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IHS Organizational Model with Block Grant Type Functions

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IHS Organizational Model

with Block Grant Type Functions

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1.0 Scope of Work and Methodology

The objective of this study was to research organizational models for the management of block-grants, to identify the functions and responsibilities of the current Indian Health Service (IHS) organization, to estimate the staffing and overhead costs for IHS, and to determine a model for IHS in the event that all direct health care services are delivered by tribal organizations instead of by IHS. The purpose for the study was to identify an organizational structure, staffing, and cost estimate for an IHS organization which is focused on the responsibilities of managing tribal self-governance and Indian Self-Determination Act funds.

The analysis required research on organizational structure, managerial responsibilities, and operational issues for a variety of Federal agencies, including the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, the Centers for Disease Control and Prevention; and, the National Institutes of Health. The analysis also involved obtaining, processing, tabulating, and summarizing IHS agency-wide budget and staffing data by accounting point, cost center, and object class to determine average staffing, personnel costs, overhead costs, and other factors which impact on the budget needs of IHS under a structure which is a block-grant management oriented.

The organizational analysis of IHS was largely based on materials compiled for previous studies.[1] Additional IHS reports and other materials on IHS mission and organizational responsibilities were analyzed. Data on organization, budget, and responsibilities for Federal agencies were obtained from the HHS "Justification of Estimates for Appropriations Committees, FY 1995" for the Public Health Service organizations.. Data were obtained from the AHA and subjected to a number of analyses in order to create a comparative basis for assessing industry supervisory ratios. IHS staffing data were collected from the Public Health Service (PHS) Work Force On-Line Data System; the IHS Ambulatory Patient Care Computer Data system; and from other IHS Offices and sources.

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[1] *Information & Management Technologies, Span of Control and IHS Staffing Patterns, HHS/PHS/IHS, Rockville, MD, January, 1995.*

The principle source of IHS staffing data was PHS payroll reports.[2] The reports contain year-to-date totals of hours paid by appropriation, by accounting point, and by location. The report also computes Full Time Equivalents (FTEs) based on a 2080 hour work year. Budget data for IHS was based on a database of FY 1994 Budget Obligations by appropriation, accounting point, cost center, object class, and location.[3] This data was summed by various categories and cross-cuts using dBASE IV and tabulated and charted using Excel 5.0 commercial PC software.

A report of the IHS payroll (Run IHS-100) by accounting point and location was made available by the IHS Office of Administration and Management, Budget Execution Branch.

A database of the complete budget by appropriation, accounting point, location, cost center, and object class was provided by the IHS Office of Information Management at the request of the IHS Office of Administration and Management, Budget Execution Branch.

2.0 Organizational Functions and Responsibilities

2.1 IHS Mission

The Indian Health Service has a unique statutory mission that does not exist in any other agency. This mission is at once focused on elevating the health care of American Indians and Alaska Natives to the highest possible level, and it is equally focused on contracting or compacting out this mission to eligible Indian organizations. The primary mission to elevate health care status requires significant technical work complexity, since it encompasses not just medical programs, but also public health, environment, engineering and construction. Providing comprehensive services to hundreds of tribal groups with fewer than 500 members and many with memberships in the tens of thousands, located in most States, requires a high degree of communication and customer interaction that increase complexity. Finally, contracting and compacting increase complexity. Today, there is an increasing emphasis on compacting. This analysis reviews the potential changes within IHS, if all health care service delivery is turned over to the tribes. A review of the IHS statutory mandate provides an insight into the genesis of this new thrust.

In 1954, The Indian Health Transfer Act[4] relocated the Indian Health Service from the Bureau of Indian Affairs because of widespread failures by the Indian Bureau to meet the health care needs of Indians. The Transfer Act provided the initial authority for contracting the operation and maintenance of Indian hospitals and health facilities to eligible organizations.[5] Since 1970, the Indian health care policy of the United States has consistently favored Indian self

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P.L. 83-568, August 5, 1954

42 U.S.C.§ 2002. See also, Act of August 16, 1957, P.L. 85-151, 42 U.S.C.§ 2005 authorizing contracts to State and local governments for Indian health care; and P.L. 86-121 (1959) authorizing matching grants to local governments for sanitation facilities.

determination in health care,[6] although it continued to authorize contracts to health care providers, with Indian consent.[7] The self determination policy in Indian health care was enacted into law in 1975 by passage of the Indian Self Determination and Educational Assistance Act.[8] Within a year another seminal piece of legislation was passed, the Indian Health Care Improvement Act.[9] This Act sought to overcome the appalling deficiencies in the Federal Indian Health care program by providing a comprehensive program for elevating Indian health care. Four years later, the 1980 Amendments to the Act were passed authorizing additional appropriations and making substantive changes, providing Buy-Indian Act contracting opportunities, and providing access to Medicare and Medicaid health programs.[10] Congress acted again in 1988 to amend the Indian Self Determination Act to authorize easier contracting of IHS health programs to Indian tribes,[11] and to amend the Indian Sanitation Facilities Act.[12] Congress

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[6] *See Message From the President of the United States Transmitting Recommendations For Indian Policy, H.R. Doc. No. 363, 91st Cong., 2d Sess. (1970), "...The time has come to break decisively with the past and to create the conditions for a new era in which the Indian future is determined by Indian acts and Indian decisions."*

[7] *Health Maintenance Organization Act, Act of December 29, 1973, P.L. 93-222, 87 Stat. 935, amending Section 1 of P.L. 83-568, Indian Health Transfer Act.*

[8] *P.L. 93-638, 25 U.S.C.§ 450 (1975).*

[9] *P.L. 94-437, 90 Stat. 1406, 25 U.S.C.§ 1601 et seq., 42 U.S.C.§ 1395-1396, 2004.*

[10] *See 25 U.S.C.§ 1601 et seq. See also Title IV of the Indian Health Care Improvement Act "Access to Health Services", authorizing the Indian Health Service to receive Medicare and Medicaid reimbursements for services provided to Indians eligible for Social Security Act programs, when the service was performed in IHS facilities. See Section 1880 "Indian Health Service Facilities" under Title XVIII of the Social Security Act.*

has also acted to enhance contracting of Indian Health care services through **compacting**, in the Tribal Self Governance Demonstration Project Amendments.[13] Most recently, Congress has sought to simplify contracting and increase contracting opportunities by amending P.L. 93-638.[14]

The statutory mission of the Indian Health Service is to elevate Indian health to the highest possible level and to provide assumption of control by Indian tribes over Indian health care programs. This statutory mission is extraordinary complex because it requires the Indian Health Service to perform at the very highest standards while simultaneously transitioning responsibility to American Indian tribes and Alaska Native organizations. Compacting will transfer the operational aspects of health care service to tribes, while IHS retains the responsibility for the delivery of technically adequate services that are designed to elevate health care to the highest level. Simultaneously, IHS must maintain an organizational structure that is a capable of ensuring the Congress that funds being transferred to American Indian tribes and Alaska Native organizations are being used effectively and efficiently.

Operationally speaking, it is not clear how the tribes will independently administer a comprehensive health care program. The IHS utilizes a combination of direct service delivery through hospitals, clinics, and health stations, and contract health services through physician and hospital providers. The combination of direct service delivery and contract health services creates a comprehensive health care services program. In addition to care that is provided through IHS

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[11] *See P.L. 100-472, October 5, 1988, 102 Stat. 2285.*

[12] *See P.L. 86-121, as amended.*

[13] *See Tribal Self Governance Demonstration Project Amendments, Senate Bill 2645, regarding negotiation of Annual Funding Agreements.*

[14] *P.L. 93-638, as amended, (See P.L. 103-413).*

and contract health services, care is also provided under contracts with tribal governments. A fiscal intermediary is used to manage claims processing and utilization review. The IHS system is complex and includes support for a wide variety of clinical and public health services, such as: maternal and child health; fetal alcohol syndrome; diabetes; alcoholism; mental health; emergency medical services; community health representatives; environmental health and sanitation; maintenance and repair of facilities; construction of hospitals and clinics; housing; hepatitis B and plague eradication; dental services; and many others. The service population, which frequently resides in remote geographic areas, has much less access to health care than the general population.[15] Not surprisingly, mortality and morbidity rates are higher than national averages.[16] The Indian Health Service provides limited health care services to Indians residing in urban areas.[17] When IHS relinquishes management of the service delivery infrastructure, it will have great difficulty in assuring the quality of service. The fate of Urban Indian Health Programs is undetermined.

Compacting could change the operations of IHS to the point where the agency functions with a structure and responsibilities similar to other PHS organizations. The transition of IHS into that structure is explored throughout this analysis.

2.2 IHS Organization and Staffing

The IHS Headquarters and its Area Offices are currently organized along traditional

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[15] *"National Health Care Reform and Indian Health Care," Roundtable, Indian Health Service, February 17, 1993; Access needs to include transportation costs in remote areas as a basic benefit, p.14.*

[16] *"Trends in Indian Health" Department of Health and Human Services, 1993*

[17] *P.L. 102-573 Indian Health Amendments, Title V, Section 501 "Health Services For Urban Indians," October 29, 1992.*

"functional" lines. Most agency staff are located at hospitals and health centers, which are operate according to hospital "team" structure parameters. The organization chart for IHS, shown in Figure 1, includes an Office of the Director, nine (9) headquarters Offices, and twelve (12) Area Offices. The Indian Health Service has a total staff of approximately 15,000 employees. When part-time and temporary employees are considered, this translates to about 14,000 FTEs. Approximately 80% of IHS staff is directly involved in providing direct health care to Indians at 142 IHS health care facilities.

A summary of IHS facilities and staff is presented in Figure 2. Headquarters staff only represent about 5% of the total. Staff in the IHS Area Offices represent another 15% of the staff total. The remaining 80% of IHS staff are employed at IHS hospitals, health centers, health facilities at Indian Schools, health stations, field sites, and other health facilities.

There are 142 IHS health care facilities. The Indian Health Service operates 42 hospitals and 65 health centers, and 35 other health facilities including field offices and health centers within Indian schools. Two of the IHS hospitals are accredited Medical Centers (Phoenix and Anchorage). IHS hospitals provide inpatient and outpatient care, and community outreach services. IHS health centers provide emergency medical services, outpatient services, and a variety of community outreach services. A summary of the number of IHS facilities by Area is presented in Figure 3. IHS staff at 42 IHS hospitals is about 10,396, with an average staff size of about 250 FTEs. IHS staff at 65 IHS health centers is 1,825, with an average of about 30 FTEs per health center. The remaining health services staff of 1,064 is distributed among 35 Service Units, health stations, field sites, and other health facilities.

