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DEPARTMENT OF HOMELAND SECURITY

Organizational Structure, Spending, and Staffing for the Health Care Provided to Immigration Detainees

Statement of Alicia Puente Cackley, Director
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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you examine issues related to the health care provided to detainees held by U.S. Immigration and Customs Enforcement (ICE), a component of the Department of Homeland Security (DHS).[1] For fiscal year 2004 through fiscal year 2007, ICE reported that 69 detainees died while in ICE custody, and during 2008, national news organizations investigated and published reports of the circumstances surrounding several detainee deaths. Other reports have also outlined concerns about the health care provided to detainees. For example, in 2007, the DHS Office of the Inspector General found problems with adherence to ICE's medical standards at two ICE facilities it reviewed where detainee deaths had occurred.[2] Additionally, members of the Congress, the media, and advocacy groups have raised questions about the health care provided to detainees in ICE custody. An explanatory statement accompanying the fiscal year 2009 DHS appropriations act directed ICE to fund an independent, comprehensive review of the medical care provided to persons detained by DHS and identified $2 million for that purpose.[3] My remarks today are based on our report, released at this hearing, entitled *DHS: Organizational Structure and Resources for Providing Health Care to Immigration Detainees*.[4]

ICE was created in March 2003 as part of DHS.[5] From fiscal year 2003 through fiscal year 2007, the average daily population of detainees in ICE custody increased by about 40 percent, with the most growth occurring

[1]Under the Immigration and Nationality Act, ICE is authorized to arrest, detain, and remove certain individuals from the United States. 8 U.S.C. §§ 1226, 1227, 1229, 1229a, 1231, and 1357. We refer to these individuals as "detainees."

[2]Department of Homeland Security, Office of the Inspector General, *ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities* (Washington, D.C., June 2008).

[3]See Comm. Print of the Comm. on Approp., U.S. House of Rep., Explanatory Statement related to the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, Pub. L. No. 110-329, Div. D., p. 636 (Oct. 2008). Section 4 of Pub. L. No. 110-329 provides that the Explanatory Statement shall have the same effect with respect to the allocation of funds and the implementation of the act as if it were a joint explanatory statement of a committee of conference.

[4]GAO-09-308R (Washington, D.C.: Feb. 23, 2009).

[5]Responsibility for detainees was transferred from the Department of Justice's Immigration and Naturalization Service to DHS's ICE.

since fiscal year 2005.[6] In fiscal year 2007, ICE held over 311,000 detainees at more than 500 detention facilities. Most of these were Intergovernmental Service Agreement (IGSA) facilities—state and local jails under contract with ICE to hold detainees. Some ICE detainees received health care services from IGSA staff, IGSA contractors, or community medical providers, and other ICE detainees received health care provided or arranged by the Division of Immigration Health Services (DIHS). DIHS is mainly composed of contract employees and officers from the U.S. Public Health Service (PHS) Commissioned Corps—a uniformed service of public health professionals who are part of the Department of Health and Human Services (HHS) and who provide services in different settings, including ICE detention facilities.

In light of questions about the health care provided to detainees in ICE custody, you requested information about ICE's organizational structure and its health care resources for detainees. Our report provides (1) a description of ICE's organizational structure for providing health care services to detainees, which includes our review of the relevant agreements between DHS and HHS regarding DIHS; (2) information about ICE's annual spending and staffing resources devoted to the provision of health care for detainees, and the number of services provided; and (3) an assessment of whether ICE's mortality rate can be compared with the mortality rates of the Federal Bureau of Prisons (BOP) and the U.S. Marshals Service (USMS)—two entities that are responsible for holding certain persons, such as criminals. To address these issues, we reviewed pertinent government reports and interagency agreements regarding DIHS; interviewed agency officials; examined ICE's fiscal year 2003 through fiscal year 2007 data on health care spending, staffing, and services;[7] and

[6]The scope of our work was primarily limited to detainees who were in ICE custody because of immigration violations and who were held at facilities that serve adults. Some of these facilities are owned and operated by ICE, some operate under contracts with ICE, and some operate through service agreements with ICE.

