Indian Health Service

Accountability Report

Fiscal Year 1998

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Message from the Director

April 1999

I am pleased to present the Indian Health Service (IHS) Accountability Report for Fiscal Year 1998. In this report, we provide a full accounting of how we spent almost $2.7 billion entrusted to us. The results of our financial statement audit are provided. In addition, we describe our programmatic accomplishments and improvements in health care services as well as facilities programs.

FY 1998 was an exciting and eventful year. The Congress provide $30 million each year for the next five years to aid in our fight against Diabetes, which effects 1 out of every 3 adult American Indians and Alaska Natives. Congress also created the Children's Health Insurance Program (CHIP). American Indian and Alaska Native children are more likely to experience many serious health conditions and have significantly less access to affordable health insurance and health care than other Americans. Given the compelling health care needs of Indian children, the Department of Health and Human Services has encouraged States to implement the CHIP program, in consultation with Tribes and Indian organizations, in a creative and flexible manner to allow Indian children to benefit to the maximum extent possible under the law.

Yet there are many challenges remaining for the IHS. While we are the richest nation on earth, an estimated 31% of American Indians and Alaska Natives live below the poverty level and have limited access to primary health care services. This simple fact does not fully capture the excess severity and intensity of illness that is associated with poverty. Nor does it fully represent the fact that many American Indian and Alaska Native communities have very little municipal infrastructure to address the burden of illness. We face the tremendous challenge of trying to maintain the public health infrastructure and eliminating the disparities in the health of minorities with resources that are less than 40% of that available to the general U.S. population.

In addition, with the year 2000 fast approaching, we are working to ensure that our information systems will remain operable and dependable. The agency has mounted a massive campaign to correct Y2K-related deficiencies in its computer-based systems and applications, networking resources, facilities, biomedical devices, and other critical support elements. Because of the clear threat to the lives and health of the agency's customers, and to those served by contracted and compacted health facilities, the agency has attempted to actively coordinate its efforts in a manner that extends the benefits of its efforts to both groups of health service providers.

Indian Health programs continued to make strides in such health areas as women's health, elder care, and injury prevention. Our efforts to promote healthy lifestyles, reduce bad eating habits, and utilize appropriate screening strategies will continue. The Indian Health providers continue to believe that health promotion and disease prevention are the most effective ways to reduce the rate of chronic diseases and improve the quality of life of the population we serve.

This report contains information that fulfills the Federal Managers' Financial Integrity Act of 1982 (FMFIA). I hereby provide reasonable assurance that taken as a whole the IHS is in compliance with the management control and financial systems requirements of the FMFIA.

Michael H. Trujillo, M.D., M.P.H., M.S.

Message from the Chief Financial Officer

April 1999

As the Chief Financial Officer of the Indian Health Service (IHS), I am pleased to present the Fiscal Year (FY) 1998 IHS Accountability Report. This is our annual report for the IHS and is meant to furnish useful, comprehensive information on IHS program activities and accomplishments as well as IHS financial management status and accomplishments. This report is provided to Congress, our stakeholders, and the general public.

The IHS employs more than 14,500 personnel of which 87% provide health care and administrative services at the local level. An organization of this size must be responsibly and efficiently managed in order to effectively achieve its mission in an environment of ever-evolving technology and increasing accountability. Therefore, we are reporting on a variety of managerial issues, particularly in the fields of finance and information systems.

The IHS has had significant accomplishments during the past fiscal year despite seemingly overwhelming challenges. The combination of employee commitment to the IHS mission and Agency partnership with tribes and urban Indian organizations produced successful results in several areas of health care delivery, and these activities are highlighted in the report.

The management of the IHS has implemented and maintained, as of and for FY 1998, financial management systems that comply substantially with Federal financial systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. These controls provide reasonable assurance that assets are protected, transactions are properly executed and recorded, and policies are followed.

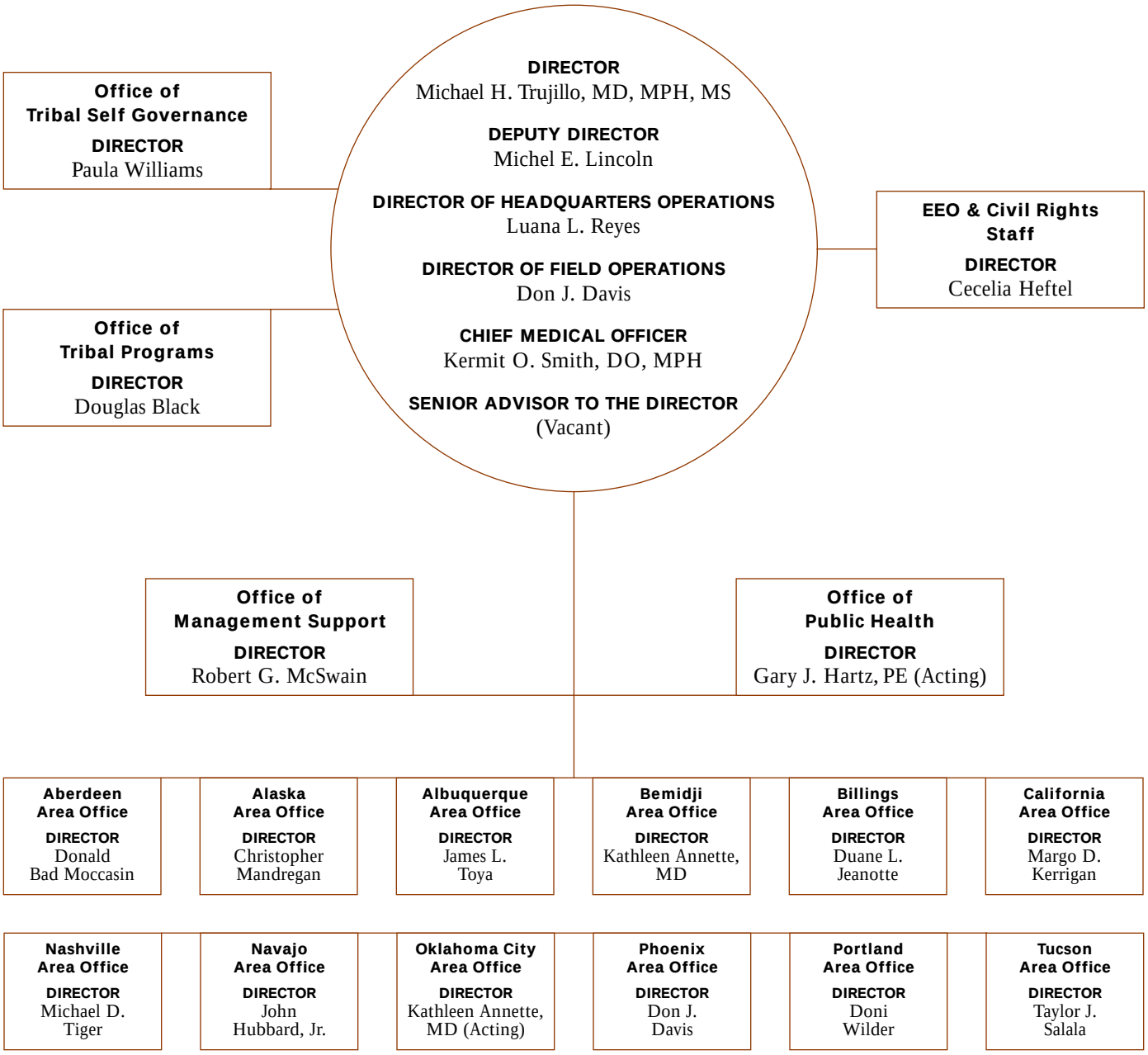
Although the principal focus of the IHS Accountability Report is on the management of its financial responsibilities, the report also covers many of the accomplishments of the Agency and the challenges facing Indian health. I believe this report amply demonstrates the progress that the IHS has made in fulfilling its mission.

Luana L. Reyes

Director of Headquarters Operations

Contents

Organization Chart



Agency Profile

The Indian Health Service (IHS), an Agency within the Department of Health and Human Services (HHS) is responsible for providing health services to American Indians and Alaska Natives. The provision of health services to federally recognized American Indians and Alaska Natives grows out of a special relationship between the Federal Government and Indian Tribes. This government-to-government relationship is given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principle Federal health care provider and health advocate for Indian people. Its mission is, in partnership with American Indians and Alaska Natives, to raise their physical, mental, social, and spiritual health to the highest level. The IHS provides health services to members of more than 550 federally recognized Tribes in 35 States.

Mission Statement

The mission of the Indian Health Service, in partnership with American Indians and Alaska Natives, is to raise their physical, mental, social, and spiritual health to the highest level.

Goal

To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indians and Alaska Natives.

Foundation

To uphold the Federal Government's obligation to promote healthy American Indians and Alaska Natives, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

Service Population

The distinctive nature of the IHS reflects the people served: almost 1.4 million American Indians and Alaska Natives throughout the United States. The IHS serves over 550 tribes — each a community with its own strong sense of individual identity. Tribal and spiritual leaders team with IHS health care providers to identify problems, plan and implement community health initiatives, and evaluate programs. Growing numbers of IHS employees are American Indians and Alaska Natives.

The IHS is the primary source of health care services for American Indians and Alaska Natives who live on or near reservations. The services provided vary from community to community, and are determined by medical priorities; the level of appropriated funds of Tribal, State, and Federal programs; and, other resources in the local area. Under current regulations and policies, the IHS does not charge eligible American Indians and Alaska Natives for the services it provides.

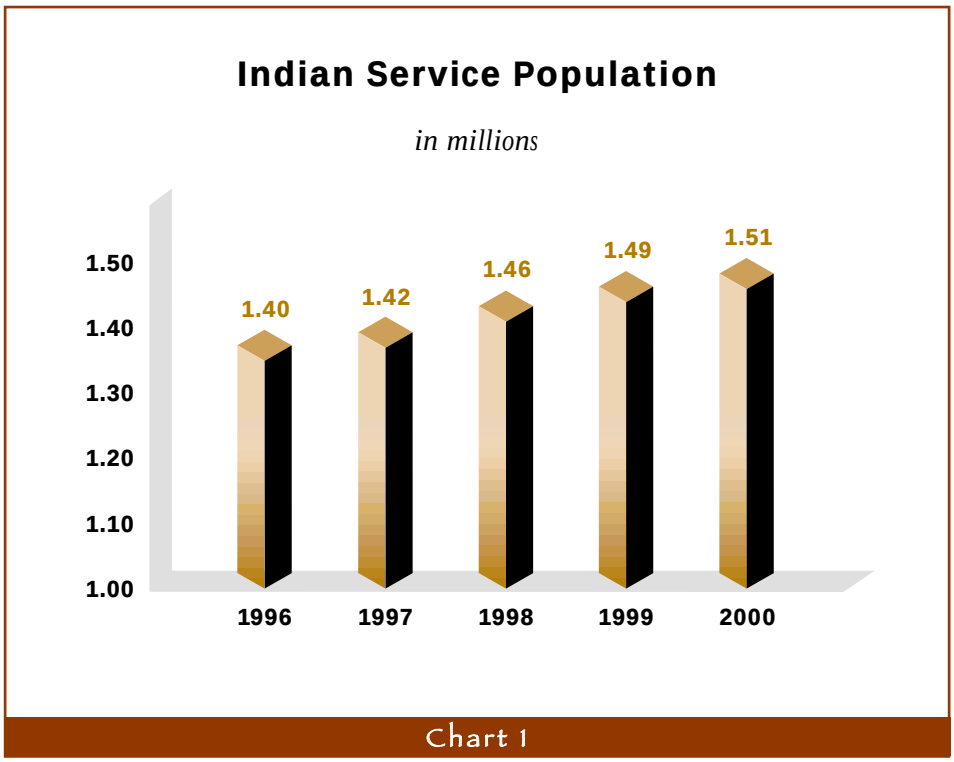


Chart 1

In fiscal year (FY) 1998, the IHS service population of American Indians and Alaska Natives who resided in areas served by IHS was approximately 1.46 million. The American Indian and Alaska Native population is increasing at a rate of about 2.0 percent per year. **(Chart 1)**

The IHS health services delivery system is managed through local administrative units called service units. A service unit is the basic health organization for a geographic area served by the IHS program, similar to a county or city health department. These are defined areas, usually located on a single Federal reservation in the continental U.S., or a population concentration in Alaska or Oklahoma. A few service units cover several small reservations; some large reservations are divided into a number of service units. The service units are grouped into larger cultural-demographic-geographic management jurisdictions that are administered by twelve Area Offices. **(Chart 2)**

Health care services are delivered through 151 (IHS 66, Tribal 85) service units composed of 550 direct health care delivery facilities, including 49 (IHS 37, Tribal 12) hospitals, 214 (IHS 59, Tribal 155) health centers, 7 (IHS 4, Tribal 3) school health centers, and 280 health stations and clinics (IHS 44, Tribal 76 health stations and 160 Alaska Village clinics). Various services are provided to American Indians and Alaska Natives in urban settings through 34 urban projects. These projects range from information referral and community health services to comprehensive primary health care centers.

An integral part of the IHS health delivery program is the purchase of medical services from non-IHS providers through the contract health services (CHS) account. Patients may be referred for episodic care to private sector hospitals and providers when the needed services are unavailable in the IHS or tribally operated facilities. Payments for eligible patients are financed through the CHS account and third party payors.

