ACTIVITY/MECHANISM BUDGET SUMMARY
Department of Health and Human Services
Indian Health Services – 75-0390-0-1-551
DIRECT OPERATION

Program Authorization:

Program authorized by U.S.C. 13, Snyder Act, and P.L. 83-568, Transfer Acts, 42 U.S.C. 2001.

	2000 Actual	2001 Appropriation	2002 Estimate	2002 Est. +/- 2000 Actual	2002 Est. +/- 2001 Approp.
Budget Authority	$50,988,000	$52,946,000	$65,323,000	+$14,335,000	+$12,377,000
FTE	1,629	1,629	1,629	0	0

PURPOSE AND METHOD OF OPERATION

Executive direction, program management and administrative support constitute critical elements in the delivery of health care to AI/AN. No unit of health service is delivered without substantial program management and administrative support from different disciplines, i.e., health assessment, policy development, finance, procurement, program evaluation, supply management, personnel, equipment, training, etc.

The many unusual circumstances relating to the direct delivery of health services to AI/AN require the adoption of special management principles and accompanying organizational structure. IHS has substantially increased its tribal consultation activities in recent years. As more tribes contract or compact to manage their own health programs, IHS has provided more technical assistance to tribes. This requires an additional dimension of administrative and program management expertise not ordinarily encountered in other Federal programs. An understanding of the way that the IHS provides, directly and indirectly through Tribal and Urban Indian health programs, a vast array of services to the diverse and dispersed AI/AN populations is important in order to appreciate the management, oversight, and tribal consultation and their direct influence on budget formulation and execution activities.

In response to these functions, the IHS has structured its organization, delegated the necessary authorities and assigned the appropriate management responsibilities in three principal levels: (1) national (Headquarters); (2) regional (Area Office); and (3) local (Service Unit or facility). This structure allows effective programmatic oversight, local management, and tribal consultation at any level, while capitalizing on the economies of scale made possible by collaborative or aggregate activities. The functions of each level are unique, interrelated, and complementary to assure an uninterrupted execution of program and administrative management. To the greatest extent practicable and feasible, the delegation of authorities at the community level has and will enable timely decisions in patient care.

Headquarters

The Headquarters provides essential integration at the national level, assuring consistency of policy and practice across the many diverse locations served by IHS. For example, without this integration, it would be impossible to address the issue of equity and ensure the integrity at a national comprehensive healthcare delivery system. Headquarters carries out national functions, including the responsibilities of a Federal Agency such as establishment, implementation, and oversight of program and administrative policy, strategic and operational planning, budget formulation and execution, administrative control of funds, Federal Managers Financial Integrity Act (FMFIA), Government Performance and Results Act (GPRA), procurement, facilities construction planning, and many related functions in compliance with applicable laws and regulations.

Headquarters staff, through two principal offices of management support and public health, advise and support the Director on programmatic and administrative issues, and respond to the many and diverse requests that come to the Agency from the Department, OMB, the Congress, and other Federal Agencies. Headquarters personnel also monitor, coordinate, and evaluate Area and local activities and programs to ensure conformance with congressional and other directives. They manage certain Nation-wide support functions such as the catastrophic health emergency fund, health facilities construction, and grant programs that make awards to tribes, urban Indian health programs, Indian organizations, and individuals, for purposes such as diabetes prevention and treatment, the development or enhancement of management infrastructure to permit tribes to manage health programs, the education of health professionals who will work in Indian communities, and the retention of health professionals by assisting with the repayment of student loans. Additionally, Headquarters personnel provide information and reports to the Congress and the Executive Branch, technical assistance to tribes and Areas, and act in an advocacy and leadership role with other Federal agencies, professional associations, and other entities that may contribute to fulfilling the IHS mission.

Area Offices

Area Offices are responsible for carrying out a dual function: (1) to participate in and establish goals and objectives implementing IHS policies, and determine priorities for action within the framework of IHS policy. As such, Area Offices coordinate their respective activities and resources internally and externally with those of other governmental and non-governmental programs to promote optimum utilization of all available health resources. The burden of negotiating, consulting, and participating with the approximately 550 sovereign Indian nations rests primarily with the Area Offices which must work in partnership with the Indian nations while remaining agents of the Federal government. And, (2) ensure the delivery of quality health care through their respective service units and participate in the development and demonstration of alternative means and techniques of health services management and delivery to provide Indian tribes and other Indian community groups with optimal ways of participating in Indian health programs. As an integral part of this dual function, the Area Offices are principally responsible for assuring the development of individual and tribal capabilities to participate in the operation of the IHS program as deemed appropriate by the tribes.

ACCOMPLISHMENTS

Self-Governance Authority

In FY 1993 and 1994, the Indian Health Service implemented a demonstration program in Tribal Self-Governance and negotiated with tribes the first 14 compacts and annual funding agreements. After the necessary policies and decisions regarding financial allocation were developed and implemented, Congress made Tribal Self-Governance Authority permanent in FY 2000. In FY 2001, we anticipate that $642 million will be transferred to support 48 compacts with tribes.