[7]We assessed the data DHS provided and we worked with DHS to address discrepancies. Subsequently, we determined that the data we used were sufficiently reliable for our purposes. Throughout our work, we used data on the average daily population—the number of beds ICE used for detainees on an average day during a fiscal year—because ICE was not able to provide reliable data on the number of unique individuals detained per fiscal year.

obtained information on ICE's mortality rate and the health care goals, services, and populations for ICE, BOP, and USMS.[8]

In summary, we found that ICE's organizational structure for providing health care to detainees is not uniform across facilities. In fiscal year 2007, 21 DIHS-staffed facilities provided or arranged for health care for about 53 percent of the average daily population of detainees, while 508 IGSA facilities provided or arranged for health care for the remaining detainees—about 47 percent of the population. Before October 1, 2007, DHS and HHS maintained annual interagency agreements through which DIHS—a component of HHS's Health Resources and Services Administration (HRSA)—provided health care for ICE detainees. As of that date, the last annual interagency agreement was terminated, and DIHS no longer is a component of HRSA. DHS officials told us that this termination—along with a 2007 Memorandum of Agreement between HHS and DHS that placed PHS officers on detail to DHS on an open-ended basis and that allowed for additional PHS officers to be detailed to DHS in the future—affected 565 direct health care providers and administrative staff. According to DHS officials, ICE now has a component known as DIHS which provides health care services to detainees.

We also found that although ICE's health care data are not complete, the available data on health care spending, staffing, and services provided generally showed growth in all three areas. For instance, from fiscal year 2003 through fiscal year 2007, reported expenditures for medical claims and program operations increased by 47 percent, while the average daily population of detainees increased by about 40 percent. However, ICE facilities do not use standardized record keeping, and are not required to routinely report data to DHS on the health care services provided to detainees. Furthermore, data were not available on the detainee health expenditures that are incurred by IGSAs.

In addition, we determined that ICE's mortality rate cannot be directly compared with BOP's or USMS's mortality rate. This is due to differences in the three agencies' health care goals and scopes of services, as well as

[8]We conducted our work from July 2008 to February 2009 in accordance with all sections of GAO's Quality Assurance framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient, appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained and the analysis conducted provide a reasonable basis for any findings and conclusions.

to demographic differences among the ICE, BOP, and USMS detainee populations.

Based on our work, we have identified a number of issues that may merit further assessment in the $2 million external study that ICE was directed to fund. These include:

- ICE's ability to access detainee population data that measure unique individuals in ICE custody, rather than the average number of beds used;
- Reporting relationships between DIHS and ICE;
- IGSA reporting requirements—including the frequency of reporting on health care services provided to detainees and the format in which health records are maintained;
- ICE's ability to routinely ensure the transfer of medical records when detainees are transferred between facilities;
- ICE's ability to identify and report the detainee health care costs incurred by IGSAs; and
- ICE's ability to identify and report medical claims expenditures by facility type—such as for all IGSAs.

After reviewing the draft report, DHS provided general comments and both DHS and HHS provided technical comments. DHS did not comment as to whether the issues we identified as meriting further assessment would be addressed in the $2 million external study. However, DHS disagreed with the way we presented some information. Specifically, the agency commented that we mischaracterized DIHS's relationship with HHS and DHS and that our report could lead to the incorrect conclusion that DIHS was transferred from HHS to DHS. DHS also stated that we mischaracterized the degree of control ICE has over detainee health care providers, ICE's ability to track the cost of health care services for detainees held at IGSAs, and other issues. After considering the agency's comments and our evidence, we maintain that the report appropriately describes ICE's organization, management structure, and ability to monitor health care spending. A complete discussion of DHS's comments and our evaluation are provided in the report.

Mr. Chairman, this concludes my prepared remarks. I would be happy to answer any questions that you or other members of the subcommittee may have.

For future contacts regarding this statement, please contact Alicia Puente Cackley at (202) 512-7114 or at cackleya@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Rosamond Katz, Assistant Director; Joy L. Kraybill; and Kevin Milne also made key contributions to this statement.

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