Tribal Self-Determination

The provision of health care to American Indian/Alaska Native people in Indian country and urban areas has become increasingly complex. Health care delivery systems are expected to be more flexible even though health care dollars are becoming scarce. New ideas in delivery methods and funding sources are now a necessity. To meet this challenge, Tribal governments can opt to exercise their sovereign rights in three ways: through P.L. 93-638 (Title I) contracts, P.L. 93-638 (Title III) compacts, or by retaining federally operated health programs.

The Federal responsibility for American Indian/Alaska Native health care is grounded in treaty obligations, case laws, the Snyder Act of 1921 (P.L. 83-568), the Indian Health Care Improvement Act (P.L. 94-437), as

well as historical obligations for the health of American Indian/Alaska Native people. The Tribal Self-Governance Demonstration Project (SGDP) was enacted by Congress as Title III (P.L. 100-472) of the Indian Self Determination and Education Act in 1988 (P.L. 93-638). The original legislation pertained to the Department of Interior but was amended (P.L. 102-184) to extend the Self-Governance Demonstration Project to Indian Health Service. Title III was amended again in 1992 (P.L. 102-573) to authorize the Secretary of Health and Human Services to negotiate Self-Governance compacts with Tribes that had completed the required planning activities. The Office of Tribal Self-Governance was established to coordinate this program. In 1994, P.L. 103-435 was enacted to extend this authority to 2012 and allow for the addition of up to 30 Tribes each fiscal year.

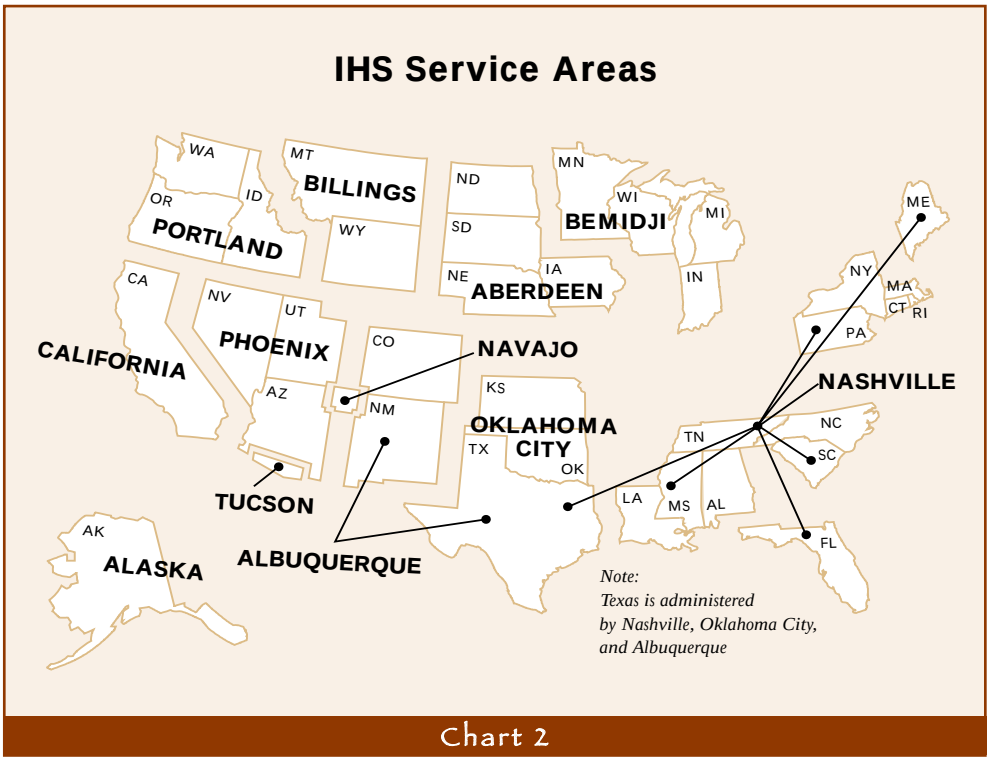


Chart 2

Discretionary Financing

The IHS programs are discretionary rather than entitlement programs. Therefore, the IHS cannot incur financial obligations in advance of an appropriations act.

Director's Initiatives

Traditional Medicine Initiative emphasizes the alliance of traditional and modern medicine practices between community traditional healers and IHS health care providers. Through this initiative, the Agency seeks to foster formal relationships between local service units and traditional healers so that cultural values, beliefs, and traditional healing practices are respected and affirmed by the IHS as an integral component of the healing process. Several IHS sites have hired traditional healers using personal services contracts and some tribally operated programs have hired traditional healers full-time. One hogan-style facility used for traditional healing purposes is built on the grounds at the Shiprock, New Mexico, health care facility.

Elder Health Care Initiative collects and provides information regarding existing elder programs, resources, and initiatives of the IHS, Federal agencies, Tribes and States to meet the health needs of American Indian and Alaska Native Elders. In FY 1997, the IHS developed and implemented an elder grants program. In FY 1998 six continuing grants were awarded to tribes and tribal organizations totaling $813,691 and a seventh grantee was authorized to continue to perform within prior year funds. The grantees are performing

satisfactorily in moving toward the goals of community elder education and services, elder services mapping, and home health services development. Examples of the work under the grants includes: a broad based assessment of tribal capacity (a) to develop and maintain an indigenous home and community based service system for community elders, and, (b) to develop and operate a certified home health program in the community.

Women's Health Initiative focuses on access to preventive services; increased surveillance and screening for diseases; increased community education; increased number of female providers; and establishing support groups and mentoring programs for young women in their communities. The focus for the last two years has been on: increasing access to direct services, refocusing the former National Indian Women's Health Steering Committee, and networking with the Public Health Service (PHS) Office on Women's Health, other PHS agencies, and private organizations on Indian women's health. The Committee received funding in 1997 and 1998 from the Office on Women's Health to conduct eight "Indian Women in Action" community mobilization workshops in tribal and urban communities. The workshop training increases capacity of local women to address their health issues, learn skills to provide their issues to community and political leaders, and initiate local support groups.

Domestic Violence and Child Abuse Prevention Initiative purpose is to improve the IHS, tribal, and urban Indian health care response to domestic violence by providing education, training, and support to health care providers. The goal is to improve health care providers' capability to provide early identification and appropriate, culturally competent responses to victims of violence against women and related issues of child abuse in American Indian and Alaska Native communities. A Family Violence Prevention Team provides crisis response, technical assistance, program development, and training to American Indian and Alaska Native communities regarding issues of domestic violence and related issues of child abuse and other forms of family violence. The Team collaborates with local, regional, and national programs to accomplish the Initiative's goals. The Team collaborated with the Family Violence Fund Health Initiative and as a result 15-20 IHS direct and tribally operated health care facilities participated in state-wide training conferences on Improving the Healthcare Response to Domestic Violence.

Indian Children and Youth Initiative allowed the IHS to propose a multi-agency initiative for American Indian and Alaska Native youth and adolescents to ensure a safe and healthy home, and community, and to ensure personal development within the context of developing communities. To share information about the Policy Initiative and to enlist support for Indian communities, the IHS and United National Indian Tribal Youth, Inc., (UNITY) sponsored a conference in February 1998. Interested non-federal organizations attended and participated in dialogue with Indian youth representatives about what their needs are and what they believe are appropriate interventions from the organizations. Input from the February conference will be used to ensure personal development of American Indian and Alaska Native youth within the context of developing safe and healthy homes and communities.

Injury Prevention Initiative focuses on reducing the incidence of severe injuries and death to the lowest level possible and increases the ability of Tribes to address their injury problems. Although the American Indians and Alaska Natives age adjusted mortality rate has decreased by 57 percent since 1973, unintentional injuries continue to be the leading cause of death for Indian people up to 45 years of age. The Director's Initiative focuses on increasing tribal community capacity building and more inter-tribal collaboration on injury prevention. To assist tribes in building infrastructures for injury prevention capacities, the IHS awarded 3-year grants totaling $304,000 beginning in fiscal year 1997 to 13 tribes. An Inter-Agency greement between the IHS and the U.S. Fire Administration provides funds to six tribal communities to build their capacity to reduce fire injuries. The Initiative encourages inter-tribal collaborative efforts such as facilitating the expansion of the Native American Injury Prevention Coalition beyond its North Dakota origin to include South Dakota and Montana. The Safe Tribal Communities Campaign for American Indian and Alaska Native Youth was reactivated in fiscal year 1998. The Campaign is a community service project for Indian youth to help address injury problems in their communities.

Health Care Financing Administration (HCFA) Initiative is aimed at increasing the understanding of the unique relationship that exists between agencies of the Federal and state governments and American Indian and Alaska Native Tribes as sovereign governments. These activities include working together to insure Tribal consultation in the development of the Department of Health and Human Services (DHHS) policies that impact Tribes. Most recently, a National meeting with HCFA and States was held in Denver in August (1998) to address key policy issues in State Medicaid reform. HCFA staff participated in training sessions with IHS in Medicaid/Children's Health Insurance Program outreach, and Medicare and Medicaid managed care models. In collaboration with HCFA, progress was made in submission of cost reports to support Medicare and Medicaid rates (in 1998). In 1999, IHS will be working with the DHHS on regional Tribal consultation policy forums.

Sanitation Facilities Initiative focuses on expanding services to existing Indian homes, then to communities and new and renovated homes. A safe and adequate water supply and waste disposal system contributes to the health of communities. When homes have adequate sanitation systems, the prevention of disease and preservation of public health are significantly improved. Tribal governments have worked in partnership with the IHS to construct essential sanitation facilities for American Indian and Alaska Native homes and communities since the passage of the Indian Sanitation Facilities Act (Public Law 86-121) in 1959. In FY 1998, the IHS provided essential new sanitation facilities to 7,784 homes and upgraded facilities to 6,589 homes. This was accomplished with contributions of $42 million from tribes and Federal agencies, in addition to the $89.1 million funds appropriated to IHS for this purpose.

Accomplishments in the IHS

The IHS Epidemiology Program increased available epidemiological services for Indian Health Service consumers, Tribes and Tribal organizations, and Urban Indians through a combination of (1) increased collaboration with the Centers for Disease Control and Prevention (CDC); and, (2) continued development of regional tribal Epidemiology Centers. As part of new agreements with CDC in Fiscal Year 1998, specialists are now available for consultation in the fields of infant mortality, community assessment, tobacco control, hepatitis prevention and control, geographic information systems, and general field epidemiology. Our Cooperative Agreements with four Native Health Boards provide additional epidemiological services at the regional and local level. Results of this enhanced capacity include completion of a major vaccination coverage survey involving Indian children in South Dakota, and facilitation of acquisition of grants for breast and cervical cancer screening by tribal groups in Alaska and Aberdeen IHS Areas.

A Public Health Support Workgroup was chartered by the Indian Health Leadership Council (IHLC) in the summer of 1998. In light of the significant erosion of funding and support for the public health infrastructure at all levels in the organization, the IHLC wanted a workgroup that focused solely on the public health infrastructure and would provide guidance and recommendations in the following areas:

- Identification of essential public health support services to be provided to direct IHS sites, and ways to ensure the delivery of these services.

- Determine how IHS will provide public health support services to compacted and contracted sites who may desire to receive some or all of these services.

The Children's Health Insurance Program (CHIP), created under the new Title XXI of the Social Security Act, will expand health coverage to uninsured children whose families earn too much for Medicaid but too little to afford to purchase private health insurance. Under this new Federal/State program, a State may choose to create or expand new child health insurance programs, expand its Medicaid program, or create a combination of both. American Indian/Alaska Native (AI/AN) children are more likely to experience many serious health conditions and have significantly less access to affordable health insurance and health care than other Americans.

Given the compelling health care needs of Indian children and these provisions, the Department of Health and Human Services has encouraged States to implement the CHIP program, in consultation with Tribes and Indian organizations, in a creative and flexible manner to allow Indian children to benefit from Title XXI to the maximum extent possible under the law.

The Quality of Work Life (QWL) Initiative, led by the HHS Secretary and implemented by the IHS Director, is intended to assist the IHS in meeting three very important organizational objectives of improving employee satisfaction, strengthening and increasing learning, and improving the planning and management of organizational change and transition.

Presently, the IHS has accomplished many things such as establishing the IHS QWL Internet/Intranet homepage with an e-mail address for employees to provide suggestions and feedback, providing Internet/Intranet access to all employees, elimination of sign-in/out sheets, establishing a new incentive awards policy, and establishing leadership training for all supervisors, managers, and executives. In future years, all employees will be offered leadership skills training as part of this initiative. These things were accomplished through the dedication and determination of IHS employees who are committed to providing quality service to both internal and external customers.

The Indian Health Service (IHS) Headquarters East Labor-Management Partnership Council (LMPC) signed their charter on the 9th day of June, 1998. The Council provides an additional forum for employees, supervisors, and management and union representatives to exchange information. The Council's activities include discussion of mutual matters of concern and interest with the goal of recommending actions or making decisions within the scope of its authority. The goal of the partnership is to improve, maintain, and protect the broad areas of personnel policies, practices, and/or working conditions to provide quality and efficient service to its customers, improving where possible the mission of the IHS. The LMPC is composed of ten members representing Union and Management.