Organizational Change

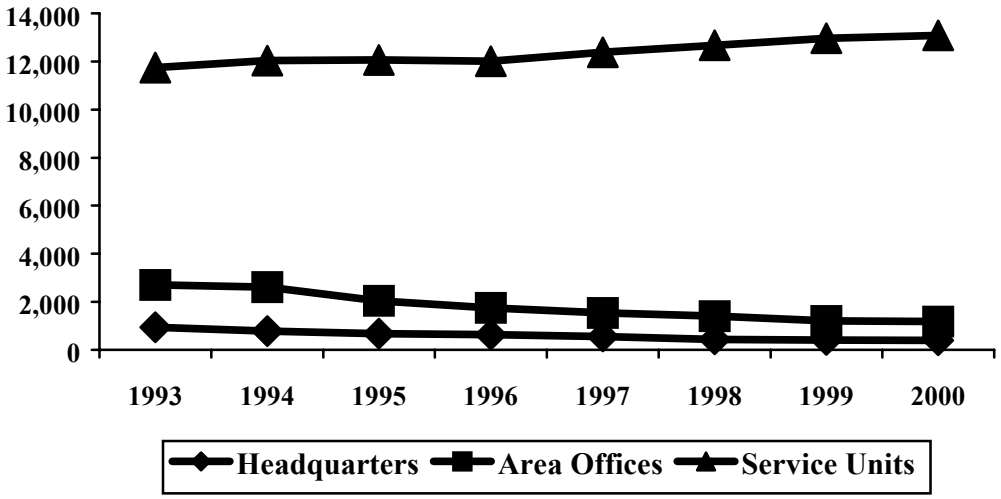
Significant changes have occurred in the Indian Health Service in recent years. Changes were necessary to ensure a structure and staffing sufficient to carry out inherent Federal functions while maximizing efficiency in management and administration to permit the shift of resources to the point of health service delivery, including federal service units and tribal health programs.

Major changes to the function and structure of the Indian Health Service Headquarters were implemented in FY 1997, as recommended by the Indian Health Design Team. Significant reductions in organizational size and complexity were achieved as nine Headquarters offices were reduced to three, and 137 Staff Offices, Divisions, Branches, and Sections were consolidated into 31 Divisions and Staff Offices. These changes eliminated the need for six Associate Directors and their Deputies, as well as three Division/Staff Directors, and 99 Branch/Section Chiefs.

Since 1997, the Aberdeen, Albuquerque and California Area Office have also restructured and streamlined their organizations. Changes in these Areas eliminated six Associate Offices, and 12 Staff Groups or Sections and the corresponding requirement for Division and Staff Directors and Branch Chiefs.

An IHS workforce report indicates that at the end of FY 2000, The Indian Health Service had 14,656 FTE on board. However, 1,359 of the FTE were assigned to tribes through Inter-Governmental Act Assignments or Memoranda of Agreement. Such agreements are important to achieving self-determination, as they minimize recruitment problems at the time of the transfer of programs to the tribes. Continued Federal support through Direct Operations includes such costs as payroll processing and workman’s compensation for FTE assigned to tribes.

Indian Health Service Employment: 1993 – 2000
Service Units Increased While Area Offices and Headquarters Decreased



IHS Business Plan

Concurrent with organizational changes, the Indian Health Service shifted to a corporate-oriented approach to conducting business. The Indian Health Service developed, together with Indian leaders, a business plan to adopt more business-like planning and practices in key segments of Indian Health Service operations. The plan set a course for management that has resulted in important accomplishments and enhanced stewardship of important resources.

First, the Indian Health Service launched a hospital cost report initiative that has helped Indian Health Service more accurately identify its hospital cost and set higher reimbursement rates for patients with Medicare, Medicaid, and or private insurance coverage. In addition, the Indian Health Service has improved its systems to identify third party eligibility, document services provided, and automate third party billing and tracking. These business initiatives have been instrumental in helping the Indian Health Service to increase third-party collections by almost $150 million, or 59%, between FY 1996 and FY 2000. In addition, Area Offices have negotiated with contract-providers, Medicare-like rates to make Contract Health Service dollars go farther, refinements to the Contract Support Cost Policy have reduced the potential for paying duplicate costs, and current efforts to link billing with accounts receivable hold the promise of strengthening internal management and operations.

Following are the funding levels for the last 5 fiscal years:

Year	Funding	FTE	
1997	$48,709,000	510	
1998	$47,386,000	465	
1999	$49,309,000	434	
2000	$50,988,000	1,629	
2001	$52,946,000	1,629	Enacted

RATIONALE FOR BUDGET REQUEST

TOTAL REQUEST -- The request of $65,323,000 and 1,629 FTE is the increase of $12,377,000 over the FY 2001 enacted level of $52,946,000 and 1,629 FTE. The increase is as follow:

Built-in Increases - +$2,377,000

The request of $406,000 for inflation/tribal pay cost and $1,971,000 for Federal personnel related cost would fund the built-in increases associated with on-going operations. Included are the FY 2002 pay raise and within grade increases. These funds will be shared with Title I and Title III tribes, as well as Federal programs.

IHS continues to strive to increase access to the IHS patient population. It is extremely critical that the IHS maintains the FY 2001 level of service to prevent any further decline in primary health services. Maintaining the current I/T/U health systems is necessary in eliminating disparities in health status between AI/AN and the rest of the U.S. population.

Federal Cost of Navajo Conversion: +$10,000,000

A recent proposal from the Navajo Nation to contract for the programs now administered through the Navajo Area Office and eight service units has created a critical and unprecedented request for funding to pay costs that will occur as a result of entering into a single P.L. 93-638 contract. As many as 4,000 Federal positions in the Navajo Area could be affected in FY 2002. Funds will be needed for severance pay for those employees the tribe does not wish to retain. Incentives for early retirement will also be offered in order to reduce the need for reduction-in-force. Although the funds are requested in Direct Operations, they would be available for the costs of displaced IHS employees whose salaries are paid out of other budget line items (e.g., Hospitals and Health Clinics). In addition, this contract can reasonably be expected to impact other Indian Health Service Areas. For example, the Albuquerque and Phoenix Areas currently provide services for a large number of Navajo patients. These Areas may find that changes in workload require changes in staffing as this new P.L. 93-638 contract is implemented.

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