IHS staff for each Area is set forth in Figure 4. The size of the IHS Areas is very different, both geographically and demographically. As a result, the number and size of health care facilities operated by IHS are different in each Area. It should be noted that both the facility counts and staff estimates are approximate. This data changes daily, as facilities change from being IHS-operated to being tribally-operated, and as people begin or terminate employment.

The Indian Health Service is organized with a Headquarters staff and twelve (12)

Area Offices. While only 5% of IHS staff is assigned to the Headquarters organization, the organization itself exists in twelve distinct locations where it performs executive direction of activities. Headquarters' activities do not involve direct health care operations since it is not a health care facility. The IHS Headquarters organization includes three locations for the Office of Engineering Services designated as the Regional Office with a staff of 68 employees.

The IHS Area Offices perform a variety of functions, among which are the management and direction of IHS health care facility operations; core public health functions; facility engineering, and environment. Each Area Office is responsible for a specific geographic area of the country. Area Offices have subdivided their regional coverage into geographical units of service, denominated as Service Units (SUDs). Each Service Unit is directly responsible for the facilities within its geographic area and is accountable for all services provided to Indian beneficiaries residing within that unit.

IHS Area Offices have very little direct responsibility for the direct medical operation of health care facilities, although several Area Offices have centralized some direct services, such as laboratory services, to minimize operating costs. The staffing level for direct health care services by Area Offices is minimal. The overall staffing level for IHS Area Offices is 2,401 employees, which is approximately 15% of the IHS staff total.

2.3 IHS Organizational Functions and Responsibilities

The IHS Headquarters and its Area Offices are currently organized along traditional "functional" lines. The headquarters organization includes an Office of the Director and nine (9) headquarters Offices. The nine Offices are:

❶ Office of Administration and Management (OAM),
❷ Office of Planning, Evaluation and Legislation,
❸ Office of Tribal Activities,
❹ Office of Health Programs (OHP),
❺ Office of Environmental Health and Engineering (OEHE),

⑥ Office of Health Program Research and Development (OHPRD),
⑦ Office of Information Resource Management (OIRM),
⑧ Office of Human Resources (OHR); and,
⑨ Office of Tribal Self-Governance (OTSG).

The Office of the Director provides overall direction and leadership for IHS. OAM provides administrative leadership, direction, and coordination of all phases of IHS management; including financial, personnel, contract, resource, fiscal, and budget activities. OPEL provides policy, planning, and legislative guidance and direction for the agency.

OTA is responsible for policy formulation regarding tribal activities and for communication between IHS and the tribal organizations. OHP provides policy formulation on the operations and management of health programs, provides technical assistance for all IHS health delivery systems, and provides leadership and direction for quality assurance activities. OEHE provides policy formulation and administrative leadership for environmental health, community injury control, real property management, sanitation facilities engineering, and other related engineering services for IHS.

OHPRD is located in Tucson and is responsible for the development of methods and techniques for improved operation and management of the IHS health care delivery systems and services. OHPRD also coordinates health research and development within IHS directed at improving the health of Indian people. OIRM provides technical guidance and support for the delivery of computing and information management services throughout IHS. OHR is responsible for human resource goals, objectives, policies, and priorities, to ensure a current and future work force for management, program delivery, and administrative support systems through IHS.

The Office of Tribal Self-Governance develops, directs, and oversees the implementation of Tribal Self-Governance policies and programs under Title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, as amended. The Office is the focal point for negotiation of self-governance compacts and funding agreements with participating tribal governments. OTSG also ensures that the responsibilities of the United States

are not waived, modified, or diminished with respect to Indian tribes and individual Indians.

The twelve (12) Area Offices have organization structures which parallel IHS Headquarters. Some of the functions of headquarters offices are combined in Area Offices. Additional offices have been organized to manage contract health services (CHS) and reimbursement responsibilities. Service delivery is managed by Service Units (SUDs), which report to the Area Director..

The organization, staffing, and staff responsibilities of the Indian Health Service have been formulated to carry out a multi-faceted mission. This mission includes:

❶ Agency management, leadership, and policy formulation,
❷ Administration and management of all IHS activities,
❸ Other inherently governmental functions,
❹ Direct operation of health care delivery systems,
❺ Direct operation of illness and injury prevention programs,
❻ Real property, facility, and environmental systems management and maintenance,
❼ Technical assistance for tribal/contractor delivery of health care services; and,
❽ Contract and compact management and administration.

In a scenario where all direct operation of health care delivery and illness/injury prevention programs were compacted to tribal governments, many of these functions would remain within the domain of IHS.

3.0 Organization Analysis of Relevant Federal Agencies

Many Federal Agencies are involved in a mission which includes public health, safety, and welfare. The organization and operation of these agencies includes a wide variety of programmatic elements. This analysis covered four government agencies involved with public health:

❶ Substance Abuse and Mental Health Services Administration,
❷ Health Resources and Services Administration,
❸ Centers for Disease Control and Prevention; and,
❹ National Institutes of Health.

3.1 Organization of Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) is part of the Public Health Services organization and is authorized by the Public Health Services Act.[18] A recent organization chart for SAMHSA is reproduced in Figure 5. SAMHSA includes nine (9) Distinct Offices and Centers, in addition to the Office of the Administrator. Eight of the nine offices and centers are focussed on a particular facet of substance abuse or mental health.

The Office of Program Management, Planning, and Communications is the organizational entity which includes all of the administrative functions for SAMHSA. Each Office or Center is responsible for the management of the contracts, grants, subsidies, and contributions within its health discipline.

Funding for direct operations for each of the Centers and for the Office of the Administrator are consolidated within the Program Management budget line item.[19] The Program

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[18] *Sec. 612 of P.L. 100-77, as amended.*

Management activity supports all agency staff except those positions providing data collection, evaluation or direct technical assistance to the States, which are supported by the block grant set-aside funds.

The Office of the Administrator (OA) provides overall management and leadership for agency-wide policy concerning substance abuse and mental health services to more effectively meet the needs of people, through improvement in treatment service systems. The OA responds to policy and data requests from outside organizations and provides administrative and management support to the entire agency through its centralized services. These include personnel services, equal employment opportunity, space and property management, and telecommunications and ADP activities. Included within the OA are staff who coordinate contract and grant review and award policies, agency program planning, and other administrative and technical staff.

An analysis of the SAMHSA budget provides a perspective on the organization size, activities, and staffing requirements. The FY1994 appropriation for SAMHSA was 753 FTEs, including overtime and holiday hours. A consolidation of the FY 1994 appropriated Budget Authority for SAMHSA by Object Class is given in Figure 6. Of the $2.15 billion total SAMHSA budget, 90% goes for grants, subsidies, and contributions. Another $145 million is appropriated for non-consulting contractual services. It is not possible to itemize the contractual services without detailed budget information.

The FY 1994 appropriation for Program Management was 725 FTEs. The Program Management budget line was $61.2 million.

The three SAMHSA Centers provide specific models for the use of block-grant funds. The Center for Mental Health Services has a budget of approximately $417 million. About two-thirds of these funds ($278 million) goes for block-grants to the States. Of the $278 million for block-grants, $264 million are distributed and $14 million is set-aside by law. Block-

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[19] *DHHS/PHS/SAMHSA, Justification of Estimates for Appropriations Committee, Fiscal Year 1995, Volume VIII.*

grant legislation generally includes a provision for a 5% mandatory set-aside, to be used by the agency for technical assistance to the States, data collection, and evaluation. The Center for Mental Health Services funds five (5) FTEs from the set-aside.

The Center for Substance Abuse Prevention has a budget of approximately $253 million. These funds are used for prevention demonstration grants and contracts, public education and dissemination grants and contracts, and training grants and contracts. The Center for Substance Abuse Prevention does not have block-grant program.

The Center for Substance Abuse Treatment has a budget of approximately $1.4 billion. About 86% of these funds ($1.2 billion) goes for block-grants to the States. Of the $1.2 billion for block-grants, $1.05 billion is distributed and $56.5 million is set-aside by law. Block-grant legislation generally includes a provision for a 5% mandatory set-aside, to be used by the agency for technical assistance to the States, data collection, and evaluation. The Center for Substance Abuse Treatment funds eighteen (18) FTEs from the set-aside.

3.2 Organization of Health Resources and Services Administration

The Health Resources and Services Administration (HRSA) is part of the Public Health Services organization and is authorized by the Public Health Services Act,[20] the Federal Coal Mine Health and Safety Act, and the Social Security Act, the Health Care Quality Improvement Act of 1986, as amended, Public Law 101- 527, and the Native Hawaiian Health Care Act of 1988. A recent organization chart for HRSA is reproduced in Figure 7. HRSA includes the Office of Operations and Management, and four Bureaus, in addition to the Office of the Administrator. The four bureaus are focussed on health resources development, primary health care, maternal and child health, and health professions.

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[20] *Sec. 612 of P.L. 100-77, as amended.*

The Office of Operations and Management is the organizational entity which includes all of the administrative functions for HRSA. Each Bureau is responsible for the management of the contracts, grants, subsidies, and contributions within its health resources and services discipline.

Funding for direct operations for each of the Bureaus and for the Office of the Administrator are consolidated within the Program Management budget line item.[21] The Program Management activity supports about 60% of the agency staff, including administration and management in each of the Bureaus. Additional staff are supported by the block grant set-aside funds.

Activities in the Office of the Administrator (OA) provide overall management and leadership for agency-wide program planning and evaluation and policy guidance concerning improved support for health resources, nation-wide. The OA responds to policy and data requests from outside organizations and provides administrative and data requests from outside organizations and provides administrative and management support to the entire agency through its centralized services. These include personnel services, equal employment opportunity, space and property management, and telecommunications. Included within the OA are staff who coordinate contract and grant review and award policies, agency program planning, and other administrative and technical staff.