The Hammer Award, initiated by Vice President Al Gore, honors federal teams that have made extraordinary progress in reinventing government. In 1998, the National Performance Review chose the Operation TRANSAM Team as recipient of the "Hammer" Award. Operation TRANSAM is a Civil-Military Cooperative program that makes use of excess medical equipment and supplies from the reduction of U.S. military forces around the world. The excess medical equipment and supplies is transferred to the IHS and distributed within the IHS health care system. Since the program began in 1995, more than $33 million in excess medical equipment and supplies has been distributed to IHS and tribal health care facilities. The Operation TRANSAM Team consists of members of the IHS Division of Administrative Support and members of the 301st Fighter Wing at NAS Carswell Field, Ft. Worth, Texas.

Key Appointments were made by the Director of the IHS in FY 1998 to fill three key leadership positions for the agency: Director, Portland Area IHS, Director, Albuquerque Area IHS, and Director, Tucson Area IHS. These appointees represent 25 percent of the IHS leadership team that manages health care and environmental health services programs through IHS Area Offices across the nation. The appointments were made after extensive consultation with tribes and urban Indian health programs regarding the requirements of each position. In addition, tribal leaders, urban Indian leaders and Federal managers collaborated to conduct interviews and recommend the most highly qualified candidates to the IHS Director for consideration. As a result, applicants knowledgeable of both the Federal requirements for the position and the unique cultural requirements of each IHS Area were appointed to these Senior Executive Service level positions.

Legislative Impacts

In FY 1998, the IHS did not have any new legislative requirements that would impact on its health and facilities programs.

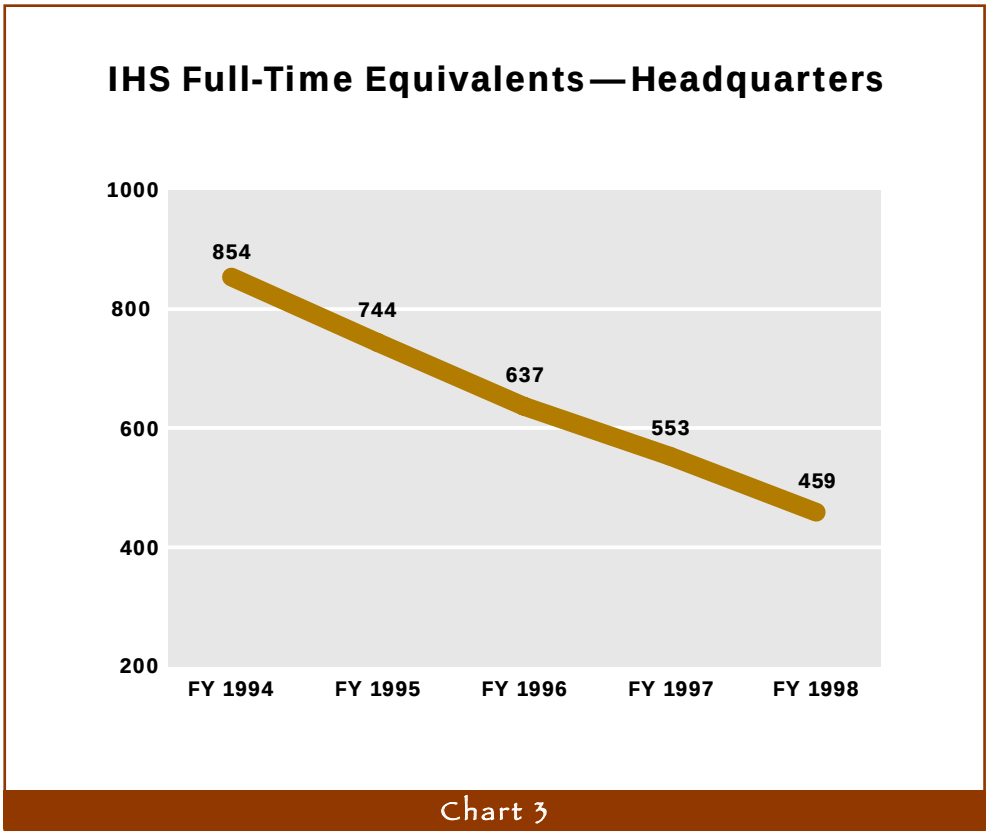


Chart 3

Challenges to the IHS

IHS completed the Headquarters reorganization in FY 1998 based on the recommendations of the Indian Health Design Team. In addition, 40 percent of Headquarters resources have been transferred to tribes. Since FY 1994, the Headquarters workforce has been reduced by an estimated 46 percent. The reductions were achieved through a combination of natural attrition, buy-outs, multi-year hiring freeze, and reassignment of some Headquarters functions and staff to Area Offices. **(Chart 3)**

The IHS has continued its committment to decentralizing control and expanding opportunities for consultation and collaboration with its local I/T/U stakeholders in setting priorities and in developing significant Agency policies. In FY 1998 this commitment was made operational through the "local level up" approach to the GPRA/Budget Formulation process and the collaborative stakeholder process used to determine the distribution of new diabetes funds. In addition, to assure this commitment is continued and expanded, the IHS developed Performance Indicator 24 in the FY 1999 performance plan. This indicator calls for the development of a formal policy for I/T/U consultation and participation approved by I/T/U representatives and the completion of a base-line survey to determine the level of satisfaction with the process.

In addition, the "Year 2000 (Y2K) Problem" became a pervasive issue affecting all of the agency's information technology activities. Described by the Department of Health and Human Services as "our most important information technology issue," the agency has mounted a massive campaign to correct Y2K-related deficiencies in its computer-based systems and applications, networking resources, facilities, biomedical devices, and other critical support elements. Because of the clear threat to the lives and health of the agency's customers, and to those served by contracted and compacted health facilities, the agency has attempted to actively coordinate its efforts in a manner that extends the benefits of its efforts to both groups of health service providers. The unique relationship with the tribes, and their physical dispersion over 35 states, continuously affect these efforts.

Trends in Indian Health

While the overall health of Native American people has significantly improved over the past several decades, it has become apparent many chronic health problems unique to Native Americans are increasing. In order to avert this alarming trend, significant efforts must continue to be directed towards the determination of the etiology and the optimal control of these health problems. Of even greater importance is the further development of comprehensive prevention and health programs including clinical services.

Selected Vital Event Rates

per 100,000 population

	1994-96 Rate AI/AN (Adjusted)	1995 Rate US All Races	Ratio AI/AN to US All Races
All Causes	699.3	503.9	1.4
All Accidents	92.6	30.5	3.0
Motor Vehicle	54.0	16.3	3.3
Other Accidents	38.6	14.2	2.7
Suicide	19.3	11.2	1.7
Homicide	15.3	9.4	1.6
Alcoholism	48.7	5.1	9.5
Diabetes	46.4	13.3	3.5
Tuberculosis	1.9	0.3	6.3
Diseases of the Heart	156.0	138.3	1.1
Cerebrovascular Dis.	30.5	26.7	1.1
Malignant Neoplasms	116.6	129.9	0.9
HIV Infection	6.2	15.6	0.4
Infant Deaths	9.3	7.6	1.2

Chart 4

In partnership with the people it serves, the IHS has initiated tremendous improvements in the health of American Indians and Alaska Natives. Infant mortality has dropped dramatically since the U.S. Public Health Service assumed responsibility for Indian health in 1955. The incidence of tuberculosis and gastroenteritis has also been reduced significantly in many areas. **(Chart 4)**

Yet difficult challenges still confront the IHS. One out of every four American Indians and Alaska Natives lives below the poverty line. The risks of illness and premature death from alcoholism, diabetes, tuberculosis, heart disease, accidents, homicide, suicide, pneumonia, and influenza are greater for American Indians and Alaska Natives than for the U.S. population as a whole.

To address these serious needs, the IHS has established:

- More than 180 substance abuse treatment programs.
- A comprehensive injury prevention program.
- Programs in nutrition, dietetics, and environmental health.
- Health screening with a full range of inpatient and outpatient clinical services.
- A program of epidemiological studies, including some in conjunction with the Centers for Disease Control, the National Institutes of Health, and the Substance Abuse and Mental Health Services Administration.

Business Initiatives

During 1998, in accordance with the IHS business plan, Area and Service Unit business offices continue to implement recommendations of the IHS Business Plan Work Group. Major IHS-wide initiatives for 1998 included the following:

- Preparation for the new Medicare hospital outpatient prospective payment system, which will require transition from encounter rate billing to itemized billing.
- Development of super bills to aid in documentation and coding of services.
- Business office coordinator meetings from the 12 areas designed to share knowledge and solutions to common problems.
- Improved identification of third party eligibility.
- Provider and business office training on documentation and coding.
- Development of cost reports in collaboration with HCFA to base Medicare and Medicaid rates.

Third party revenue generation is a major priority of IHS. Because some service units rely on third party revenue for as much as 25% of clinical operations, a number of the business initiatives concentrate on the issue of third party collections.

Government Performance and Results Act (GPRA), P.L. 103-62

The IHS had welcomed the GPRA as an extension of the public health planning model that it has used for many years. During FY 1998, the IHS worked on performance plans for FY 1998, FY 1999 and FY 2000. The FY 1998 performance plan represents our unofficial pilot project addressing two health areas (dental and diabetes). Data for this exercise were collected during FY 1998 for nine dental and nine diabetes indicators and will be analyzed over the first half of FY 1999. The Office of Management and Budget (OMB) recognized the IHS dental pilot as a model for the Department in following GPRA implementation.

With the full implementation of GPRA mandated for FY 1999, the IHS revised and finalized the FY 1999 performance plan and drafted the FY 2000 performance plan in concert with the budget formulation activities. This joint GPRA/budget formulation process involved the diverse IHS stakeholders beginning at the local level and moving up to Areas and ultimately IHS Headquarters. Both of these performance plans were drafted to support four broad IHS Strategic Objectives which will guide the Agency into the next millennium:

Strategic Objective 1:
Improve Health Status

To reduce mortality and morbidity rates and enhance the quality of life for the eligible American Indian and Alaska Native population.

Strategic Objective 2:
Provide Health Services

To assure access to high quality comprehensive public health services (i.e., clinical, preventive, community-based, educational, etc.) provided by qualified culturally sensitive health professionals with adequate support infrastructure (i.e., facilities, support staff, equipment, supplies, training, etc.)

Strategic Objective 3:
Assure Partnerships and Consultation with I/T/Us

To assure that I/T/Us, and IHS Area Offices and Headquarters achieve a mutually acceptable partnership in addressing health problems:

- Providing adequate opportunities for I/T/Us and American Indian and Alaska Native organizations to participate in critical functions such as policy development and budget formulation.
- Assuring that I/T/Us have adequate information to make informed decisions regarding options for receiving health services.

Strategic Objective 4:
Perform Core Functions and Advocacy

Consistent with the IHS Mission, Goal and Foundation, to effectively and efficiently:

- Advocate for the health care needs of the American Indians and Alaska Natives, and
- Execute the core public health and inherent Federal functions.

These Strategic Objectives are essential for the realization of the IHS Mission, Goal, and Foundation over the next 5 years by setting the programmatic, policy, and management course for the Agency. They are also consistent with the most recognized approach to evaluating health care organizations in that they address the structure, process, and outcomes of health care delivery and have served to provide the conceptual and philosophical framework for the development of the annual performance plans.

The FY 1999 performance plan is an attempt to direct resources to the most critical health problems identified by consumers and Tribal leadership. The FY 2000 performance builds on the FY 1999 plan but with greater commitment to restore declining critical health services and beginning to address the significant health disparities that exist between the American Indian and Alaska Native population and the U.S. general population. The indicators for these plans represent health process, impact (i.e., reductions in risk factors), and outcome (i.e., improved mortality or morbidity) measures in four categories:

Treatment
17 indicators for FY 1999, 18 for FY 2000

Prevention
3 indicators for FY 1999, 8 for FY 2000

Capital Programming/Infrastructure
3 indicators for FY 1999 and FY 2000

Consultation, Partnerships, Core Functions, and Advocacy
4 indicators for FY 1999 and 5 for FY 2000

Some of these indicators represent primary prevention that attempts to prevent a disease or condition from occurring (e.g., immunizations or controlling weight to prevent heart disease or diabetes). Others are "secondary preventive" in nature in that they attempt to reduce the morbidity and mortality associated with a disease or condition after it has occurred (e.g., reducing diabetic complications). Given that there will always be ten leading causes of death, the IHS focus is to intervene earlier in the processes that contribute significantly to mortality and morbidity, rather than target end point problems such as heart attacks and stroke. This is the essence of the public health approach that has resulted in the improvements in health status of American Indians and Alaska Natives.

Also included are indicators for assessing how consumers perceive the quality of and access to services, and how the stakeholders perceive the IHS performance in assuring adequate consultation and in advocating for the needs of American Indians and Alaska Natives. In addition, indicators have been developed addressing the Agency's effectiveness in building collaborative relationships with other organizations to address cross-cutting issues, to meet the accountability requirements of an Agency in the Department, and to improve the quality of worklife for employees.

A major challenge in selecting indicators for a one-year plan is that many of the processes necessary for intervening in complex chronic diseases require years or decades of focused efforts to realize significant progress, even with significant resource enhancements. Therefore, only a few of these indicators directly address health outcomes, while most are incremental activities that will lead to such outcomes over time. In addition, several directly embrace the principles and intent of the National Partnership for Reinvention and link directly with the HHS Secretary's Initiatives. Lastly, virtually all health problem-related indicators support the Healthy People 2000 and draft 2010 goals for the nation and all support the HHS Strategic Plan.

