordination and provider retention. This offers a much greater value to ICE than placing the MCCs in a high-stress environment that approves nearly all TARs—about 850 per week. Even with this pressing workload, most TARs are approved quickly. Between the start of FY 2005 and the end of FY 2008, the maximum average amount of time needed to approve or deny a TAR request was slightly more than 4 days. Facility experts we interviewed said that most approvals take 1 or 2 days.

MCCs expressed frustration with their collateral duty of resolving general system-related issues for TARWeb users. The MCCs are the point of contact for connection or password problems. MCCs, who are registered nurses, not computer systems experts, said that they spend too much time on system-related issues. DIHS officials said that the DIHS systems support office is also understaffed and reluctant to make system changes or process requests for TARWeb access without authorization from management. Individuals other than the MCCs should resolve system-related problems. The MCCs would then be able to focus on their core responsibilities.

We recommend that the Assistant Secretary, U.S. Immigration and Customs Enforcement:

Recommendation #3: Make appropriate policy changes so that managed care coordinators are no longer responsible for facilities' TARWeb system access and password reset issues.

Improvements to TARWeb Would Enhance the Process

Although TARWeb collects a large amount of data, facilities staff noted the system's minimal analytical capabilities. TARWeb does not provide facilities with information such as detailed reports on detainee health care trends. Some detention facilities have created their own internal detainee health care tracking tools. If TARWeb provided data analysis reporting, the facilities would be better able to understand the services provided to detainees. We encourage DIHS to solicit information regarding specific reports to ensure that the reporting function meets facilities staff needs.

Also needed is a method to prioritize TAR submissions. Larger immigration detention facilities can experience a sizeable number of detainee intakes in a single day. Although care for emergency conditions does not require pre-authorization, routine TARs can be of varying severity levels. TARs are reviewed on an as-received basis. TARWeb does not have a method to indicate which requests are more urgent. A prioritization function would decrease the volume of calls MCCs receive for expedited review of particular TARs and create a more efficient workflow.

We recommend that the Assistant Secretary, U.S. Immigration and Customs Enforcement:

Recommendation #4: Develop TARWeb data reporting capabilities that incorporate the suggestions of facilities' staff.

Recommendation #5: Develop a prioritization system in TARWeb for facilities to identify more urgent detainee medical care requests.

Expanded MCC Work in Case Management Is Necessary

The MCCs are overwhelmed with TARs and other duties that diminish their ability to function as case managers. Nonetheless, case management is important for some ICE detainees. For example, cancer patients require detailed case management to understand the ongoing clinical issues of each case. Follow-up care is a vital part of ongoing health maintenance for various medical conditions. The current TAR process allows for case management, but an expansion of the MCC role in the process is necessary.

Case management is an essential component of any managed care system. The Case Management Society of America defines case management as:

A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

An online job description listed case management as a primary function of the MCC position. Through work with detention facilities and medical providers, MCCs collaborate to develop care plans for detainees who have specific health problems, such as cancer or chronic diseases. Case management can benefit ICE as well as detainees, since it can help to identify providers who can provide follow-up health services. Although many detained aliens are in ICE custody for only a few days, those with severe health problems can benefit from case management.

Case management can be time-consuming because of the variables in each detainee's medical history and condition. MCCs noted that additional training on case management is necessary. Currently, MCCs are not required to be certified case managers. One clinician said that, owing to the pressing nature of other MCC duties, "true case management does not happen in some cases." More MCC staff and a reduction in the pre-authorization workload would ensure that the case management principle is fully implemented for ICE detainees.

MCCs described the case management process as a burden in some instances. Additional staffing would help MCCs evaluate detainees' health conditions, develop and implement discharge plans, coordinate medical resources, and monitor detainee progress. MCCs said that they do not have enough time to manage the cases of some detainees. Moreover, a large amount of work can be necessary to coordinate with hospitals and facility staff to understand the ongoing condition of a particular detainee.

Detention facility staff had a variety of opinions on the case management process. In many cases, facilities are not very involved in the process, which frustrates some onsite clinicians. Conversely, one facility staff member concluded that clinical staff at the detention facility is "drowning" in the details of some cases because of interaction with hospitals, discharge planning, and

patient information requests. MCCs can interact daily with hospital and facility staff regarding each detainees' case. More case management will help MCCs support the managed care program and will ensure more consistent involvement in case management across detention facilities. The case management process is important for effective detainee care.