An analysis of the HRSA budget provides a perspective on the organization size, activities, and staffing requirements. The FY1994 appropriation for HRSA was 2,054 FTEs, including overtime and holiday hours. A consolidation of the FY 1994 appropriated Budget Authority for HRSA by Object Class is given in Figure 8. Of the $2.93 billion total HRSA budget, 91% goes for grants, subsidies, and contributions. Another $167 million is appropriated for other services. It is not possible to itemize the other (contractual) services without detailed

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[21] *DHHS/PHS/HRSA, Justification of Estimates for Appropriations Committee, Fiscal Year 1995, Volume VIII.*

budget information.

The FY 1994 appropriation for Program Management was 1,453 FTEs. The Program Management budget line was $121.8 million.

The four HRSA Bureaus provide different staffing models due to the nature and scope of their activities and funding. The Bureau for Primary Health Care has a budget of approximately $899 million. About two-thirds of these funds ($603 million) goes to support community health centers. Another 7% of the budget provides field personnel and services, including 607 FTEs. These 607 FTEs are the only staff funded from the Bureau for Primary Health Care budget. The Bureau for Primary Health Care does not have any block-grant programs.

The Bureau for Health Professions has a budget of $282 million. This Bureau provides matching funds for student loans in the health care professions. There are no direct staff attributed to this budget.

The Bureau for Maternal and Child Care has budget of $792 million. About 87% of these funds ($687 million) are allocated to block-grant funding. The enabling legislation provides for two set-asides, totaling $112 million, leaving about $575 million for grants to States. There is no indication in the HRSA budget package of any block-grant funds being set-aside for technical assistance or data collection and evaluation.

The Bureau for Health Resources Development has a budget of about $8 million. This Bureau has no block-grant program, nor is any direct budget support for staff indicated.

The Family Planning Program, authorized under Title X, Section 1001 of the Public Health Services Act is funded within HRSA, although it is administered by the PHS Office of the Assistant Secretary of Health. This program has a budget of $180 million and a staff of 50 FTEs.

The Program Management budget is used to fund the staff which plans, directs, and

administers all agency activities. The staff of 1,453 is distributed among all HRSA Offices and Bureaus. The total HRSA staff is 2,054 FTEs. Of these, 607 are staff for direct services in the Bureau of Primary Health Care, and fifty are part of the Family Planning Program; leaving 1,397 FTEs in HRSA, all funded as part of Program Management.

The Program Management staff by HRSA organization is:

494 FTEs ..... Bureau of Primary Health Care
248 FTEs ..... Bureau of Health Professionals
196 FTEs ..... Maternal and Child Health Bureau
229 FTEs ..... Bureau of Health Resources Development
230 FTEs ..... Office of the Administrator

3.3 Organization of the Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC) is part of the Public Health Services organization and is authorized by the Public Health Services Act,[22] the Federal Mine Safety and Health Act of 1977[23], and the Occupational Safety and Health Act of 1970[24]. A recent organization chart for CDC is reproduced in Figure 9. CDC includes eight (8) Offices and seven (7) Centers, in addition to the Office of the Administrator. Six of the Offices and all seven Centers are focussed on a particular facet of disease and injury prevention.

The Office of Program Support is the organizational entity which includes all of the administrative functions for CDC. Each Office or Center is responsible for the program

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[22] *Titles III, VII, XI, XV, XVII, XIX, and XXVII of the Public Health Service Act.*

[23] *§101, §102, §103, §201, §202 ,and §203 of the Federal Mine Safety and Health Act of 1977.*

[24] *§20, §21, and §22 of the Occupational Safety and Health Act of 1970.*

budget line item.[25] The Program Management activity supports only central office activities. Program operations funds are budgeted separately. Those positions providing data collection, evaluation or direct technical assistance to the States, are supported by the block grant set-aside funds.

Activities in the Office of the Administrator (OA) provide overall management and leadership for agency-wide policy concerning substance abuse and mental health services to more effectively meet the needs of people, through improvement in disease prevention policies and practices. The Office of Program Planning and Evaluation responds to policy and data requests from outside organizations, while the Office of Program Support provides administrative and management support to the entire agency through its centralized services. These include personnel services, equal employment opportunity, space and property management, and telecommunications and ADP activities.

An analysis of the CDC budget provides a perspective on the organization size, activities, and staffing requirements. The FY1994 appropriation for CDC was 6,502 FTEs, including overtime and holiday hours. A consolidation of the FY 1994 appropriated Budget Authority for CDC by Object Class is given in Figure 10. Of the $2.05 billion total CDC budget, about 75% goes for grants, subsidies, and contributions. Another $111 million is appropriated for research and development contracts.

The FY 1994 appropriation for Program Management was 68 FTEs. The Program Management budget line was $3.13 million. CDC provides a budget exhibit entitled "Administrative Costs"[26]. This part of the CDC budget totals $403 million. The total personnel compensation is about $256 million, which is greater than the personnel compensation line in the

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[25] *DHHS/PHS/CDC, Justification of Estimates for Appropriations Committee, Fiscal Year 1995, Volume II..*

[26] *DHHS/PHS/CDC, Justification of Estimates for Appropriations Committee, Fiscal Year 1995, Volume II, page 10.*

total CDC budget. There is no explanation for this inconsistency.

The Center for Disease Control and Prevention provides different models for different programs within the Centers and Program Offices. There is a block grant program to States for Preventative Health & Health Services. The total funding of $148.7 million includes funding for 17 CDC FTEs for program operations. This staffing represents about 3.5% of the total block grant amount.

Three other activities within CDC also include grants. These activities primarily fund research efforts. The programs are for:

- Sexually Transmitted Diseases,
- Immunization,
- Tuberculosis elimination.

The funding for these activities totals $744.6 million. Of this total, $123.3 is used for Program Operations. Program Operations funds 493 FTEs for these three activities.

Other CDC activities do not report any separate staff or funds for program management, programs operations, or administration.

3.4 Organization of National Institutes of Health

The National Institutes of Health (NIH) is part of the Public Health Services organization and is funded in 1994 by the FY 1994 Appropriations Act for the Department of Labor, Health and Human Services, and Education.[27] The NIH organization is made up of twenty-four (24) distinct research institutes, plus the Office of the Director, the National Library of Medicine, the Office of Buildings and Facilities, and the Office of AIDs

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[27] *P.L. 103-112.*

The NIH Office of the Director is the organizational entity which includes centralized management and policy activities for NIH as a whole. An organization chart for the NIH Office of the Director is shown in Figure 11. Each of the Institutes and the Library of Medicine are ultimately responsible to the Director of NIH..

An NIH Management Fund was established in 1957, by Public Law 85-67. The MF was created to finance a variety of centralized research support services and administrative activities which are required for the efficient and effective operation of all NIH programs and facilities. This fund uses a small portion of the funds from each Institute. The 1994 budget for the NIH MF was $464 million. The NIH hospital and other clinical services are supported by the MF. The Management Fund supports 3,688 FTEs, of which 2,114 are clinical services staff. Of the balance (1,574 FTEs), 118 FTEs provide computer services and 769 FTEs provide intramural research support services.

The NIH Service and Supply Fund (SSF) was established in 1953, under 42 U.S.C. 231. The SSF was created to finance a variety of centralized research support services and administrative activities which are required for the efficient and effective operation of all NIH programs and facilities. The SSF provides a single means for consolidating the financing and accounting of business-type operations involving the sales of services and commodities to customers (the Institutes). The 1994 budget for SSF was $261.6 million. The Services and Supply Fund supports 1,202 FTEs, of which 185 FTEs provide data processing services and 845 FTEs provide administrative services.

Each Institute of NIH has its own Office of the Director (OD) and one or more offices to provide financial, personnel, information resource management, administrative services, grant and contract administration, and oversight of Equal Employment Opportunity. None of the Institutes of NIH provide any block grants.

The twenty-four Institutes have total staff of 10,584 FTEs. Of these, 1,086 are staff in the Directors' Offices. Each Institute prepares its budget to reflect their extramural research programs and their intramural programs. The research management and support (RMS) is

grant and contract administration, and oversight of Equal Employment Opportunity. None of the Institutes of NIH provide any block grants.

The twenty-four Institutes have total staff of 10,584 FTEs. Of these, 1,086 are staff in the Directors' Offices. Each Institute prepares its budget to reflect their extramural research programs and their intramural programs. The research management and support (RMS) is specifically identified within intramural research. Resource Management and Support is described as:

"The activity (which) provides the resources that contribute to the overall management and policy direction of the Institute's extramural programs."

Figure 12 shows a tabulation of the research management and support FTEs for each Institute. The RMS staff of 3,206 FTEs is about one-third of the total staffing of the Institutes. Of the roughly $11 billion total budget, RMS has a budget of about $350 million..

3.5 Common Features of Organizations

Each of the organizations which were studied provides billions of dollars in grants, subsidies, and contributions. Each organization budgets a significant amount of money for program management and support. The smallest organization, SAMHSA, has a staff of about 700 FTEs, with a program management and support budget in excess of $61 million. NIH has a research management and support staff of over 4,000 FTEs with a budget of over $350 million.

Typically, additional staff is devoted to technical assistance and data collection and evaluation. Block-grant programs fund this staff from a set-aside, which is usually 5% of the total block-grant amount. Organizations which do not have block-grants usually have an office for program planning and program evaluation.

The FY 1994 budgets for the four organizations is summarized by object class in Figure 13. Staff costs appear to average about $50,000 for personnel compensation, with an

additional 25% for personnel benefits. It is difficult to generalize about the overhead costs of these organizations, because it is not possible to specifically identify the portions of the budget costs which directly apply to staff overhead. Rent may apply to clinical or research facilities used by contractor staff. Contractual services may include support services which directly support the operation and maintenance of facilities for the staff. A cursory review shows that an overhead factor of 25% should be applied to personnel compensation plus fringe for overhead and support costs for staff.

4.0 Analysis of Indian Health Service Programs and Functions With Self-Governance

The Indian Health Service would still retain many important responsibilities, even if all of the direct delivery of health care services were compacted to tribal organizations. The functions remaining would include:

❶ Agency management, leadership, and policy formulation,
❷ Administration and management of all IHS activities,
❸ Other inherently governmental functions,
❹ Real property, facility, and environmental systems management and maintenance,
❺ Technical assistance for tribal/contractor delivery of health care services; and,
❻ Contract and compact management and administration.