IHS Planning and Budgeting

The IHS Budget Planning Phase for FY 1998 began in 1996 following the IHS initial budget request to the Department of Health and Human Services (DHHS), continued with a formal submission to the Office of Management and Budget (OMB) in September 1996, and concluded with the submission to the Congress in February 1997. The IHS Director presented the Agency budget to Congress in March 1997. The Congressional review of the Agency budget included hearings that involved government and outside witnesses. Congress approved and passed the Agency appropriations act on November 14, 1997, after which OMB apportioned funds to the Agency for expenditures throughout the fiscal year.

Overview of FY 1998 Budget

The $2,459,787,000 FY 1998 budget of IHS is derived from four sources of revenue:

- Annual discretionary appropriations for the annual operation costs of various IHS health services delivery programs.
- Discretionary appropriations for the construction of health facilities (primarily hospitals and clinics) and for sanitation facilities (primarily water supply and waste disposal).
- Collections for services provided to American Indians and Alaska Natives who are also eligible for third party payments and reimbursements from other Federal, state, and private insurance programs.
- Mandatory five-year Diabetes funding. **(Chart 5)**

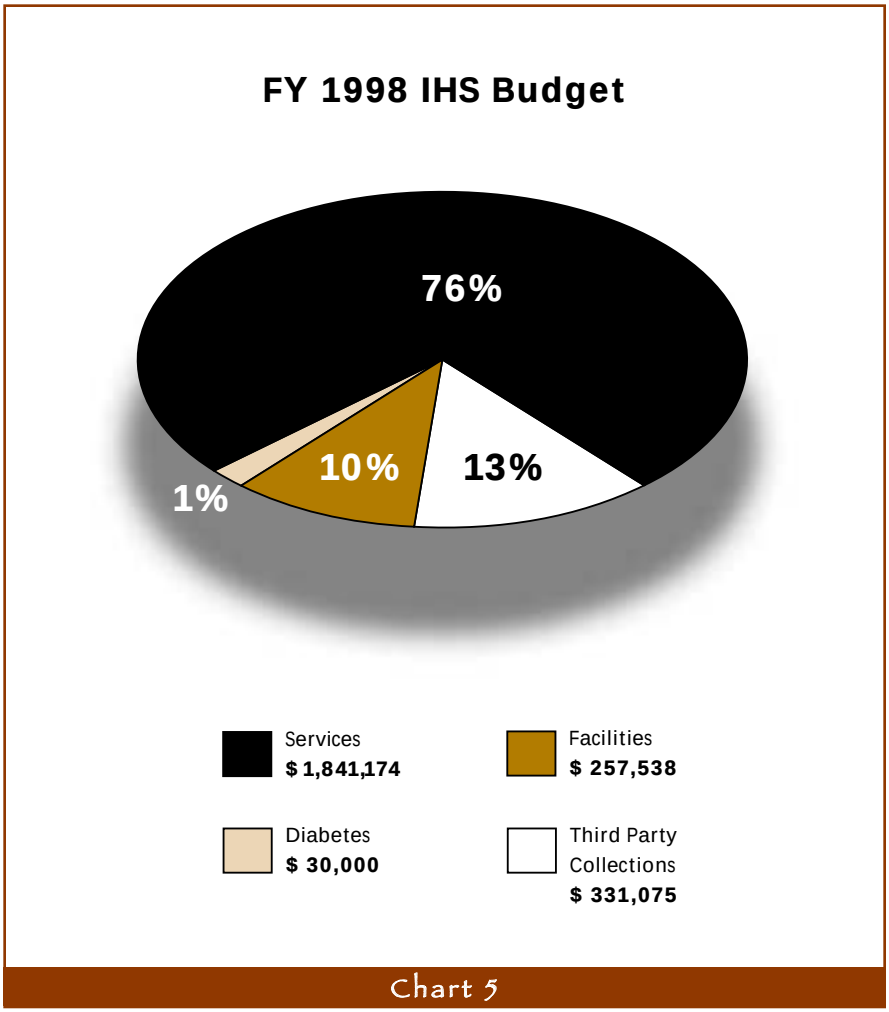


Chart 5

FY 1998 Revenue Highlights

Overall IHS resources increased to $2.46 billion in FY 1998, an increase of 4.5 percent over FY 1997. The Services appropriation encompassed 76 percent of total revenue; the Facilities appropriation made up 10 percent; Third Party Collections were 13 percent of the total revenues; and, the mandatory Diabetes funding provided 1 percent of the total in FY 1998. **(Chart 6)**

For FY 1998, the major sources of third party revenue included Medicare ($85.9 million), Medicaid ($212.0 million), and Private Insurance ($41.0 million). In addition, $4.7 million is collected in rent of quarters of health care staff to offset some of the costs of operation, maintenance, and improvement to staff quarters.

When controlled for medical price inflation, which was approximately 2.6 percent in FY 1998, the real purchasing power of the IHS revenues increased by only 1.9 percent.

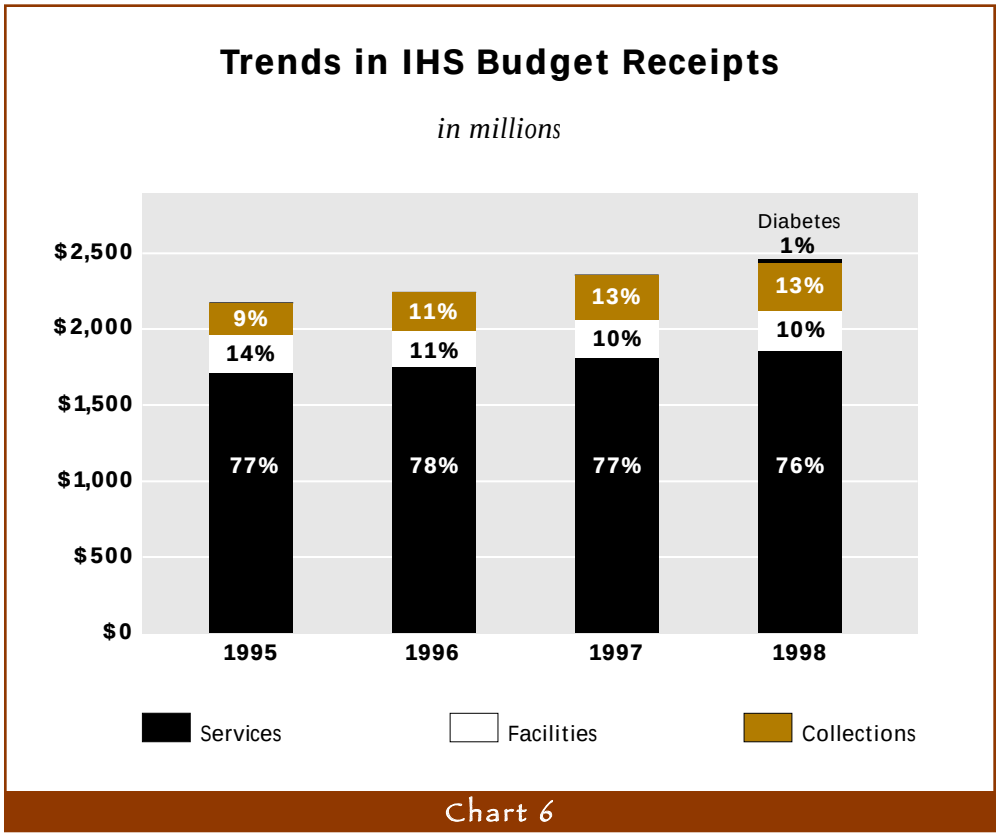


Chart 6

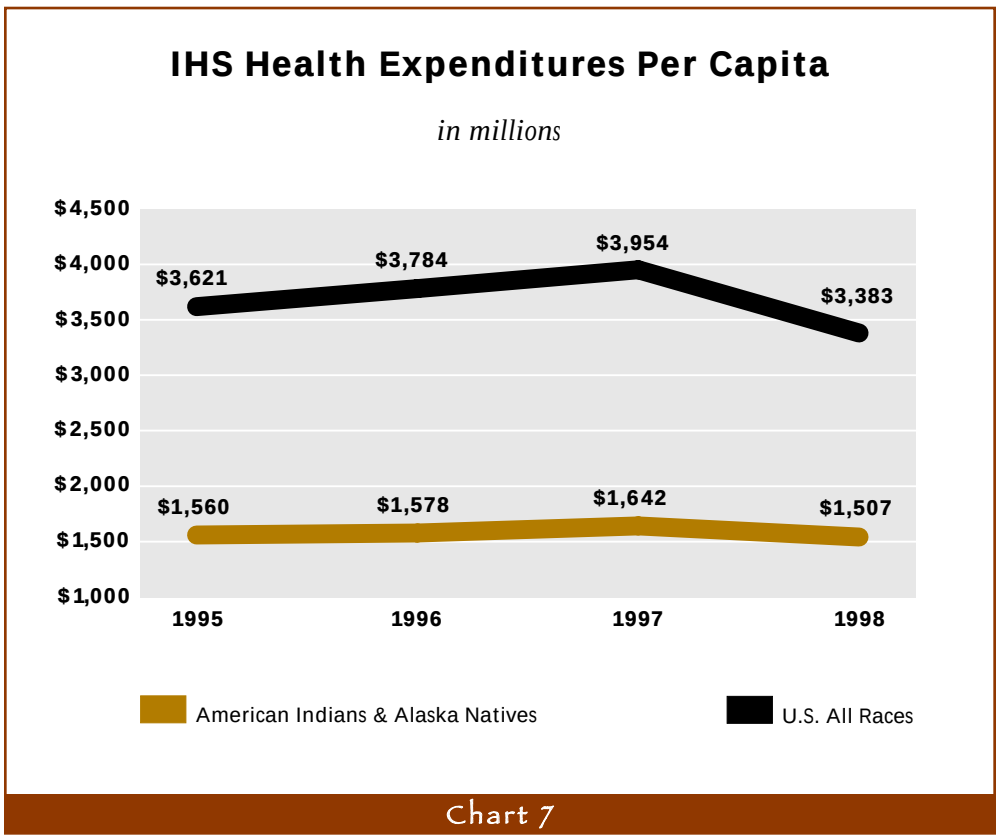


Chart 7

Per capita budgeted revenues relative to 1.46 million eligible American Indians and Alaska Natives residing in the IHS service areas decreased to $1,507 per person in FY 1998, a decrease of 0.8 percent from FY 1997. The U.S. rates also decreased to $3,383 per person in FY 1998, a decrease of 1.4 percent from FY 1997. **(Chart 7)**

The percentage of total IHS funding for Federally operated programs for administrative and general support functions was 13 percent in FY 1998.

Total funding for tribal contracts, compacts, grants, and other sources herein referred to as Self Determination Awards amounted to $920 million in FY 1998. **(Chart 8)**

IHS 1998 Program and Support Funds

Federal and Tribal Programs

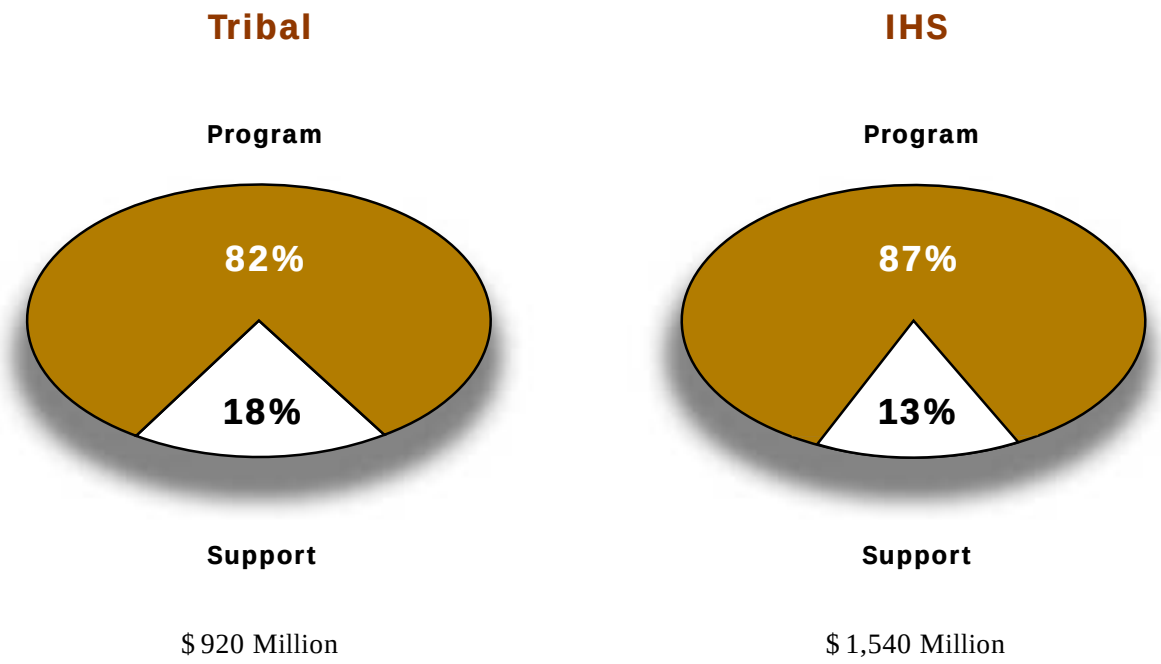


Chart 8

Health Programs

The twenty IHS budget line items are the initial point to view the IHS programs. Third party revenues and reimbursements for staff quarters have been applied to programs, where applicable. For each of these line items, there is a FY 1998 funding level, a brief purpose and background statement, and major accomplishments. The IHS is in the process of assessing its program accomplishments and performance measures based on GPRA requirements to determine which should be used to support future budget requests. The GPRA requirements have identified FY 1999 as the first budget year that Federal agencies will be developing annual performance plans.