We recommend that the Assistant Secretary, U.S. Immigration and Customs Enforcement:

Recommendation #6: Develop policies that formalize necessary training and an expanded case management role for the managed care coordinators.

Detention Facilities Need Assistance Working With Providers

Maintenance of Outside Provider Relationships Is Difficult

ICE must compete with other health plans and payers for access to outside medical services. This is an inherent difficulty for ICE. Detention facility staff cited cases where health care providers elected not to treat ICE detainees any longer. Some providers, staff believed, felt that their other patients would find it uncomfortable to share a waiting room with someone wearing a prison uniform and in hand and leg restraints. Also, delays in claims payment were a concern of providers. Physicians and hospitals may elect not to treat ICE detainees if several months pass before they receive payment for authorized care. ICE officers we interviewed said that they occasionally receive calls from collection agencies because of unpaid medical bills. One frustrated TAR expert at a facility said, "No one wants to take this insurance."

TAR experts at the facilities we visited provided details on care access concerns. Even facilities in urban areas can have problems finding providers who will care for ICE detainees. These problems are compounded when facilities are located far from concentrations of hospitals or physicians. Ensuring that certain specialists, such as neurologists or psychiatrists, remain interested in seeing ICE detainees is of concern across several facilities. Even when providers are located, some specialist visits require that detainees be transported to urban areas distant from the facility.

Detention facility personnel said that they are actively working to maintain provider networks with hospitals and doctors that treat

detainees. This requires frequent e-mails or conversations about providers' problems, usually related to claims payment. One facility expert, who feels like a "telemarketer" when trying to convince providers to treat detainees, noted that thank-you notes and holiday cards are sent to providers to ensure continued access to certain services. MCCs may sometimes be involved in resolving provider issues. Imminent collapse of provider access does not seem likely across the facilities we visited. However, efforts are needed to ensure more timely and frequent access to authorized care.

Correcting delays in provider payments can also save federal funds. Experts at the Veterans Affairs Financial Services Center (FSC), which processes claims for ICE, said that the FSC requires a revenue flow to make timely payments to providers. However, quarterly payment by ICE to the FSC is sometimes delayed. In those situations, provider payments are not processed within the 30-day period required under the *Prompt Payment Act*. Claims paid after 30 days accrue interest that must be paid to providers. FSC data established that interest payments resulting from delays in the ICE funding transfer amounted to \$110,081 from October 2007 through March 2009, an average of \$6,115 per month. This is a waste of tax dollars, as well as a source of payment delays to providers, which can decrease their desire to treat ICE detainees.

Difficulty finding medical providers increases the amount of time between authorization of a TAR and the provision of needed health services. We asked for any analysis or studies that have tracked the length of time between approval of a TAR and the medical appointment. ICE has not completed such an analysis. Data related to the gap between TAR approval and receipt of health services would identify facilities that are having difficulty arranging for outside detainee care. Such analysis could detect when more effort is needed to establish or maintain provider relationships. Shortages in outside medical providers could be corrected at some facilities through the use of DIHS clinical personnel.

We recommend that the Assistant Secretary, U.S. Immigration and Customs Enforcement:

Recommendation #7: Expand managed care coordinator support to detention facilities to improve maintenance of relationships with outside care providers.

Recommendation #8: Ensure more timely transfer of funds to the Financial Services Center to increase compliance with the *Prompt Payment Act* and to decrease interest paid on authorized medical claims.

More Provider Education Would Enhance the Overall Process

Outside medical providers furnish necessary medical care to immigration detainees. These providers work with a wide range of public and private insurance, but often do not know ICE's coverage rules or how to submit claims properly after an approved TAR denotes that care can be reimbursed. This leads to unnecessary payment denials and frustration among providers. Enhanced efforts to educate providers about the payment process would have a positive effect on ICE's relationships with providers.

For the first 6 months of FY 2009, the FSC denied 38.5% of medical claims submitted for ICE detainees. During our interview with FSC staff, they suggested that ICE create a handout for medical providers that would describe elements of the TAR process and claims payment rules. ICE officers who transport detainees to provider offices may not be able to convey the details of medical coverage policies or information required for payment of claims. A written document presented to hospitals or physicians should improve providers' understanding of the process.

Detention facility and FSC staff said that claims often do not include required information, such as the Alien Number, used to identify detainees. Another important part of a claim that can be missing is the date of service. This is necessary to ensure that the individual was an ICE detainee when services were rendered. We were told that some providers did not submit claims within the deadline established in policy. The additional information should also be available on the DIHS website.