4.1 Residual Staffing for IHS Headquarters

The IHS Headquarters organizations would each retain some, if not all, of their current responsibilities. The residual staffing at IHS Headquarters would be commensurate with the reduction in activities.

The Office of the Director provides overall direction and leadership for IHS. The current staff of about 40 FTEs would not change.

OAM provides administrative leadership, direction, and coordination of all phases of IHS management. The resource allocation, budget formulation, and administrative management functions would not change. Supervision of Federal employees and some procurement functions would be reduced, since the staff size would be smaller and the procurement activities would diminish. The current staffing of about 170 FTEs might be reduced by about 20% to about 135 FTEs.

OPEL provides policy, planning, and legislative guidance and direction for the agency. These responsibilities still remain with tribal compacting, so the staff of about 40 FTEs would not change very much.

OTA is responsible for policy formulation regarding tribal activities and for communication between IHS and the tribal organizations. The current staff of about 20 FTEs would not change.

OHP provides policy formulation on the operations and management of health programs, provides technical assistance for all IHS health delivery systems, and provides leadership and direction for quality assurance activities. Many of OHP's activities could be assumed by the tribal organizations with self-governance. However, some functions, such as quality assurance, cannot be completely delegated to the tribes. The current OHP staff of about 170 FTEs could be reduced by about 75% to about 45 FTEs.

OEHE provides policy formulation and administrative leadership for environmental health, community injury control, real property management, sanitation facilities engineering, and other related engineering services for IHS. The "ownership" of Federal buildings is not expected to change with tribal self-governance. Furthermore, the engineering support for the infrastructure is not seen as a direct health care service which will be included in tribal compacts. Under these circumstances, IHS will retain all of the responsibilities for OEHE support. The current staff of about 56 FTEs would remain intact.

OHPRD responsibilities include coordination health research and development within IHS directed at improving the health of Indian people. This activity could and should be retained, even in an environment of total tribal compacting. Other activities within OHPRD could be curtailed. The current staff of OHPRD could be reduced from about 125 FTEs to about 75 FTEs.

OIRM provides technical guidance and support for the delivery of computing and information management services throughout IHS. These services will still be vital to IHS operations and to support data collection and evaluation. The OIRM staff of about 80 FTEs would not change.

OHR is responsible for human resource goals, objectives, policies, and priorities, to

ensure a current and future work force for management, program delivery, and administrative support systems through IHS. The dramatic reduction in staff, from about 15,000 Federal employees to less than 3,000 Federal employees means OHR could be reduced from about 120 FTEs to about 40 FTEs.

The Office of Tribal Self-Governance develops, directs, and oversees the implementation of Tribal Self-Governance policies and programs. This Office would have expanded responsibilities and increased activities under the scenario being considered. A staff of about 25 FTEs appears to be a reasonable estimate.

The IHS Headquarters staffing with compacting could be reduced from about 825 FTEs to about 576 FTEs with the assumptions made in the analysis.

4.2 Residual Staffing for IHS Area Offices

The twelve (12) IHS Area Offices are primarily involved with resource allocation, promotion of health care preventative services, liaison with the tribal organizations and management and administrative support for the direct delivery of health care services. The role of the Area Offices will change dramatically with tribal compacts.

The liaison between IHS and the tribal organizations will be more important than ever. Unless the current organization structure is changed, each Area Director will be the point person for compact interpretation and attempts to reopen negotiations. The Office of the Area Director will have more activity than before.

Some aspects of tribal compacting are uncertain. The responsibilities for third-party collections, for direct support of telecommunications and computing, and any place of recourse for dissatisfied tribal clients may all rest with the Area Offices.

Additionally, the Area Offices may be the primary locations for technical support,

as well as for data collection and evaluation.

The staffing and budget for Area Offices is difficult to estimate with any reliability. The particulars for each Area Office are virtually impossible. It is reasonable to expect that an Area Office can carry out its duties under self-governance with a staff of about 25 FTEs. Larger Areas with more tribes, more compacts, and larger resources to monitor may require additional staff. Total staffing required for Area Offices is estimated at about 400 FTEs. This level is a dramatic reduction from the current level of about 2,400 FTEs.

5.0 Estimates of Indian Health Service Staffing and Overhead Costs

One objective of this analysis was to derive cost estimating parameters for the staffing and operation of IHS under differing structural scenarios. Therefore, it was important to classify the costs associated with operations and maintenance into categories which could be related to staffing, support, or contracting and grants. Cost estimates for the Indian Health Service were derived by processing the budget obligations for FY 1994.[28]

The total budget of the Indian Health Service was about $2.2 billion. Certain appropriations were earmarked for specific activities. This analysis summed the budget by object class and by cost center, independent of appropriation. Figure 14 shows the budget totals by object class for the entire IHS. Analysis of the expenditure types within each object class yields details about specific expenditures; however, the one detail of interest for this study was the split of contract expenditures (Object Class 25) into Tribal Contracts (Object Class 25.8) and Other Contracts. About one-fourth of the total budget currently goes for personnel compensation. Another 7% of the budget goes for personnel benefits (about 25% of the personnel costs). About 30% of the current budget goes for Tribal Contracts and Self-Governance compacts. It should also be noted that most of the supplies budget (about 6% of the total) is used for medical supplies.

The staffing at IHS was estimated on the basis of payroll. An analysis of the total compensation hours for FY 1994[29] was used to calculate Full Time Equivalent (FTE) staff on the basis of a 2080 hour work year. IHS had 13,997 FTEs for FY 1994.

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[28] *A database of the complete budget by appropriation, accounting point, location, cost center, and object class was provided by the IHS Office of Information Management at the request of the IHS Office of Administration and Management, Budget Execution Branch.*

[29] *A report of the IHS payroll (Run IHS-100) by accounting point and location was made available by the IHS Office of Administration and Management, Budget Execution Branch.*

Another cut at IHS data was made based on Cost Centers. The classification by Cost Center was an initiative undertaken about five years ago by the financial management group of the Public Health Service (the custodian of IHS obligation data). There are about 100 cost centers ranging from Program Management to medical disciplines, such as cardiology. It is the judgment of the IHS Budget Execution Branch that the data coding by cost center category is not consistent across Accounting Points. The Cost Center data includes a prefix for type of location. The six prefixes are:

0 - Headquarters
1 - Area Office
2 - Hospital
3 - Clinic
5 - CHS
8 - Tribal

The budget by Cost Center shows 18% of the funding for Headquarters. Each IHS Area Office is designated as an Accounting Point (AP). IHS Headquarters is designated with two APs; HQ East (AP 94) and HQ West (AP65). The funding for each Accounting Point is shown in Appendix B. It is noteworthy that the total funds for the two Headquarters Account Points totals about $199 million. If the budget data is coded correctly, about $183 million allocated as "Headquarters" funds is actually obligated for expenses incurred in the Area Offices, Hospitals, Clinics, or for Tribal purposes.

An organization funding analysis was tabulated for each IHS Accounting Point by Object Class and by Cost Center Prefix. These tabulations are included as Appendix B. A comparison of staffing by Accounting Point is shown in Figure 15. Currently, six of the Areas have a staff of over 1,000 FTEs, with the Phoenix staffing level over 2,000 and Navajo staffing over 3,000. Most of this staff is associated with the IHS Hospitals and Health Centers. The staff in IHS Area Offices was tabulated from the PHS Workforce Database. Figure 16 shows the Area Office staff. Ten of the twelve Area Offices have a staff size of about 200 or less. Oklahoma Area Office and Alaska Area Office each have a staff of between 300 and 400 employees.

The budget and staffing data did not lend itself to separation of Area Office funds by Cost Center. Therefore, average costs could only be computed by Accounting Point. The average compensation for IHS is about $42,000 . The average personnel compensation per FTE was computed for each Accounting Point. This is shown in Figure 17. The average compensation for the two Headquarters Accounting Points is over $50,000, as is the average compensation for California and Alaska.

Fringe benefits average about 30% of personnel compensation agency-wide. The fringe percentage for each Accounting Point is shown in Figure 18. Only the Alaska Accounting Point varies significantly from the average. Alaska fringe is almost 50%.

Overhead expenses are complex to estimate, because it is difficult to determine which elements are directly related to labor and which expenses are programmatic, independent of staff. For this analysis, rent, supplies, and equipment was included in overhead. It appears that part of supplies expenditures goes for medical supplies, not an overhead item; however, some of the expenditures in Object Class 25 (Contracts) probably goes for overhead supplies and services. The IHS average overhead labor cost is about 30% of the labor compensation plus fringe. The average labor overhead was calculated for each Accounting Point. Figure 19 shows these calculations. The overhead for each Accounting Point is below 35%, except the Headquarters - East (AP 94) overhead, which is about 90%. This idiosyncracy was reviewed with the IHS Budget Execution Branch. It seems that certain expenses, including

6.0 Findings and Recommendations

Federal Agencies primarily responsible for the distribution and management of grants, subsidies, and contributions have a substantial organization for program management and support. IHS Headquarters is currently carrying out these functions, supported by activities in the Area Offices. The IHS Headquarters organization could be restructured to fully carry out the self-governance program management and support mission within AP94 (Rockville).

Federal block-grant programs usually include a legislated set-aside for technical assistance and data collection and evaluation. Federal extramural research programs are supported by professionals familiar with the research discipline. The agency staff for program assistance and evaluation is organized by discipline. The IHS Area Offices could be reorganized to carry out technical assistance and data collection and evaluation, as well as direct liaison with the Tribes.

A residual staff size for IHS Headquarters of 600 FTEs is consistent with the staff size found at SAMHSA and HRSA. This size would be considered modest when compared to CDC and NIH. CDC and NIH are more representative of the mission and organization for current IHS activities, including delivery of direct health care services.

A residual staff size of 25-40 FTEs for each Area Office seems appropriate for the responsibilities of providing technical assistance and data collection and evaluation, in addition to tribal liaison. This would yield a total staff of about 400 FTEs for the Area Offices.

Staff costs are difficult to estimate. An average compensation for a restructured IHS is probably about $50,000, annually. As a generalization, an average FTE with an average compensation of $50,000 would require a total of about $80,000 for total support (with 25% fringe and 25% overhead). Additional support costs for IHS include telecommunications and computer systems and software. These services are currently funded by IHS Headquarters.