The twenty IHS budget line items for FY 1998 follow.

Program: Hospital & Health Clinics

FY 1998 Program Level: $1,233,176,000

The primary accomplishment of the hospitals and clinics is the provision of millions of inpatient and ambulatory medical services to 1.4 million American Indian and Alaska Native users. In FY 1998, the IHS and tribal general hospitals admitted over 68,000 patients. Although the recent trend in inpatient services has been downward, both in the IHS and nationally, the IHS and tribal direct admissions increased by 0.4 percent between FY 1997 and FY 1998. The IHS and tribal direct health clinics provided about 7 million ambulatory medical services, a growth of 10 percent since FY 1996 and 93 percent since 1980.

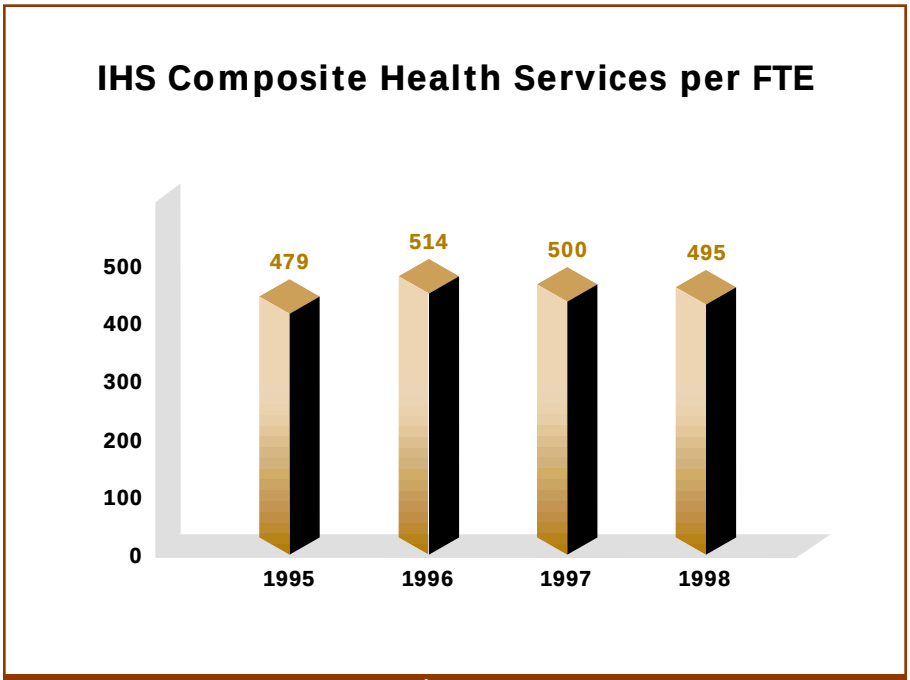


Chart 9

Composite Health Services per FTE

Employee productivity decreased slightly from FY 1997 to FY 1998 as measured by a composite health services index that includes hospital admissions, outpatient visits, dental services, nutrition services, environmental health services, and public health nursing visits. The decrease is in part related to incomplete reporting of workload data. **(Chart 9)**

Trends in Selected Patient Services

The number of health services provided to American Indians and Alaska Natives is an indicator of IHS program output and health status trends among the American Indian and Alaska Native population.

Accomplishments:

- Over 57,000 patients were admitted to IHS hospitals and over 11,000 patients to tribal hospitals in FY 1998. Admissions showed a small increase (0.4 percent) over FY 1997 but have been generally declining, which parallels the Nation-wide decline in hospitalization;
- Ambulatory services reflected a 10 percent increase from FY 1997 to FY 1998, reaching a level of approximately 7 million in the IHS (4.3 million) and tribal (2.7 million) facilities. The demand for ambulatory services exceeds space and staff capability and often results in backlogs and extended periods of outpatient waiting. **(Chart 10)**

IHS Trends in Selected Patient Services

	1995	1996	1997	1998
IHS Direct Admissions	56,796	55,656	56,219	56,000[2]
All Other Admissions	28,088	31,242	27,384[1]	n/a[3]
IHS Direct Ambulatory Medical Visits	4,156,146	4,108,800	4,224,095[1]	4,200,000[2]
All Other Ambulatory Medical Visits	2,165,803	2,718,241	2,643,158[1]	n/a[3]
Dental Services	2,058,032	2,400,646	2,052,076	2,123,895
Environmental Services (Estimated)	163,200	166,400	169,800	173,200
Nutrition Services	234,250	237,464	237,464[4]	237,464[4]
PHN Visits	381,350	692,900[5]	339,283	321,434
CHR Contacts	3,611,113	3,884,867	3,079,399[6]	2,280,000[6]
Homes	11,889	15,913	16,103	14,373

1 Preliminary—awaiting FY 1997 final data to be obtained after computer system conversion. **2** Estimated—awaiting FY 1998 final data. **3** FY 1998 CHS workload lags behind Direct workload because CHS payments occur well into the next fiscal year. **4** Estimated for 1994. Nutrition services data not compiled in 1997. Estimated for 1998 because compilation is not yet complete. **5** This workload count was tabulated during a period of transition to a new reporting system and may include multiple years of data. **6** The decrease is due to tribal programs taking IHS administrative funds through tribal shares and not submitting CHR workload data.

Chart 10

Diabetes

IHS Diabetes Program
FY 1998 Program Level: $7,700,000

Special Diabetes Grants for Indians
FY 1998 Program Level: $30,000,000

Funds to the IHS Diabetes Program support 19 model diabetes programs/centers of excellence at local community levels located in 23 different I/T/U sites. In addition, these funds support 12 Area Diabetes Control Programs and the National Diabetes Program office.

IHS also administers the Grants for Special Diabetes Programs for Indians (SDPI) authorized by Section 330C, of the Public Health Service Act, as amended. Approximately $30 million per year for a total of 5 years was made available to IHS facilities, Indian tribes/tribal organizations and urban Indian organizations. The grant funds are being used for diabetes prevention and treatment services for American Indians and Alaska Natives.

Diabetes continues to grow in epidemic proportions in Native American communities. In some American Indian communities, up to half of the adults have diabetes. Diabetes is 4-8 times more common in American Indians compared to the general U.S. population.

Accomplishments:

- A national I/T/U workgroup (established to provide tribal consultation regarding the SDPI) reviewed the diabetes grants process and made recommendations to the IHS Director. All funds for Year 01 grant activities have been distributed with a total of 286 non-competitive grants awarded and a process developed for Year 02 reporting and funds distribution.
- An IHS/CDC interagency agreement is now in place. Methodologies for assessing prevalence of diabetes by area, service unit, gender and age groups have been developed and automated; a methodology for identifying newly diagnosed diabetes is under development; and a drug utilization review in I/T/U settings of two new diabetic oral agents is currently in process.
- Provided and expanded the surveillance of diabetic complications and measurements of quality care outcomes through the IHS Diabetes audit process and RPMS.
- New diabetes patient educational resources were made available for patients, providers and community programs; a basic training program for health professionals on Type 2 diabetes was developed and a train the trainers workshop to develop faculty to teach this curriculum was offered.

Program: Dental

FY 1998 Program Level: $65,517,000

Because oral diseases seldom result in death or severe disability, the importance of treating and preventing them is often overshadowed by other health priorities, particularly in times of declining per capita funding for health care. However, studies conducted within Indian communities have demonstrated that oral health conditions profoundly influenced their quality of life, including their ability to attend school, work, sleep, eat, and socialize. Thus, it is not surprising that during FY 1998, dental care was identified by consumers across IHS Areas as one of the five highest priorities in developing the FY 2000 budget request. While providing clinical care is the dental program's highest priority, in recent years both the percentage of the population seen annually and the total number of services provided have declined. The reason for these declines are multifaceted but include:

- Absorbing mandatory cost increases including three different pay increases for Commissioned Corp Dental Officers.
- High turnover and vacancy rates for dentists because of lack of pay parity with private sector opportunities.
- Declining clinical productivity of providers because of inexperience of staff and loss of dental public health infrastructure (a 65% reduction) to support orientation and guidance in clinical efficiency and effectiveness.

In light of these trends and contributing problems, IHS is working to assure the capability to support staff development, efficient and effective dental clinic management, and to implement effective oral health promotion/disease prevention activities with a reduced dental public health infrastructure has become essential. To achieve this goal, self-directed work groups have been formed composed of remaining dental staff from Headquarters and Area Offices, along with local dental program staff.

Accomplishments:

- Dissemination of a completely revised Oral Health Program guide to local IHS, Tribal and Urban program clinics.
- Development of alternative "state-of-the-science" treatment regimens and pilot sites to address periodontal disease in diabetics and children's dental decay.
- Development of a protocol and initial training of field staff for the IHS-wide FY 1999 survey of oral health status and treatment needs.

Program: Mental Health

FY 1998 Program Level: $39,379,000

The Indian Health Service (IHS) Mental Health and Social Service Program is a community oriented clinical and preventive service program. While improvements have been made in the physical health status for Native Americans, behavioral health problems (substance abuse, suicide, family violence, child abuse, depression, diabetes) have continued to increase. The workload reported by field staff indicate serious mental health and social problems in many American Indian and Alaska Native communities on reservations and in urban settings.

Accomplishments:

- Continue to fund 12 tribal child abuse prevention and treatment programs.
- Implemented with SAMHSA a number of activities including the implementation of the 9 Circles of Care Initiative Grants, 5 Children's Mental Health Service Grants to Indian Country and Starting Early/Starting Smart for early childhood prevention programs. Also two studies, one to determine American Indian/Alaska Native access to services and planning participation in the Mental Health Block Grants to states, and the other study is to determine the need for an Adolescent Substance Abuse/Mental Health RTC in Alaska. In year one of these multi-year programs, SAMHSA will make available approximately $12 million dollars in grant funds for these activities and $1 million in technical assistance funds.
- Developing several new and continuing MOA's with the Office for Victims of Crime for colposcopic exam equipment to enhance clinical and forensic examinations of child abuse victims for funding a forensic clinical psychologist at Wind River for 3 years and for Child Protection Team trainings.

Program: Alcohol and Substance Abuse

FY 1998 Program Level: $91,782,000

Presently, the IHS funds approximately 300 American Indian and Alaska Native alcoholism/substance abuse programs that provide a multitude of treatment and prevention services to rural and urban communities. Alcoholism and substance abuse continue to be a leading contributor to health problems among American Indians and Alaska Natives. Although alcoholism age-adjusted death rates have dramatically decreased from 59.0/ 100,000 in 1980 to 41.6/100,000 in 1995, the alcoholism mortality rate of American Indians and Alaska Natives (when adjusted for miscoding of Indian race on death certificates) is 9.5 times the U.S. all races rate. It is widely held that the abuse of alcohol, either directly or indirectly, affects 95 percent of American Indians and Alaska Natives.

Accomplishments:

- Continuation of primary care provider training workshops to enhance professional skills in addiction, prevention, intervention and treatment skills. The IHS developed a special module for public health nurses. Training 24 physicians and other primary care providers was conducted through a contract with the Clinical Support Center.
- The Chemical Dependency Management Information System is now fully on line. Support for two software enhancement projects provides further integration and coordination of assessment, treatment planning, and case management.
- Ten of the 12 IHS Areas have operating Youth Regional Treatment Centers, with the California Area being the latest to establish their centers.

Program: Contract Health Services

FY 1998 Program Level: $373,373,000

The IHS Contract Health Services (CHS) program supplements the health care resources available to eligible American Indian and Alaska Native people with the purchase of medical care and services that are not available within the IHS direct care system. The IHS purchases both basic and specialty health cares services from local and community health care providers, including hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and patient transportation services such as ground and air ambulance. The CHS program also supports the provision of care in IHS and tribally operated facilities, such as specialty clinics, e.g., orthopedics and neurology, and referrals to specialists for diagnostic services.

Accomplishments:

- The IHS pays the residual amounts of medical claims for American Indian and Alaska Native patients with authorized referrals to private providers. The IHS paid 46.0 cents on each dollar billed to the IHS fiscal intermediary in FY 1998 compared to 48.7 cents on each dollar billed in FY 1997. The IHS held the line on inflation from FY 1997 to 1998 by having its costs to billed charges decrease by 2.7 cents.
- Approximately 54 percent of charges billed to the IHS were paid by third party payors in FY 1998, up from 52 percent in FY 1997. This represents savings from contracts, discounts, or unallowed charges. Together these represent $205 million billed charges saved in FY 1998.
- The IHS paid a net amount of $1,046 per inpatient day after third party reimbursements and other discounts had been applied to the bills charged. The IHS managed care practices and other cost controls contributed to counteract cost increases that are caused by medical inflation.

Catastrophic Health Emergency Fund

A Congressionally authorized Catastrophic Health Emergency Fund (CHEF) of $12 million, funded within the IHS base appropriation, provides a complimentary resource that enhances local CHS operating budgets for certain high cost cases. In FY 1998, the threshold was $19,000 based on the change in the annual consumer price index as mandated by congressional legislation. The $12 million CHEF budget funded approximately 800 cases in amounts ranging from $5,000 to $558,000.