We recommend that the Assistant Secretary, U.S. Immigration and Customs Enforcement:

Recommendation #9: Create provider education materials to ensure better understanding of the ICE detainee health care process and the need for accurate and timely submission of claims.

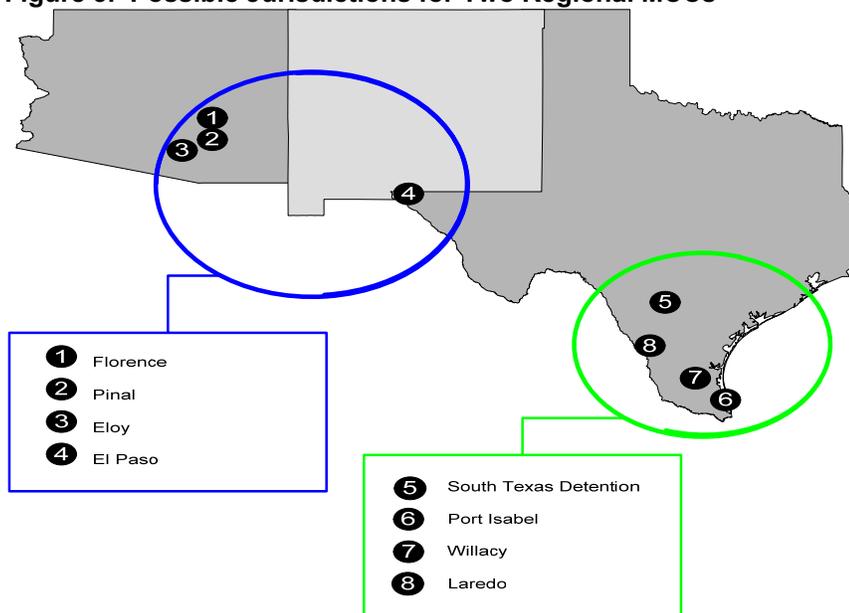
Local or Regional MCCs Would Offer Various Benefits

Currently, MCCs are based at DIHS headquarters. A limited number of local or regional MCCs would provide an important presence to augment detention facilities' staff efforts to work with providers and supplement case management. DIHS clinicians in headquarters and at detention facilities expressed support for the establishment of regional MCC positions. Use of regional MCCs should not eliminate the need for a certain number of MCCs at DIHS headquarters. Having some MCCs in Washington, DC is sensible, especially since meetings with the DIHS Medical Director and ICE detention staff are an important part of an MCC's overall role.

Regional MCCs would be the conduit for local issues between detention facilities and ICE. Provider retention and education efforts would be another obvious role for regional MCCs. Facility staff we interviewed said that recruiting new providers or maintaining existing networks is a vital, but burdensome, aspect of the detainee health care process. Regional MCCs would contribute to facilities' provider relations efforts.

Figure 3 shows two groups of four facilities that combined accounted for 23.4% of TAR submissions in the first 6 months of FY 2009. Regional MCCs based in both areas could function as the primary contact for care authorizations, medical records issues, and claims problems.

Figure 3. Possible Jurisdictions for Two Regional MCCs



Source: OIG, derived from multiple sources.

DIHS field MCCs could also perform Covered Services Package education efforts that would be necessary if ICE shifts to decreased pre-authorization. This additional education would be national in scope, but a regional MCC would offer direct support for it at a small number of nearby facilities. Regional MCCs could also work with ICE officers who receive inquiries about health coverage or medical claims to support resolution of problems and expand outreach to those medical providers.

We recommend that the Assistant Secretary, U.S. Immigration and Customs Enforcement:

Recommendation #10: Implement a regional managed care coordinator staffing plan and develop supplemental policies that describe the roles and responsibilities of these new personnel.

Conclusion

This report focused on the strategic management of the ICE Treatment Authorization Request process. Additional case management and enhancements to the way ICE authorizes and pays for medical services will improve overall detainee health care. A dramatic change to the TAR submission process can support expanded case management and a greater focus on retaining physicians and hospitals in areas near ICE detention facilities. Facility staff and clinicians we interviewed showed a commendable devotion to caring for immigration detainees. With a

reduction in the administrative burden associated with the TAR process, local MCCs, and expanded support to facilities, ICE can better meet its legal responsibilities for detainee health care.