There are some IHS costs for direct operation of IHS hospitals and health centers

which are obscured within the budget. These include the centralized supply services, centralized labs and pharmacies, prevention programs which are developed and promoted within IHS Headquarters, training programs, recruitment, and support for JCAHO accreditation. All of these activities would cease under self-governance, unless specific alternatives are agreed to between the Agency and the Tribes.

The current IHS budget provides a basis for establishing a budget within the framework of self-governance. The total IHS budget is about $2 billion. The current Headquarters budget is $381 million. Within the Headquarters budget, about $270 million goes for tribal contracts, capital improvements, self-governance, and undistributed clearing accounts. In a residual scenario, the IHS Headquarters budget would be about $110 million. Nearly all of the IHS Headquarters functions remain intact under self-governance, so the residual budget of $110 million should also remain intact, with perhaps a modest decrease to $100 million.

If the guideline of a 5% set-aside is accepted as reasonable, then IHS could establish a fund of about $100 million for technical assistance and data collection and evaluation. This set-aside would be a fixed percentage of the tribal contract/compact and would include support for both the Area Offices and for the services which the Tribes wished IHS to continue providing.

Of the total set-aside, about $50 million would be used for Area Office core staffing ($32 million for 400 FTEs, fully loaded, plus about $1.5 million per Area Office for other expenses). The balance ($50 million) would be available to support direct services, such as training, health promotion program development, or centralized financial services. The tribal compact negotiations would focus on the individual Tribal share of the total direct budget (after Headquarters reductions) and the services which IHS could provide within the purview of the 5% set-aside.

APPENDIX A

FIGURES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

APPROVED: [signature]

DATE: 11-4-93

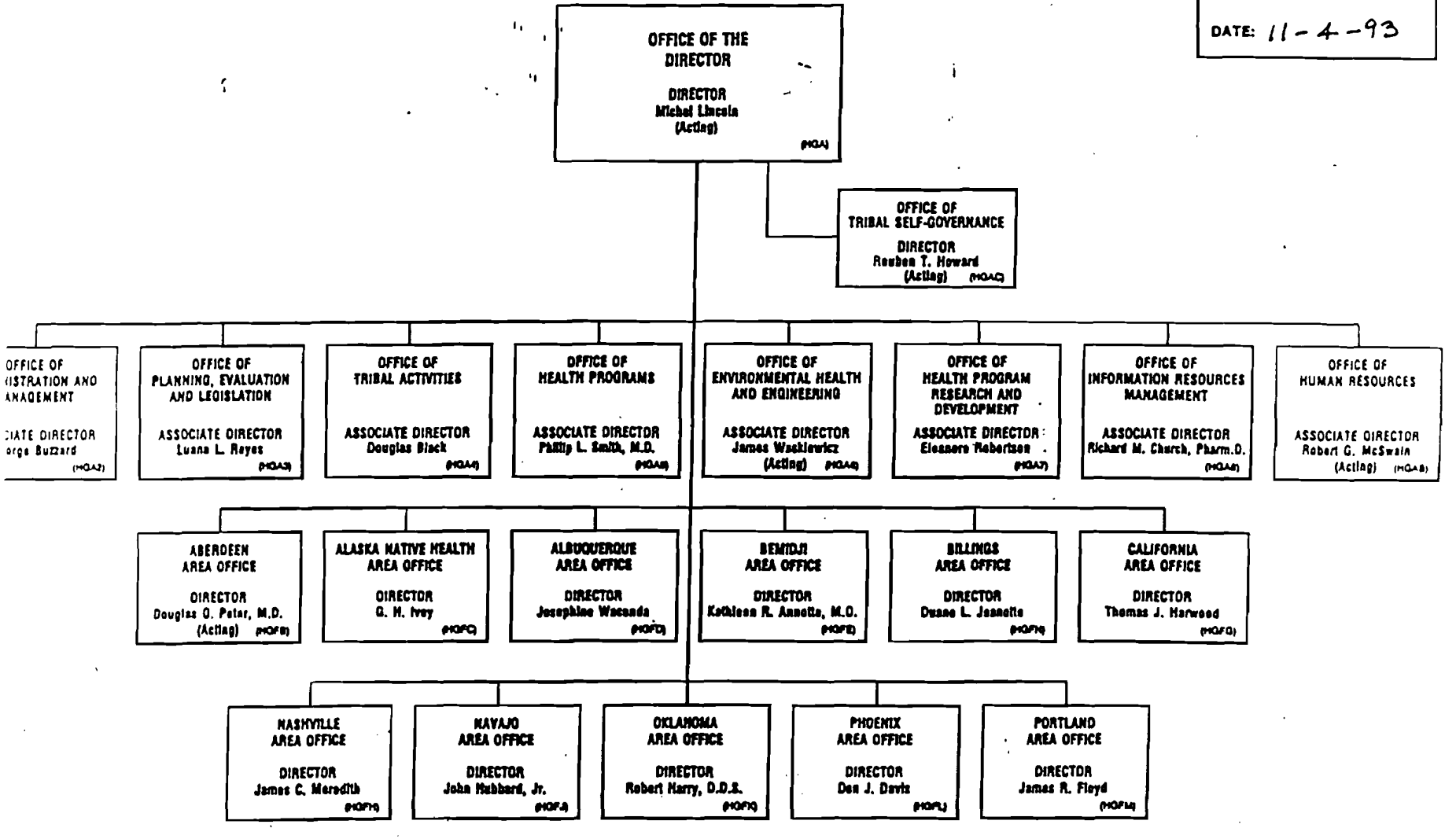


TABLE 2. SUMMARY OF IHS FACILITIES AND STAFF

	Number of Locations	Staff (FTEs)	(%)
TOTAL IHS	240	13,997	100%
HEADQUARTERS - EAST (AP94)	1	371	3%
HEADQUARTERS - WEST	1	151	1%
HEADQUARTERS - TUCSON	1	104	1%
HEADQUARTERS - SUPPLY DEPOT	1	40	0%
HEADQUARTERS - ABD,NAV,OKL,PHX,OTH	5	20	0%
REGIONAL OFFICES - OES	3	57	0%
AREA OFFICES	12	2,037	15%
SERVICE UNITS	74	n/a	n/a
HOSPITALS	42	8,820	63%
HEALTH CENTERS	65	1,548	11%
OTHER HEALTH FACILITIES	35	844	6%

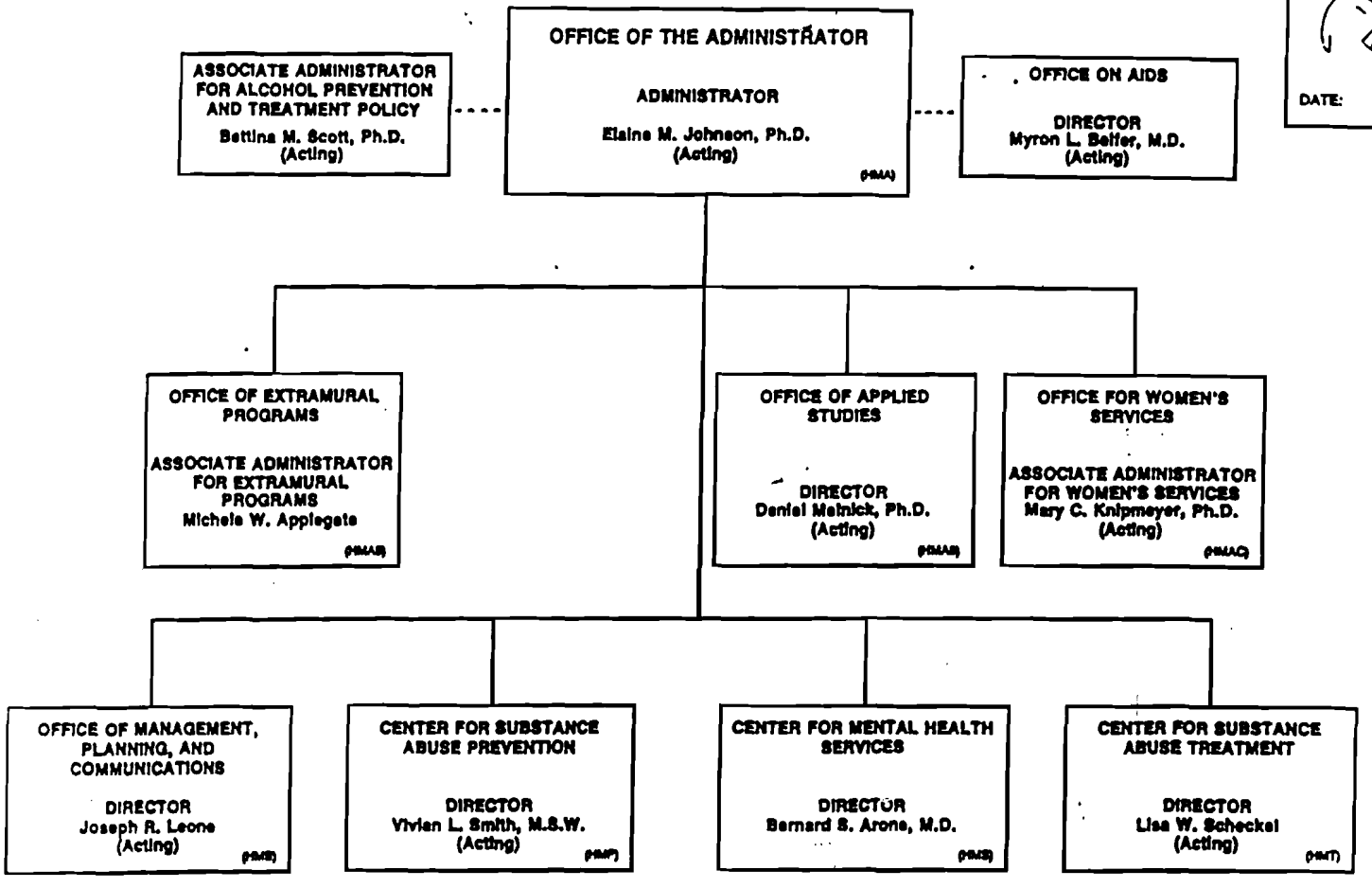
Data Sources: Staff tabulations prepared from PHS Work Force On-Line Data System, as of 8/20/94