Program: Public Health Nursing

FY 1998 Program Level: $28,198,000

The primary focus of Public Health Nursing* (PHN) is on health promotion and disease prevention in the community. The PHN practice includes the provision of consultation to community health representatives, therapeutic services in the home, counseling, education, coordination of patient services and advocacy at the community level. The distinguishing characteristics of the services provided is its focus on the health needs of specific population groups, especially those most vulnerable or those who are at high risk for disease, disability or other health impairments.

Accomplishments:

- Implemented first annual PHN education update.
- Implemented PHN specific Patient Care Component form for unique PHN data collection.
- Improved workload data retrieval, especially in area of Health Promotion/Disease Prevention.

* *Clinical and ambulatory nursing included in Hospitals & Health Clinics budget line item*

Program: Health Education

FY 1998 Program Level: $8,932,000

The goal of the IHS Health Education program is to support American Indian and Alaska Native community's capacity to build and to promote healthy lifestyles with the appropriate use of health services. The program also participates in developing and managing health education programs to meet their communities health needs. The Health Education program is committed to the vision of strong, effective communities that support Indian families in raising healthy Indian children.

Accomplishments:

- Expanded a national patient education project from 6 sites to 20 sites which included Federal and Tribal health programs.
- Continued efforts to promote comprehensive school health education in Indian schools-funds were provided to 15 new school sites to implement school health education programs.
- Provided patient education training for physicians, nurses and health educators.
- Began preliminary development of process to meet the new JCAHO standard on Health Promotion/Disease Prevention.

Program: Community Health Representatives

FY 1998 Program Level: $44,312,000

The Community Health Representative (CHR) program plays an important role in the successful implementation of IHS/tribal health promotion/disease promotion initiatives. The programs, well positioned within their communities, provide the needed educational and related services that can result in healthier lifestyles for their people. Considered an effective health care program, the CHR program has established an efficient network system to deliver initiatives for health promotion and disease prevention to American Indians and Alaska Natives.

Accomplishments:

- About 2.3 million client-patient contacts were made which is a decrease from 3.1 million client-patient contacts in FY 1997**;
- Revised the CHR 3 Week Basic Training curriculum which emphasized the Public Health concept. Major revisions were made to the training curriculum. Sections were expanded and updated with current information as well as new sections added—Documentation, Elder Care, Mental Health Problems.
- Developed a Refresher Training curriculum which also emphasized the Public Health concept allowing the participants to apply these concepts in the work they do as a CHR. Both curricula have been tested during 3 sessions of the CHR 3 Week Basic Training and 3 sessions of the CHR Refresher Training. Recommendations were made and necessary changes were made. The curricula became available to the CHR tribal programs in January 1999.

** *The decrease in client-patient contacts and decrease in the number of CHRs successfully completing the CHR 3 week basic training is due to the increase in tribes taking their shares through Title I contracts or Title III compacts and opting not to fund the Uniband contract that provides their Community Health Representative Information System (CHRIS) II reports; therefore, their data are not included in the Annual report of the CHR program.*

Program: Immunization Programs—Alaska

FY 1998 Program Level: $1,328,000

The Viral Hepatitis and Immunization Programs of the Alaska Native Tribal Health Consortium were developed to address high rates of hepatitis A and B, and Haemophilus influenzae type b (Hib) in Alaska Natives. The programs apply research on the epidemiology of these infections in Alaska Natives to develop successful vaccination and treatment programs that have potential to control or eliminate these and other vaccine-preventable diseases.

Accomplishments:

- Hepatitis B immunization of most Alaska Natives with ongoing immunization of more than 96% of Alaska Native newborns resulting in a decrease in acute hepatitis B incidence from 215 to less than 5 per 100,000, and elimination of the hepatitis B carrier state in children less than 10 years of age in at least one region.
- The first demonstration that semi-annual screening of hepatitis B carriers for alpha fetoprotein levels significantly improved 5 and 10 year survival for liver cancer.
- Increased 2-year-old (4-3-1) immunization rates in Alaska Native tribal programs from 49-73 percent in 1990, to 70-99 percent in 1997-98 with rates in 7 of 11 programs greater than 80%.
- Use of a sequential Hib vaccine schedule and immunization rates of more than 90 percent in 2-year-old children led to decrease from 8 (1997) to 3 (1998) Hib cases in children less than 5 years of age.

Other Programs

Program: Urban Indian Health

FY 1998 Program Level: $25,288,000

The 1990 U.S. census data indicated that approximately 56 percent of the total U.S. American Indians and Alaska Natives live in urban areas. The urban program provides health care and referral services to urban American Indians and Alaska Natives through twelve clinics and 22 community services, alcohol and substance abuse, AIDS, mental health and adult alcohol inpatient programs.

Accomplishments:

- Provided an estimated 611,000 patient care contacts in 1998, a decrease from last year's estimate attributable to more accurate reporting.
- Entered into an Interagency agreement between the Office of Minority Health (OMH) and the IHS to promote the delivery of primary care services to Urban American Indian and Alaska Natives through the Seattle Indian Health Board (SIHB) using a cultural appropriate residency training model.
- Entered into a cooperative agreement between the National Council of Urban Indian Health (NCIUH) and the IHS for the purpose of Urban Indian Health program advocacy and education.
- Secured a $1.5 million set aside funding for diabetes services.

Program: Indian Health Professions

FY 1998 Program Level: $28,720,000

A critical element of The Indian Health Care Improvement Act (IHCIA), Public Law (P.L.) 94-437, as amended, is Title I, Indian Health Professions. Title I and Title II provide three interdependent objectives: (a) enable American Indians and Alaska Natives to enter the health care professions through a carefully designed system of preparatory, professional, and continuing educational assistance programs; (b) serve as a catalyst to the development of Indian communities by providing educational opportunities and enabling American Indian and Alaska Native health care professionals to further Indian self-determination in the delivery of health care; and (c) develop and maintain American Indian psychology career recruitment programs as a means of encouraging Indians to enter the mental helath field. The training of American Indian and Alaskan Native people serves as a catalyst to the development of Indian communities, with the resultant increase in the general health status of American Indians and Alaska Natives.

Accomplishments:

Program by Section	**Awards**
Section 102: *Recruitment Program*	4
Section 103: *Preparatory (Scholarship) Program*	194
Section 104: *Scholarship Program*	377
Section 105: *Extern Program*	250
Section 108: *Loan Repayment Program*	248
Section 110: *Tribal Recruitment & Retention Program*	7
Section 112: *Nursing Program*	8
Section 114: *INMED Replication Program*	1
Section 120: *Tribal Matching Grants*	4
Section 217: *Indians into Psychology*	3

Program: Tribal Management

FY 1998 Program Level: $2,348,000

The Indian Self-Determination Act (ISDA) authorized funding to develop the capacity of Tribes to manage health care programs. Congress simplified the process by which Tribes may assume management of IHS programs and created a model agreement by passing the ISDA amendments referenced in P.L. 100-472, P.L. 103-413 and P.L. 104-109. These amendments provide maximum participation and support of the right of Tribes to control, manage, and operate their own health programs.

Accomplishments:

- Increased the number of tribally operated health programs during the last 10 years. In 1988, $217 million, (22 percent) of the IHS services programs were delivered by Indian Tribes while in FY 1998, it was approximately $920 million, (43 percent).
- Awarded 30 new grants and 2 competing continuing grants in FY 1998.

Program: Direct Operations

FY 1998 Program Level: $47,386,000

Management and administrative support constitute a critical element in the delivery of health care to American Indians and Alaska Natives. No unit of health service is delivered without substantial administrative support from different disciplines, i.e., finance, supply management, personnel, equipment, training, advocacy, leadership, public health support, etc.

Accomplishments:

- Consulted extensively with tribes in the hiring of three key positions: Directors of Albuquerque, Portland, and Tucson Areas. As a result, applicants knowledgeable of both the Federal requirements for the position and the unique cultural requirements of each IHS Area were appointed to these Senior Executive Service level positions.
- Continued the shift to a more corporate-oriented way of conducting business using the business plan developed together with Indian leaders and worked on such initiatives as preparation for the new Medicare hospital prospective payment system, which will require transition from encounter rate billing to itemized billing.
- Continued "local-level-up" approach to identifying health care priorities, budget formulation, and establishing GPRA performances measures including expanded participation of tribal programs in GPRA efforts.

Program: Self-Governance

FY 1998 Program Level: $9,106,000

The Indian Health Care Improvement Act amendments of 1992 provided IHS the authority to fund tribal self-governance demonstration projects and to establish within the IHS an Office of Tribal Self-Governance. The Office of Tribal Self-Governance administers the self-governance projects including negotiation of compacts and Annual Funding Agreements (AFAs) with the Tribes.

Accomplishments:

- In FY 1997 negotiated 34 Compacts and 48 Annual Funding Agreements totaling $350 million.
- In FY 1998 negotiated 39 Compacts and 55 Annual Funding Agreements totaling $410.5 million and also awarded 7 planning grants.
- For FY 1999 negotiated 42 Compacts and 59 Annual Funding Agreements (AFA) totaling $452.9 million. The 59 AFAs represent 254 tribes or 45.7% of the federally recognized tribes and over 31% of the total IHS user population.

Program: Contract Support Cost

FY 1998 Program Level: $168,702,000

Funding for Contract Support Costs (CSC) provides to Tribes the costs incurred in the operation of Self-Determination contracts and compacts authorized the Indian Self-Determination Act (ISDA). By definition, these costs to the tribal programs exceed the amount spent by the Agency at the location of service; therefore, these costs must be a supplement to the direct program funding provided, in order to maintain an equitable opportunity for Tribes who choose to operate programs under this legislative authority. The largest component of CSC is indirect costs (approximately 80 percent).

Accomplishments:

- Awarded in FY 1998, $168.7 million to Tribes to provide necessary administrative and related support functions for direct tribal program operations exceeding $600 million.
- Transferred to Tribes $7.5 million from the Indian Self-Determination Fund (ISDF) for new and expanded programs in FY 1998.

Facilities Programs

Program: Maintenance & Improvement

FY 1998 Program Level: $44,134,000

A total of $39,434,000 was appropriated in 1998 for maintenance and improvement of health care facilities. An additional $4,700,000 million was collected in quarters return funds to maintain staff quarters. The slight decrease in funding from FY 1997 to FY 1998 was due to non-recurring emergency supplemental funds of $129,000 in FY 1997.

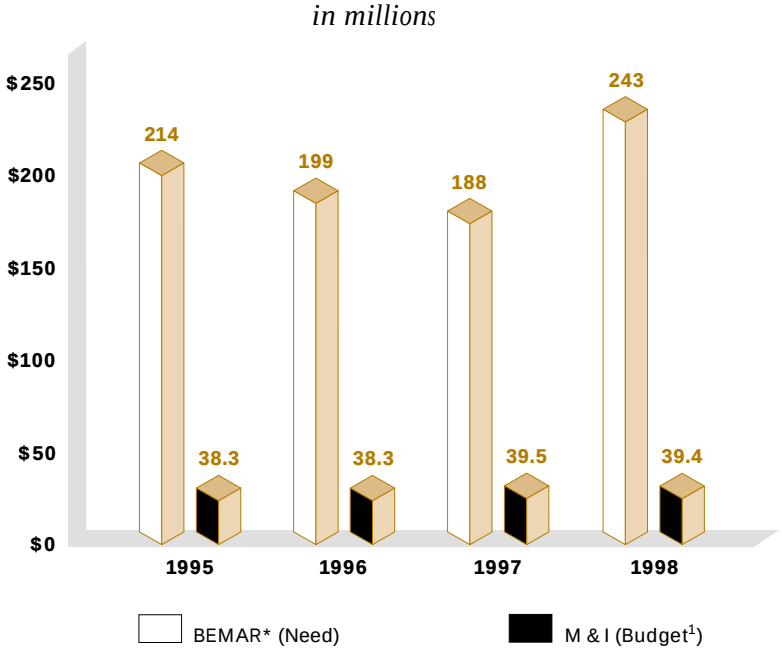


Chart 11

Maintenance and Improvement program objectives include:

- Providing routine maintenance in the IHS and tribally owned and operated buildings and grounds; and,
- Achieving compliance with building codes and accreditation standards of the JCAHO or other accreditation bodies.

Accomplishments:

- For routine maintenance and projects: approximately $23,992,000 was provided to the IHS Areas for daily maintenance activities and projects to maintain the current state of health care facilities.
- Approximately $12,442,000 was provided to the IHS areas to reduce the identified Backlog of Essential Maintenance, Alteration and Repair (BEMAR) deficiencies.
- For Environmental Compliance, approximately $3,000,000 was provided to allow most IHS health care facilities to receive full environmental assessments. Tribally owned health care facilities will receive assessments upon request by the tribe.

Program: Sanitation Facilities Construction

FY 1998 Program Level: $89,082,000

The Indian Sanitation Facilities Act, P.L. 86-121 authorizes IHS to provide essential sanitation facilities to Indian homes and communities. The IHS Sanitation Facilities Construction (SFC) program, an integral component of the IHS disease prevention activity, carries out those authorities, using funds appropriated for sanitation facilities construction to provide potable water and waste disposal facilities for American Indians and Alaska Natives.