Management Comments and OIG Analysis

ICE concurred with each of our ten recommendations. We evaluated ICE's written comments and have made changes to the report where we deemed appropriate. A summary of the ICE response to our recommendations and our analysis is included below. A copy of the ICE response, in its entirety, is included as Appendix B.

We have closed Recommendation #3 because ICE has taken corrective action. Our remaining nine recommendations are *resolved and open* pending additional information in the ICE corrective action plan due within 90 days of the issuance of this report.

Recommendation #1: End or greatly reduce the amount of pre-authorization required under the Treatment Authorization Request process.

Management Comments to Recommendation #1

ICE informed us that DIHS is implementing revisions that will greatly reduce the need for pre-authorization for necessary care. DIHS will also no longer require a TAR for follow-up visits related to care that was already authorized. Additional analysis will be done to reduce the burden of the care authorization process.

OIG Analysis

This recommendation is *resolved and open* pending further details on the prior authorization process. Additional details on specific changes made will demonstrate that the TAR process is being streamlined effectively.

Recommendation #2: Revise the Covered Services Package to provide more guidance on coverage policy for a process that minimizes pre-authorization of most services.

Management Comments to Recommendation #2

ICE intends to have a draft revision to the CSP prepared soon. This new version of the coverage guidance will include information about the move toward significantly less prior authorization.

OIG Analysis

This recommendation is *resolved and open*. As part of the corrective action process, ICE should provide the OIG a copy of the revised CSP and additional detail on how the CSP will diminish pre-authorization for detainees' medical care.

Recommendation #3: Make appropriate policy changes so that managed care coordinators are no longer responsible for facilities' TARWeb system access and password reset issues.

Management Comments to Recommendation #3

In June 2009, changes were implemented that relieved MCCs of the responsibility for responding to system access and password problems.

OIG Analysis

This recommendation is *closed*. No further action is required.

Recommendation #4: Develop TARWeb data reporting capabilities that incorporate the suggestions of facilities' staff.

Management Comments to Recommendation #4

ICE noted that work is being done to revise TARWeb data fields and integrate staff suggestions. Additional review will take place to determine whether suggested changes are feasible.

OIG Analysis

This recommendation is *resolved and open*. In the corrective action process, ICE should inform us of changes that have been suggested, and actions taken.

Recommendation #5: Develop a prioritization system in TARWeb for facilities to identify more urgent detainee medical care requests.

Management Comments to Recommendation #5

ICE acknowledged that this recommendation would improve the timeliness of authorizing detainee care. DIHS will explore how a prioritization system would work to ensure that MCCs are able to address those non-emergency TARs that are a higher priority.

OIG Analysis

This recommendation is *resolved and open*. We share ICE's view that a prioritization system, even with fewer TARs requiring authorization, can improve timeliness of detainee access to health care. However, ICE's formal response did not provide detail on how and when the system will be changed to accommodate this change.

Recommendation #6: Develop policies that formalize necessary training and an expanded case management role for the managed care coordinators.

Management Comments to Recommendation #6

ICE noted that the MCCs are vital to the managed care program. Management is interested in facilitating necessary training, including a focus on case management, to ensure that MCCs remain informed about new information in their field. DIHS will consider a recurrent training plan to meet the needs of the MCCs.

OIG Analysis

This recommendation is *resolved and open*. The focus of this recommendation is an expanded case management role. Once that is developed, MCCs will require formal case management training. We request ICE provide information about progress in these areas in its Corrective Action Plan.

Recommendation #7: Expand managed care coordinator support to detention facilities to improve maintenance of relationships with outside care providers.

Management Comments to Recommendation #7

DIHS will evaluate expanding the number of managed care coordinators that support this program. Under consideration is providing a minimum of two managed care coordinators for each of the three regions. This would allow for backup should a coordinator be out of the office. It would also allow more support to assist the facilities with case management of some of the more complicated medical patients.

OIG Analysis

This recommendation is *resolved and open*. The ICE Corrective Action Plan should provide us with detail about specific new responsibilities MCCs will be given to nurture and sustain relationships with providers.

Recommendation #8: Ensure more timely transfer of funds to the Financial Services Center to increase compliance with the *Prompt Payment Act* and to decrease interest paid on authorized medical claims.

Management Comments to Recommendation #8

ICE managers welcomed this recommendation in our meetings related to the draft report. Action on this recommendation includes review of budget and financing procedures related to the transfer of needed funds to the FSC.