Note: Employee counts are from personnel records; staff FTEs are computed from payroll data

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

Substance Abuse and Mental Health Services Administration

APPROVED Richard Kusserow
DATE: 10/26/93

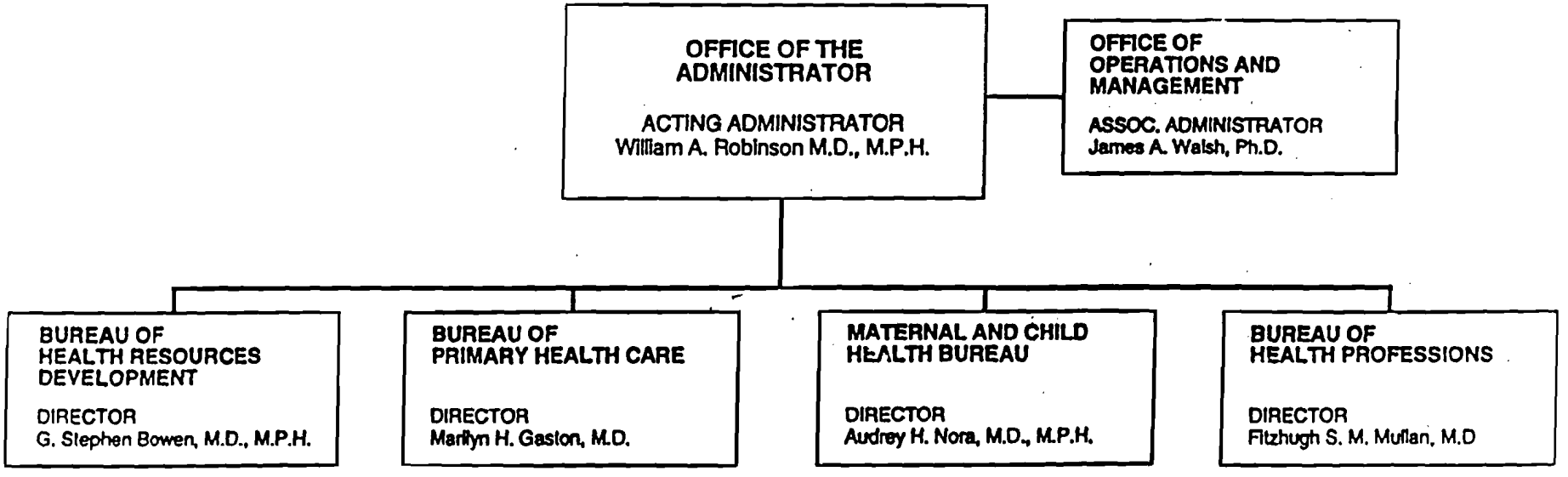


Substance Abuse and Mental Health Services Administration

Budget Authority by Object Class, FY 1994 Appropriation

		FTEs	753
Object Class	Description		
11	Personnel Comp.		$35,090,000
12	Pers. Benefits		$6,512,000
21	Travel		$1,535,000
22	Transportation of things		$102,000
23	Rent, Commun, Utilities		$5,990,000
24	Printing & Reproduction		$2,242,000
25	Contractural Services		$161,679,000
26	Supplies		$328,000
31	Equipment		$887,000
	Investments & Loans		$0
XX	Grants, subsidies & contributions		$1,935,813,000
Total budget authority by object class			**$2,150,178,000**

DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION



Health Resources and Services Administration

Budget Authority by Object Class, FY 1994 Appropriation

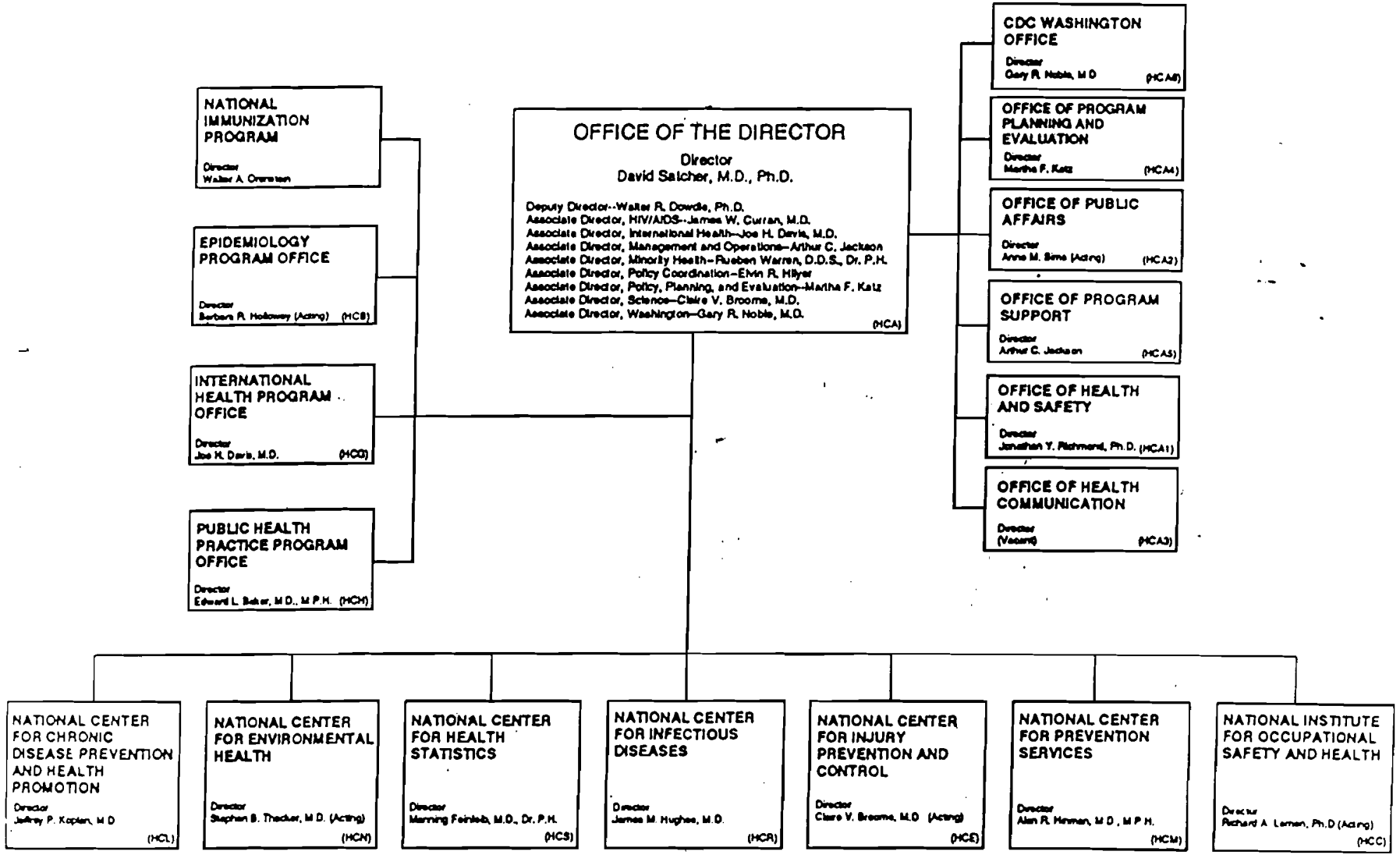
	FTEs	**2,054**
Object Class	Description	
11	Personnel Comp.	$106.880,000
12	Pers. Benefits	$22,354,000
21	Travel	$3.320.000
22	Transportation of things	$1,216,000
23	Rent, Commun, Utilities	$10,791,000
24	Printing & Reproduction	$750,000
25	Contractural Services	$79,481,000
26	Supplies	$3,108,000
31	Equipment	$2,247,000
	Investments & Loans	$7,800,000
XX	Grants, subsidies & contributions	$2,688,223,000
Total budget authority by object class		**$2,926,170,000**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

January 1994

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)



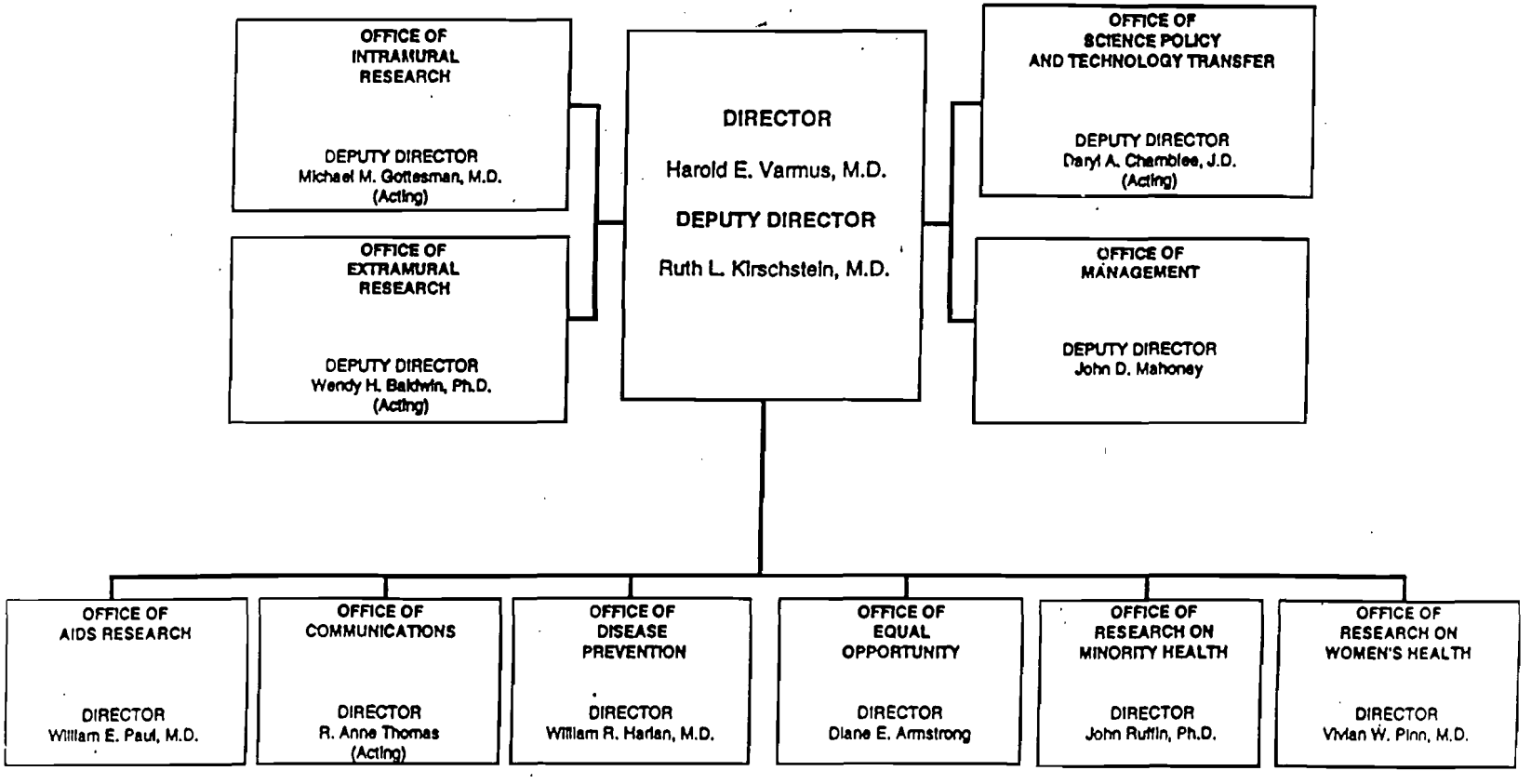
Center for Disease Control and Prevention