Accomplishments:

- Provided essential sanitation facilities to 4,529 new/like-new Indian homes and to 1,937 first service existing homes. With additional funds from Housing and Urban Development (HUD), IHS also provided sanitation facilities to 1,318 new HUD-sponsored housing units.
- The staff also assisted Tribes by providing engineering services to many other Tribes that independently funded their own projects.
- Received approximately $42.0 million in SFC contributions from other Federal agencies, States, and Tribes. Combined with SFC appropriation, the total SFC program has funded approximately 477 projects in FY 1998.

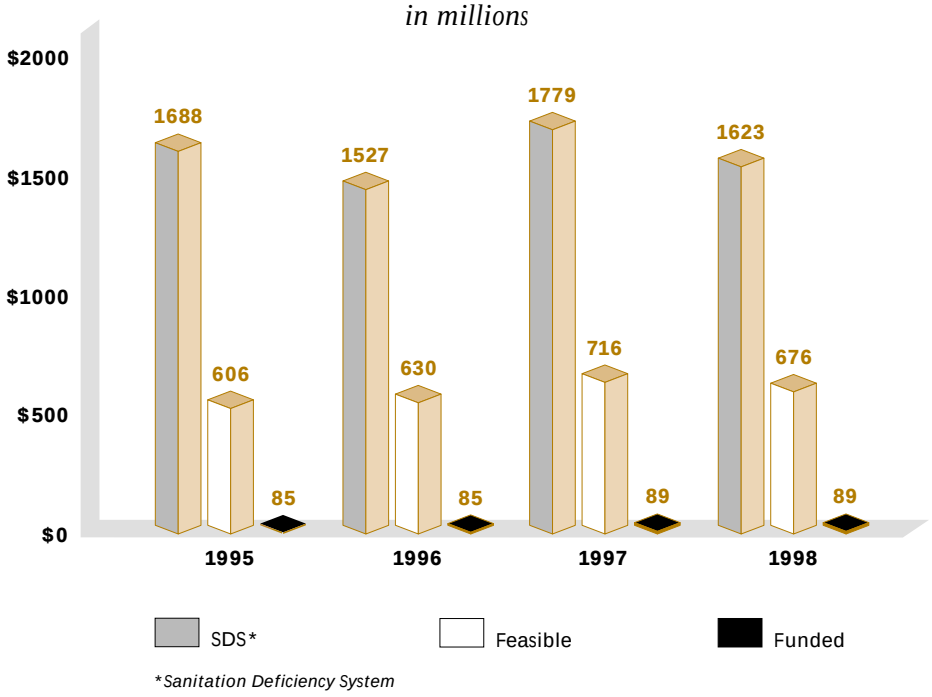


Chart 12

Program: Health Care Facilities Construction

FY 1998 Program Level: $14,400,000

The objectives of the IHS Health Care Facilities Construction program are to enhance IHS health care delivery capacity by providing for optimum availability of functional, well-maintained IHS and tribally-operated health care facilities and providing adequate staff housing at IHS health care delivery locations if no suitable housing alternative is available. The IHS capital improvement program, funded through this Health Care Facilities Construction budget activity, constructs health care facilities and staff quarters, and provides new and replacement dental units.

Accomplishments:

- Provided $13,900,000 to begin construction of the Hopi health center, located in Polacca, Arizona.
- Provided $500,000 for new or replacement dental units.

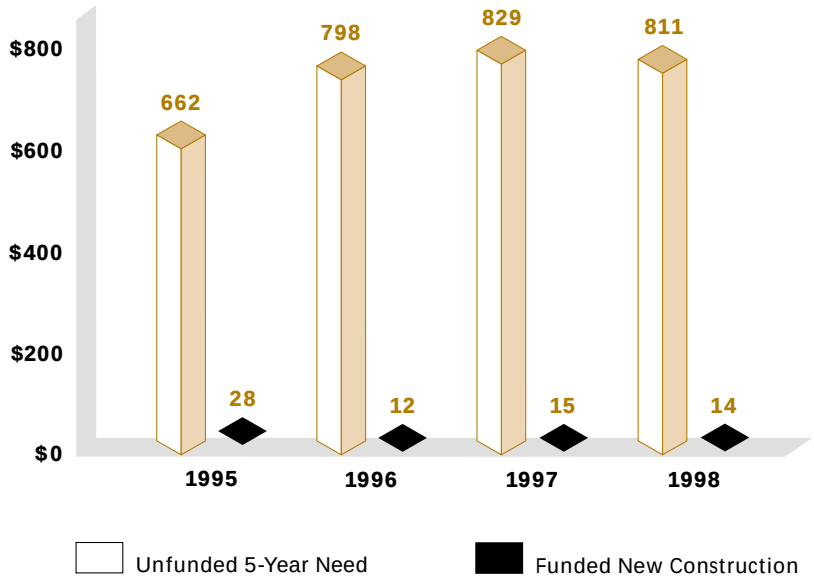


Chart 13

Program: Facilities and Environmental Health Support

FY 1998 Program Level: $101,617,000

Indian Health Facilities programs, managed at Headquarters and carried out by Area and service unit staffs, provide an array of health care facilities and staff quarters construction, maintenance, and operation services; as well as community and institutional environmental health, injury prevention, and sanitation facilities construction services. Services are delivered directly by Federal employees or by tribal contractors.

Accomplishments:

Facilities Support

- Provided Area offices and service units with staff to operate and maintain the health care buildings and grounds, and to service medical equipment. This responsibility includes an inventory of approximately $224 million of medical equipment, 49 hospitals, 195 health centers, more than 2,100 staff quarters, 289 smaller health stations and satellite clinics, 8 school health centers, and 7 youth regional treatment centers.

Environmental Health Support

- Provided sanitation facilities to Indian Homes and communities by implementing approximately 2,818 projects to provide sanitation facilities, funded personnel to manage the injury prevention program, and performed environmental health services; and,
- Worked with other agencies to secure additional funding to initiate projects to provide sanitation facilities for 1,318 HUD housing units, 297 Bureau of Indian Affairs units, 4,232 new/like-new housing units, and 8,526 existing housing units;

Office of Environmental Health and Engineering

- Funded personnel who have management responsibilities for National policy development and implementation, budget formulation, congressional report preparation, health care facilities construction, and other national program related duties.

Program: Equipment

FY 1998 Program Level: $13,005,000

The IHS medical equipment inventory is approximately $244 million in laboratory, x-ray, and biomedical equipment. Accurate diagnosis and effective therapeutic procedures depend on using safe and effective equipment to assure the best possible health outcomes. The average life expectancy for the current medical inventory is approximately 6 years depending on the intensity of use, maintenance, and technical advances. In addition, this activity funds equipment for replacement clinics built by Tribes using non-IHS funding sources.

Accomplishments:

- The equipment program distributed approximately $10 million to existing health care facilities to replace and purchase new medical equipment.
- A total of approximately $3.0 million to equip new health care facilities being funded with non-IHS funds was divided by fifty-one tribal applicants.
- IHS received medical equipment from the Department of Defense's TRANSAM 97 program which delivered a total of $12 million of excess equipment to IHS service units and tribes.

Other Statutory Requirements

Federal Managers' Financial Integrity Act of 1982 (FMFIA)

In 1997, IHS conducted management control reviews under Section 2 of FMFIA, and no material weaknesses were identified. The IHS is continuing to revise the Management Control Plan and will integrate efforts to meet the requirements of the FMFIA with other efforts to improve effectiveness and accountability. The IHS obtains its primary finance and accounting systems from the Division of Financial Operations, Program Support Center, HHS, which reports independently on Section 4 compliance of the FMFIA. A copy of the IHS' annual assurance statement to the Assistant Secretary for Management and Budget, required under FMFIA, is included in this year's Accountability Report on page 35.

Chief Financial Officer Act

These financial statements have been prepared to report the financial position and results of operations of the Indian Health Service (IHS), as required by the Chief Financial Officers' Act of 1990. They have been prepared from the books and records of the IHS in accordance with the form and content for entity financial statements specified by the Office of Management and Budget (OMB) Bulletin 97-01 and the IHS accounting policies.

Prompt Payment Act

The Division of Financial Operations (DFO) issues an annual report which tracks the performance of not only the IHS but also other customers including the Office of the Secretary, the Administration of Aging, and the Program Support Center. For FY 1998, DFO reported that 97.4 percent of invoices were paid on time, exceeding the Federal government's goal of 95 percent.

Inspector General Act (Management Responsibilities)

The Office of Inspector General (OIG) and the General Accounting Office (GAO) reports are processed according to IHS Circular 95-12 related to the Chief Financial Officer Act (CFOA), Public Law 101-576, financial statement audits, and FMFIA management controls. The circular prescribes policies and procedures for preparing responses to audit reports. There are report formats for comments on draft reports, final reports, and semi-annual follow-up reports.

Federal Civil Penalties Inflation Adjustment Act (CMP)

The IHS does not have any issues relating to the CMP.

Federal Financial Management Improvement Act of 1996 (FFMIA)

The results of the auditors' test of compliance disclosed no instances of noncompliance with laws and regulations that are required to be reported under Government Auditing Standards and OMB Bulletin 93-06.

The Clinger-Cohen Information Technology Management Reform Act (ITMRA)

The Clinger-Cohen Information Technology Management Reform Act, P.L.104-106, Section 5001 (as amended), repealed the central authority of the Administrator of the General Services Administration. The Act requires each executive agency to institute a program and investment control, and exercise authority to conduct acquisition of information technology. A Chief Information Officer is to be designated with duties and qualifications. The Director, Division of Information Resources, serves as the IHS Chief Information Officer. A variety of reporting requirements are integral to the Clinger-Cohen process, and serve to ensure that Act's requirements are proactively applied to the information technology activities of the agency.

Debt Collection Improvement Act of 1996 (DCIA)

The Program Support Center (PSC) provides debt collection services to IHS under the Debt Collection Improvement Act (DCIA) of 1996 and various laws and regulations associated with debt collection. The PSC has applied to Treasury to become a designated Debt Collection Center as prescribed by Treasury and the DCIA. The IHS report on "Receivables Due from the Public" for FY 1998 indicates a 89 percent collection rate on receivables which totaled approximately $254 million. This is a 19 percent increase over the FY 1997 collection rate of 70 percent on receivables totaling an estimated $149 million The debts reported consist primarily of Area Office medically related debts, and headquarter debts associated with Scholarship service pay-back defaults. Debts delinquent are referred by the PSC to the Treasury Offset program for administrative offset, a private collection agency for further collection action, reported to consumer reporting agencies, and if determined necessary referred to the Department of Justice for judgment and enforced collection. For debtors having few or no assets, a determination is made on the individual's ability to pay and whether it is feasible or in the government's best interest to continue to collect.

Financial Statements Interpretation

In FY 1998, the Department of Health and Human Services established revised accounting standards permitting the issuance of additional financial statements. The IHS Financial Statements for the period ending September 30, 1998 now include a Statement of Budgetary Resources and a Consolidated Statement of Changes in Net Position. The charts and tables in this report are based on a combined Federal and Tribal Gross Cost in the Statement of Net Cost.

The financial statements have been prepared to report the financial position and results of operations pursuant to the Chief Financial Officers Act of 1990. The financial statements have been prepared from the books and records of the Indian Health Service; however, the elements in the accounting system used to monitor and control funds are different from those used to prepare the financial reports.

The financial statements should be interpreted from the perspective that the Indian Health Service is a component of the Federal Government. Contingent liabilities are not covered by immediate cash reserves and will be liquidated upon actual resulting liability and enactment of appropriations by Congress.

Expense Highlights

FY 1998 Expenses by Object Class

The IHS differs from most Federal programs by providing direct services to the people they serve. Some of the services IHS provides includes operating hospitals and clinics, providing dental and mental health services, and providing sanitation facilities for American Indian and Alaska Native homes.