OIG Analysis

This recommendation is *resolved and open*. ICE's corrective action plan should include data showing the amount of interest paid since our fieldwork concluded. Policy changes should focus on fuller compliance with the *Prompt Payment Act*.

Recommendation #9: Create provider education materials to ensure better understanding of the ICE detainee health care process and the need for accurate and timely submission of claims.

Management Comments to Recommendation #9

ICE's response noted that DIHS will create the recommended training materials.

OIG Analysis

This recommendation is *resolved and open*. We require additional details on the types of training material created to address this issue. ICE should also provide a timeline to show how much new material is planned and how it will be made available to providers.

Recommendation #10: Implement a regional managed care coordinator staffing plan and develop supplemental policies that describe the roles and responsibilities of these new personnel.

Management Comments to Recommendation #10

ICE's response focused on future studies regarding the implementation of a regional managed care coordinator system. DIHS used regional MCCs and the agency remains open to re-implementing that paradigm.

OIG Analysis

This recommendation is *resolved and open*. Although ICE concurred with the recommendation, ICE only committed to reevaluate the current model and determine the feasibility of reinstating regional MCCs. It is possible that a complete and objective study will reveal costs and benefits that argue against our recommended action. In that event, we will close the recommendation. In its Corrective Action Plan, ICE should describe the methodology and the timeline for the reevaluation analysis.

Appendix A

Purpose, Scope, and Methodology

We initiated this inspection based on our continued interest in ICE detention management operations. We sought to determine whether the Treatment Authorization Request process was efficient. Our research included legal cases and literature on the health care industry and immigration detention. Our review of ICE data focused on the 30-month period from October 2006 through March 2009.

We conducted 24 interviews, which included MCCs, DIHS physicians, and staff in the ICE Office of Professional Responsibility and the DHS Office for Civil Rights and Civil Liberties. We had a phone interview with experts at the FSC of the Department of Veterans' Affairs in Austin, Texas. We interviewed clinical staff at seven detention facilities and had phone conversations with five others. The facilities were selected to ensure input from geographically diverse locations that had submitted a significant number of TARs.

The seven facilities we visited were:

- Berks County Family Residential Facility, Leesport, Pennsylvania
- El Paso Service Processing Center, El Paso, Texas
- Eloy Contract Detention Facility, Florence, Arizona
- Pinal County Detention Facility, Florence, Arizona
- Port Isabel Service Processing Center, Los Fresnos, Texas
- Willacy Contract Detention Facility, Raymondville, Texas
- York County Prison, York, Pennsylvania

Our phone conversations were with facility staff at:

- Buffalo Contract Detention Facility, Batavia, New York
- Etowah County Detention Center, Gadsden, Alabama
- Kenosha County Detention Center, Kenosha, Wisconsin
- North Las Vegas Detention Center, North Las Vegas, Nevada
- Northwest Detention Center, Tacoma, Washington

These 12 facilities accounted for 28.7% of TARs submitted in the first 6 months of FY 2009 and 20.6% of the TARs submitted during the 30-month period of our review.

We conducted our review between February and June 2009 under the authority of the *Inspector General Act of 1978*, as amended,

Appendix A
Purpose, Scope, and Methodology

and according to the *Quality Standards for Inspections* issued by President's Council on Integrity and Efficiency.

Appendix B Management Comments to the Draft Report

Office of the Assistant Secretary

U.S. Department of Homeland Security
500 12th Street, SW
Washington, DC 20024



**U.S. Immigration
and Customs
Enforcement**

November 5, 2009

MEMORANDUM FOR: Carlton I. Mann
Office of Inspector General

FROM: Robert F. De Antonio 
Director
Audit Liaison Office

SUBJECT: ICE Response to Office of Inspector General Draft Report titled, "The Immigration and Customs Enforcement Process for Authorizing Medical Care for Detained Immigrants"

U.S. Immigration and Customs Enforcement (ICE) provides the following response to the subject Office of the Inspector General (OIG) draft report.

OIG Recommendation 1: "End or greatly reduce the amount of preauthorization required under the Treatment Authorization Request process."