Budget Authority by Object Class, FY 1994 Appropriation

	FTEs	**6,502**
Object Class	Description	
11	Personnel Comp.	$224,768,000
12	Pers. Benefits	$57,731
21	Travel	$11,074,000
22	Transportation of things	$3,156,000
23	Rent, Commun, Utilities	$30,206,000
24	Printing & Reproduction	$4,412,000
25	Contractural Services	$173,503,000
26	Supplies	$7,673,000
31	Equipment	$8,964,000
	Land and Structures	$15,434,000
XX	Grants, subsidies & contributions	$1,571,884,269
Total budget authority by object class		**$2,051,132,000**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
National Institutes of Health

Office of the Director



NATIONAL INSTITUTES OF HEALTH

FY 1994 STAFF & BUDGET BY INSTITUTE

	STAFFING - FTEs						BUDGET
Institute	TOTAL	OD	RMS	OPPE	OAM	OPRM	
NCI	2,400	385	516				$1,868,810,000
NHLBI	885	10	465	34	50		$1,222,903,000
NIDR	362	8	88	41	19		$158,089,000
NIDDK	560	71	109				$705,616,000
NINDS	716	70	125				$608,545,000
NIAID	1,144	171	322				$520,792,000
NIGMS	188	34	135	51	36		$851,566,000
NICHD	523	9	189		90		$498,769,000
NEI	257	42	29				$281,879,000
NIEHS	735	90	104		137		$258,641,000
NIA	458	76	89				$418,639,000
NIAMS	150	37	36				$220,485,000
NIDCD	117	14	60		33		$161,316,000
NIMH	957	8	315			74	$526,262,000
NIDA	401	21	266			65	$281,825,000
NIAAA	244	7	83			41	$176,160,000
NCRR	102	n/a	102				$270,532,000
NINR	52	3	39	5	11		$46,574,000
NCHGR	153	7	54		30		$128,701,000
FIC	80	23	80				$12,825,000
Subtotal	10,584	1,086	3,206	131	406	180	$9,218,929,000
NLM	614		100				$116,899,000
OD	717	658	717				$207,861,000
Cen. Svcs.	4,889						
B&F							$111,039,000
Ofc Aids Res.							$1,301,045,000
TOTAL - NIH	16,804	1,744	4,023	131	406	180	$10,955,773,000

COMPARISON OF BUDGETS FOR OTHER ORGANIZATIONS

		SAMSHA	HRSA	CDC	NIH
	FTEs	703	2,054	6,502	16,804
Object Clas	Description				
11	Personnel Comp.	$35,090,000	$106,880,000	$224,768,000	$644,941,000
12	Pers. Benefits	$6,512,000	$22,354,000	$57,731	$134,706,000
21 & 22	Travel & transportation	$1,637,000	$4,536,000	$14,230,000	$24,255,000
23	Rent, Commun, Utilities	$5,990,000	$10,791,000	$30,206,000	$15,034,000
24	Printing & Reproduction	$2,242,000	$750,000	$4,412,000	$16,587,000
25	Contractural Services	$161,679,000	$79,481,000	$173,503,000	$1,987,656,000
26	Supplies	$328,000	$3,108,000	$7,673,000	$117,835,000
31	Equipment	$887,000	$2,247,000	$8,964,000	$89,557,000
	Investments & Loans	$0	$7,800,000	$15,434,000	$1,000
XX	Grants, subsidies & contribs.	$1,935,813,000	$2,688,223,000	$1,571,884,269	$7,925,201,000
		$2,150,178,000	$2,926,170,000	$2,051,132,000	$10,955,773,000

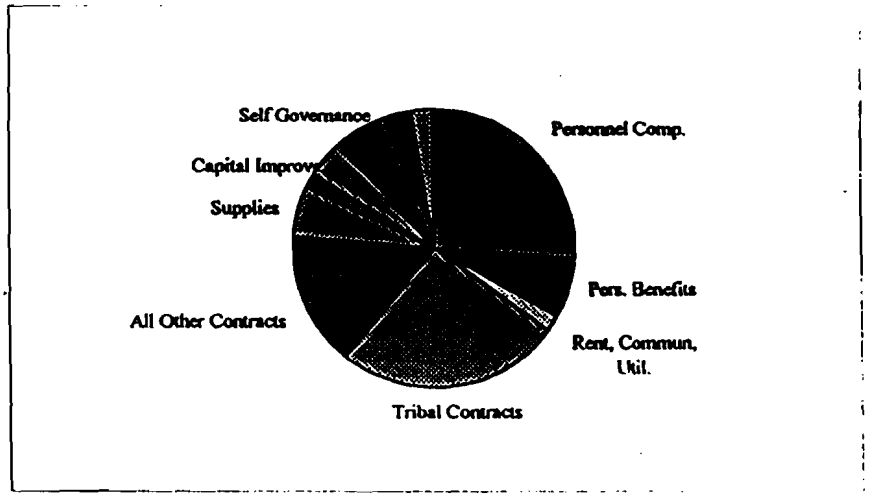
ORGANIZATION ANALYSIS FOR: I H S

Total FTEs: 13.997

Total Budget: $2.155.467.114

BUDGET BY OBJECT CLASS

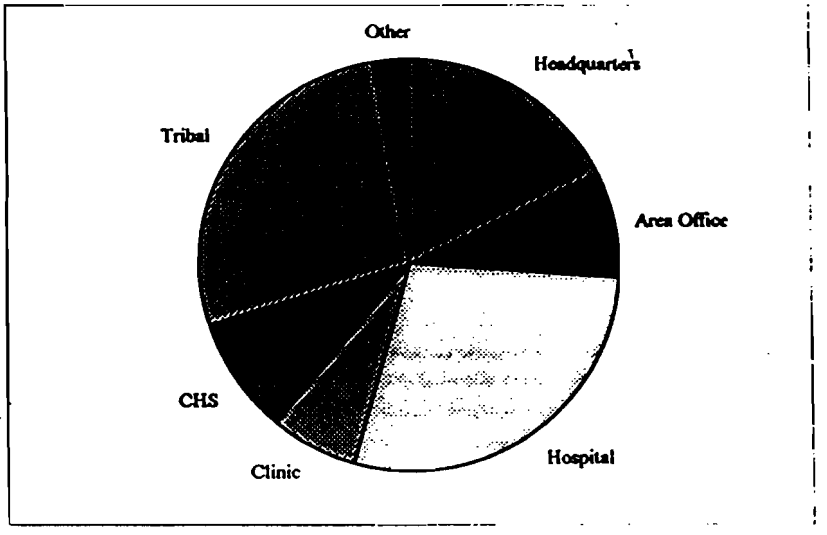
Object Class	Description	Budget $$	%
11	Personnel Comp.	$562,529,459	26%
12	Pers. Benefits	$151,460,836	7%
23	Rent, Commun, Util.	$42,919,378	2%
25.8	Tribal Contracts	$555,495,783	26%
25.X	All Other Contracts	$334.594.754	16%
26	Supplies	$124.302.660	6%
31	Equipment	$36,416,014	2%
32	Capital Improve.	$95.876.174	4%
41	Self Governance	$113.532.580	5%
96	Undistrib. Clrg. Acct.	$83.790.366	4%
XX	Other	$54.549.109	3%