The largest IHS expense is Grants ($1,017M) which represents tribally compacted and contracted services under

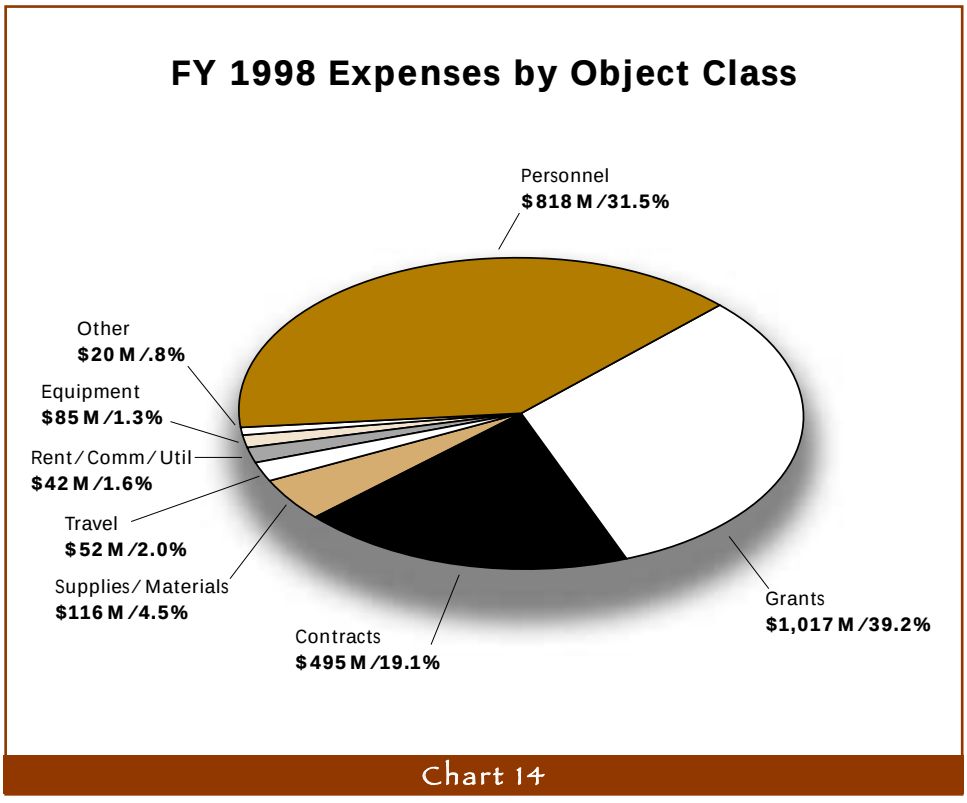


Chart 14

Public Law 93-638. With over 14,500 employees, Personnel is another large expense ($818M). Approximately 87 percent of IHS personnel is located at the service unit level, providing direct services. The category "Other" includes Printing and Reproduction, Insurance Claims and Indemnities, Bad Debt, and Property Depreciation (For more detailed information, see section: Notes to Accompanying Charts, note for Chart 15). **(Chart 14)**

Trends in Expenses by Object Class

Trends in Expenses by Object Class relate the changes (based on a combined Total Federal and Tribal Gross Cost on the Net Cost Statement) in expenses for FY 1995 through FY 1998. In FY 1998, IHS consolidated all tribally compacted and contracted services under Grants, resulting in a sharp increase in the Grants category and a noticeable decrease in Contractual Services. In addition, the increase from $2 million to $20 million for the Other category is the result of property depreciation being reported for the first time in FY 1998. **(Chart 15)**

Full-Time Equivalents

The Full-Time Equivalent (FTE) level in FY 1998 was 14,516 FTEs, an increase of 51 FTEs over the FY 1997 level of 14,465 FTEs. Expenses for IHS personnel were 31.5 percent of the total IHS expenses based on the Federal and Tribal Gross Cost on the Statement of Net Cost. **(Chart 16)**

Trends in Expenses by Object Class

in millions

Categories	1995		1996		1997		1998	
Personnel	$891	41.3%	745	33.1%	$826[1]	32.4%	$818	31.5%
Travel	52	2.4%	46	2.0%	48	1.9%	52	2.0%
Supplies/ Material Comm/Util	60	2.8%	80	3.6%	97	3.8%	116	4.5%
Rents	42	1.9%	43	1.9%	40	1.6%	42	1.6%
Equipment	69	3.2%	81	3.6%	83	3.3%	35	1.3%
Contracts	903	41.9%	738	32.8%	851	33.3%	495	19.1%
Grants	114	5.3%	516	22.9%	605	23.7%	1,017	39.2%
Other*	24	1.1%	2	0.1%	2	0.1%	20	0.8%
Totals	$2,155	100.00%	$2,251	100.00%	$2,552	100.00%	$2,595	100.00%

**See section: Notes to Accompanying Charts.* [1] Includes Imputed Personnel Costs of $71.3M

Chart 15

Full-Time Equivalent Employees

Personnel Costs as a Percent of Total Costs

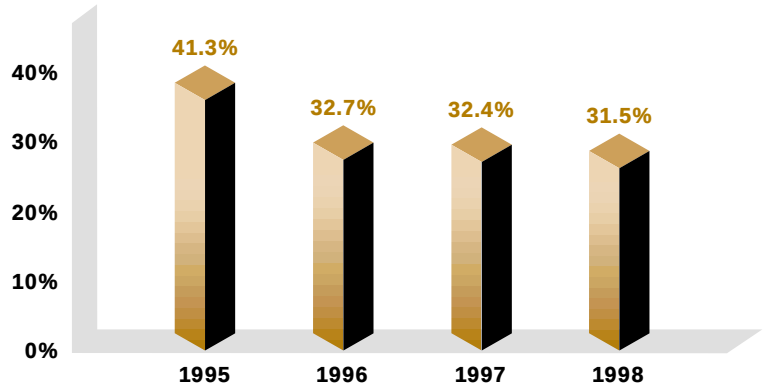


Chart 16

Notes to Accompanying Charts

Chart 1. Indian Service Population

IHS service population estimates are taken from Table 2.1 in the annual IHS statistical publication *Trends in Indian Health, 1998-1999* (in publication preparation). Estimates are based on 1990 U.S. Census counts of self-identified American Indians and Alaska Natives residing in counties within the IHS service delivery area. These 1990 Census counts are projected for later years through the use of State birth and death certificate records for calendar years 1987 to 1996. The natural increase (births minus deaths) for this 10 year period is the basis for preparing the IHS service population estimates for years after the 1990 Census.

Chart 2. IHS Service Areas

Map provides geographical location of the 12 Area Offices and the respective States served by each Area Office. The map includes the IHS Headquarters location in Rockville, Maryland.

Chart 3. Full-Time Equivalents (FTE), Headquarters

FY 1998 actual FTE for Headquarters is taken from Sup-68 in the FY 2000 Justification of Estimates for Appropriations Committees; FY 1997 actual FTE for Headquarters is taken from Sup-66 in the FY 1999 Justification of Estimates for Appropriations Committees; FY 1996 actual FTE for Headquarters is taken from Sup-61 in the FY 1998 Justification of Estimates for Appropriations Committees; FY 1995 actual FTE for Headquarters is taken from Sup-60 in the FY 1997 Justification of Estimates for Appropriations Committees; FY 1994 actual FTE for Headquarters is taken from a monthly FTE report generated by the Program Support Center's Workforce Online Data System.

Chart 4. Vital Event Rates

Vital Event rates for American Indians and Alaska Natives residing in the IHS service area are taken from the annual IHS statistical publication Regional Differences in Indian Health, 1998-1999 (in publication preparation). These rates are derived from data furnished annually to the IHS by the National Center for Health Statistics (NCHS). NCHS obtains birth and death records for all U.S. residents from the State departments of health, based on information reported on official State birth and death certificates.

Chart 5. FY 1998 Program Level

FY 1998 appropriations and third party collections found in the FY 2000 Justification of Estimates for Appropriations Committees on page IHS-2, the Program Level Funding Summary Report.

Chart 6. Trends in Budget Receipts

Budget receipts data are taken from the following: For FY 1998 data, see the FY 2000 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1997 data, see the FY 1999 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1996 data, see the FY 1998 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1995 data, see the FY 1997 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report.

Chart 7. Health Expenditures per Capita

The 1994 and 1995 national health expenditures per capita are taken from Table 8 of the Health Care Financing Review, Fall 1996 Volume 18 Number 1. The 1996 and 1997 estimates were projected by increasing the 1995 per capita expenditures by 4.5 percent, the average increase in per capita expenditures for FY 1994 to 1995. The 1998 national health care expenditure per capita is estimated based on the trend of 1992 to 1996 national health care expenditures per capita taken from Table 10 of Health Care Financing Review, Fall 1997, Volume 19, Number 1. Excluded were expenditures for nursing home care, program administration, net cost of private health insurance, government public health activities, research, and construction. The U.S. resident population estimate for 1998 was obtained from; Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050, P-25-1130, Table 1, Part A. Excluded for the purposes of U.S. per capita calculation were 1998 IHS expenditures and 1998 IHS active user population estimates. The IHS health care expenditures by IHS Area per capita in current 1998 dollars were prepared by dividing the 1998 IHS active user population estimates (1998 IHS active user population estimates were prepared for each IHS Area, by increasing the final 1997 active user population counts by the % increase of the IHS service area population 1997 to 1998) into total receipts-services budget authority plus collections/reimbursements.

Chart 8. 1998 Program and Support Funds

The IHS Federal administrative and support percentage was estimated by taking the funding for IHS cost centers 1-10 plus facilities and environmental health support divided by total IHS Federal funding. The tribal administrative and support percentage was determined by taking tribal services and facilities contract support funding divided by total tribal funding. Tribal contract support funding for compacts is not reported by the Tribes to HAS. Source: Cost Center 1-10 list, and FY 2000 Justification of Estimates for Appropriations Committees, FY 1998 Crosswalk, plus M & M, private insurance and quarters funding. It is important to note that there is a difference in IHS cost center and tribal contract support definitions.

Chart 9. Composite Health Services Per FTE

Composite health services is the weighted sum of 2.5 x admissions, 1 x outpatient visits, 1 x dental services, 1x nutrition services, 1 x environmental health services, and 1x public health nursing services. Services per FTE were calculated by dividing total IHS FTEs into the composite services total.

Chart 10. Trends in Selected Patient Services

Services data are taken from *Trends in Indian Health 1998-1999* (in publication preparation).

Chart 11. Maintenance & Improvement

For FY 1998 data, see the FY 2000 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1997 data, see the FY 1999 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1996 data, see the FY 1998 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1995 data, see the FY 1997 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report.

Chart 12. Sanitation Facilities

For FY 1998 data, see the FY 2000 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1997 data, see the FY 1999 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1996 data, see the FY 1998 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1995 data, see the FY 1997 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report.

Chart 13. Health Care Facilities Construction

For FY 1998 data, see the FY 2000 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1997 data, see the FY 1999 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1996 data, see the FY 1998 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report. For FY 1995 data, see the FY 1997 Justification of Estimates for Appropriations Committees, page IHS-2, the Program Level Funding Summary Report.

Chart 14. FY 1998 Expenses by Object Class

Expenses by object class are based on the combined Federal and Tribal Gross Cost on the Statement of Net Cost, part of the FY 1998 IHS Financial Statements. Other expenses include Printing and Reproduction, Insurance Claims and Indemnities, Property Depreciation, Bad Debt and Other.

Chart 15. Trends in Expenses by Object Class

Source: Unaudited Financial Statements for FY 1998; Audited Financial Statements for FY 1996 and FY 1997; Unaudited Financial Statements for FY 1995. FY 1995, $23,913 (M) Printing and Reproduction, Insurance Claims and Indemnities, Depreciation and other. FY 1996, $2,281 (M) Printing and Reproduction, and Insurance Claims and Indemnities. FY 1997, $2,057 (M) Printing and Reproduction, and Insurance Claims and Indemnities. FY 1998, $20,346 (M) Printing and Reproduction, Insurance Claims and Indemnities, and Property Depreciation.

Chart 16. Full-Time Equivalent Employees

The FY 1998 FTE number is taken from IHS-7 of the FY 2000 Justification of Estimates for Appropriations Committees. The FY 1997 FTE number is taken from IHS-7 of the FY 1999 Justification of Estimates for Appropriations Committees. The FY 1996 FTE number is taken from IHS-06 of the FY 1998 Justification of Estimates for Appropriations Committees. The FY 1995 FTE number is taken from IHS-6 of the FY 1997 Justification of Estimates for Appropriations Committees. The FTE costs as a percent of total costs are obtained by dividing expenses for personnel salaries and benefits by total expenses. See note 12 above for the sources of expenses by object class.

Audit Overview

In FY 1998, the Office of Management and Budget (OMB) Bulletin 97-01 introduced re-formatted financial statements: the consolidated statement of net cost, the consolidated statement of changes in net position, the combined statement of budgetary resources, and the combined statement of financing. IHS received a qualified opinion on the consolidated balance sheet, the consolidated statement of net cost and the consolidated statement of changes in net position while the remaining financial statements received a disclaimer because of the lack of detailed documentation and analyses. Government-wide, the re-formatted financial statements were challenged and tested in a real-life setting. Agencies did not have time to provide detailed analyses, which the auditors needed to perform a proper audit. Overall, the auditors provided disclaimers to various agencies across the Department of Health and Human Services because of the lack of detailed documentation and analyses. It is expected that the proper tools and documentation will be available for the FY 1999 audit and this disclaimer will be corrected.

Auditor's Qualified Opinion on Principal Financial Statements

As required by the Government Management and Reform Act, P.L. 103-356, a FY 1998 independent Auditor's Report was issued for the IHS collective financial statements for the year ending September 30, 1998. The IHS has received a qualified opinion from the auditors. Although the IHS is cited for four material weaknesses, only one "Analysis & Annual Activity in Net Position Accounts" caused the IHS to not have a clean audit. The other three non-qualifying material weaknesses are Financial Reporting, Reconciliation of Recorded Division of Payment Management Grant Balance, and Accounts Payable & Undelivered Orders Transaction Processing.

Qualified Material Weakness: Analysis & Annual Activity in Net Position Accounts

According to the auditor's report, the IHS continues to not reconcile its net position accounts with revenue and expense (operating) activity ledger and budgetary activity in its general ledger during the year. The net position balance on the balance sheet is comprised of two line items:

- unexpended appropriations (unobligated appropriations and undelivered orders) and
- cumulative results of operations. Unobligated appropriations are comprised of "Available" and "Unavailable". The Program Support Center's Division of Financial Operations (DFO), which provides the IHS accounting services, was unable to provide complete details or analysis of these amounts.

The auditor has recommended that IHS should reconcile its operating and budgetary activity in the general ledger to the change in net position accounts, to ensure that the financial statements properly reflect net position activity for the year. In addition, appropriate analysis and support for the composition of the net position at September 30 and for the year then ended should be maintained. In order to avoid problems with this analysis at the end of the year, the auditor recommended that the analysis be done periodically during the year.

Corrective Action

The IHS and DFO are developing a plan of action to correct the four material weaknesses. It is anticipated that the material weaknesses will be corrected by the conclusion of the FY 1999 audit.