ICE Response to OIG Recommendation 1: ICE concurs. The Division of Immigration Health Services (DIHS) is developing a process that expands the ability for the automatic approval of some requests by the on-site clinical director or designee. Automatic approval will save time and allow faster access to necessary care for detainees. DIHS is also developing a system that will negate the need to submit multiple Treatment Authorization Requests (TARs) for certain conditions. For example, if a detainee is pregnant, all her prenatal visits, lab work and tests will be grouped into one request. There are many instances where this "grouping" or "bundling" of services can be utilized. This will alleviate the need to submit a TAR for each service, greatly reducing the number of TARs submitted overall. DIHS is also exploring other ways to address this recommendation to realize greater efficiencies in providing health services to detainees.

OIG Recommendation 2: "Revise the Covered Services Package to provide more guidance on coverage policy for a process that minimizes pre-authorization of most services."

www.ice.gov

Appendix B

Management Comments to the Draft Report

Subject: ICE Response to OIG Draft Report: "The Immigration and Customs Enforcement Process for Authorizing Medical Care for Detained Immigrants"
Page 2 of 3

ICE Response to OIG Recommendation 2: ICE concurs. DIHS has already begun this process and expects to have draft guidance prepared by the end of November 2009. The new package will minimize the need for pre-authorization for a number of services.

OIG Recommendation 3: "Make appropriate policy changes so that managed care coordinators are no longer responsible for facilities' TARWeb system access and password reset issues."

ICE Response to OIG Recommendation 3: ICE concurs. DIHS has already addressed this recommendation and our Information Technology (IT) personnel now have this responsibility. This change was implemented June 19, 2009.

OIG Recommendation 4: "Develop TARWeb data reporting capabilities that incorporate the suggestions of facilities' staff."

ICE Response to OIG Recommendation 4: ICE concurs. DIHS is already working with its IT department to revise fields in TARWeb and will review to determine the feasibility of implementing these fields.

OIG Recommendation 5: "Develop a prioritization system in TARWeb for facilities to identify more urgent detainee medical care requests."

ICE Response to OIG Recommendation 5: ICE concurs. This would assist in identifying the requests for non-emergency services that are of a high priority. DIHS is willing to explore developing a prioritization system to classify these urgent care services and to modify the TARWeb system to be able to prioritize and highlight urgent requests.

OIG Recommendation 6: "Develop policies that formalize necessary training and an expanded case management role for the managed care coordinators."

ICE Response to OIG Recommendation 6: ICE concurs. The strength of the managed care program model is the nurse case managers. Therefore, every effort will be made for the staff to be able to keep abreast of the emerging policies and practices in nursing and specifically in the case management field. DIHS will review the feasibility of adding this training to their standard recurrent training plan.

OIG Recommendation 7: "Expand managed care coordinator support to detention facilities to improve maintenance of relationships with outside care providers."

ICE Response to OIG Recommendation 7: ICE concurs. DIHS will evaluate expanding the number of managed care coordinators that support this program. Under consideration is providing a minimum of two managed care coordinators for each of the three regions. This would allow for backup should a coordinator be out of the office. It would also

Appendix B

Management Comments to the Draft Report

Subject: ICE Response to OIG Draft Report: "The Immigration and Customs Enforcement Process for Authorizing Medical Care for Detained Immigrants"
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allow more support to assist the facilities with case management of some of the more complicated medical patients.

OIG Recommendation 8: "Ensure more timely transfer of funds to the Financial Services Center to increase compliance with the Prompt Payment Act and to decrease interest paid on authorized medical claims."

ICE Response to OIG Recommendation 8: ICE concurs. ICE will review its budget and financing procedures to ensure that the funding to support processing of claims through the Veterans Administration is done in a timely manner.

OIG Recommendation 9: "Create provider education materials to ensure better understanding of the ICE detainee health care process and the need for accurate and timely submission of claims."

ICE Response to OIG Recommendation 9: ICE concurs. DIHS will develop educational materials and training for the providers that deliver healthcare to the ICE detainees to help their administrators better understand this process.

OIG Recommendation 10: "Implement a regional managed care coordinator staffing plan and develop supplemental policies that describe the roles and responsibilities of these new personnel."

ICE Response to OIG Recommendation 10: ICE concurs. We agree to provide existing managed coordinators with clarification and information about their roles and responsibilities. The specific roles and responsibilities for the nurse case managers will be reviewed and documented in the DIHS policies and standard operating plans as appropriate. DIHS previously used regional managed care coordinators. DIHS will reevaluate that model to determine if re-implementing it is feasible and would result in efficiencies being realized.

Should you have questions or concerns, please contact Margurite Barnes, OIG portfolio manager at (202)732-4161 or by e-mail at Margurite.Barnes@dhs.gov.

Appendix C
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