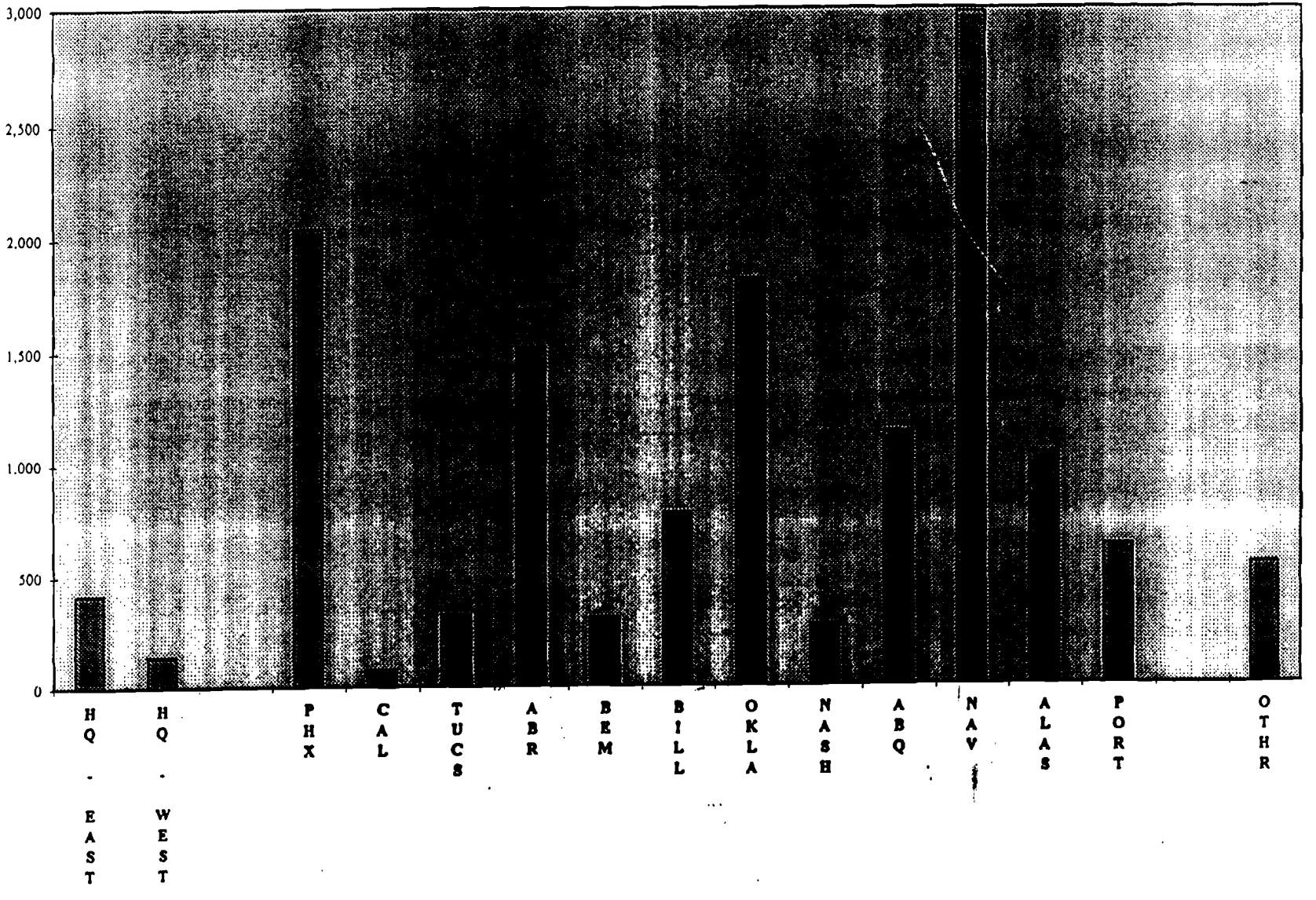


ORGANIZATION ANALYSIS FOR: I H S (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$381,453,166	18%
1	Area Office	$183,228,435	9%
2	Hospital	$607,428,428	28%
3	Clinic	$144,336,102	7%
5	CHS	$199,904,855	9%
8	Tribal	$582,016,163	27%
X	Other	$57,099,966	3%

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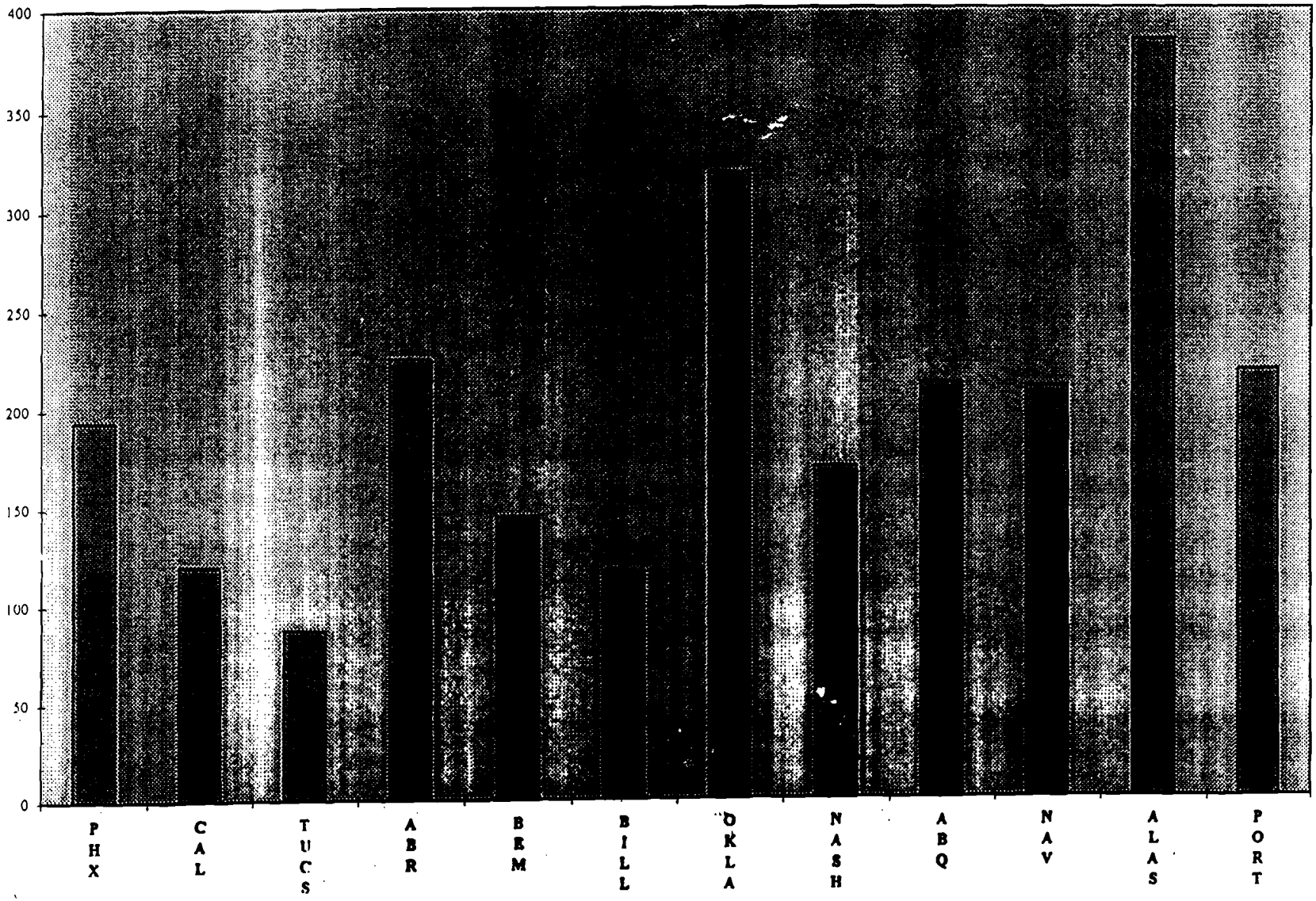
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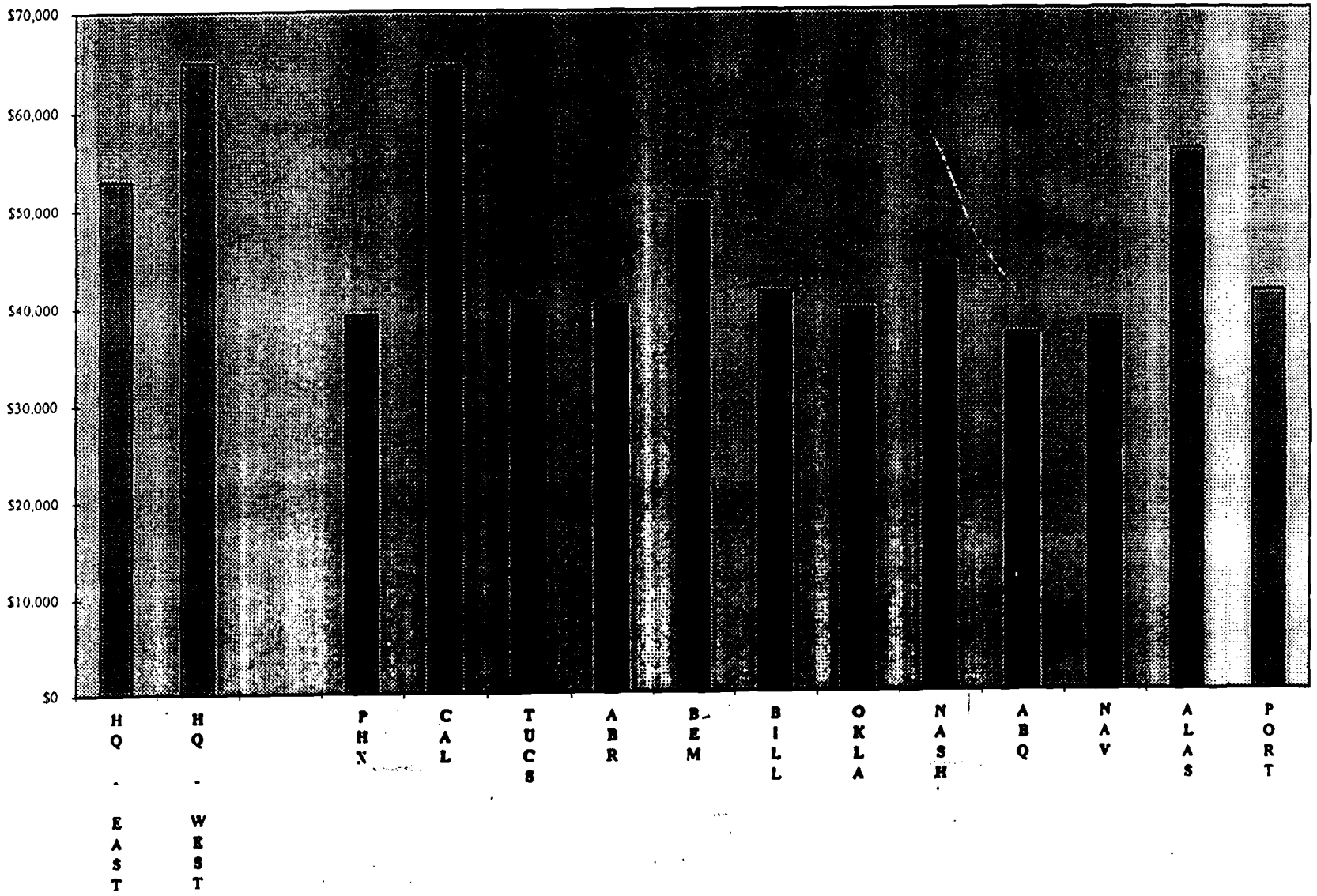
Sheet1 Chart 3



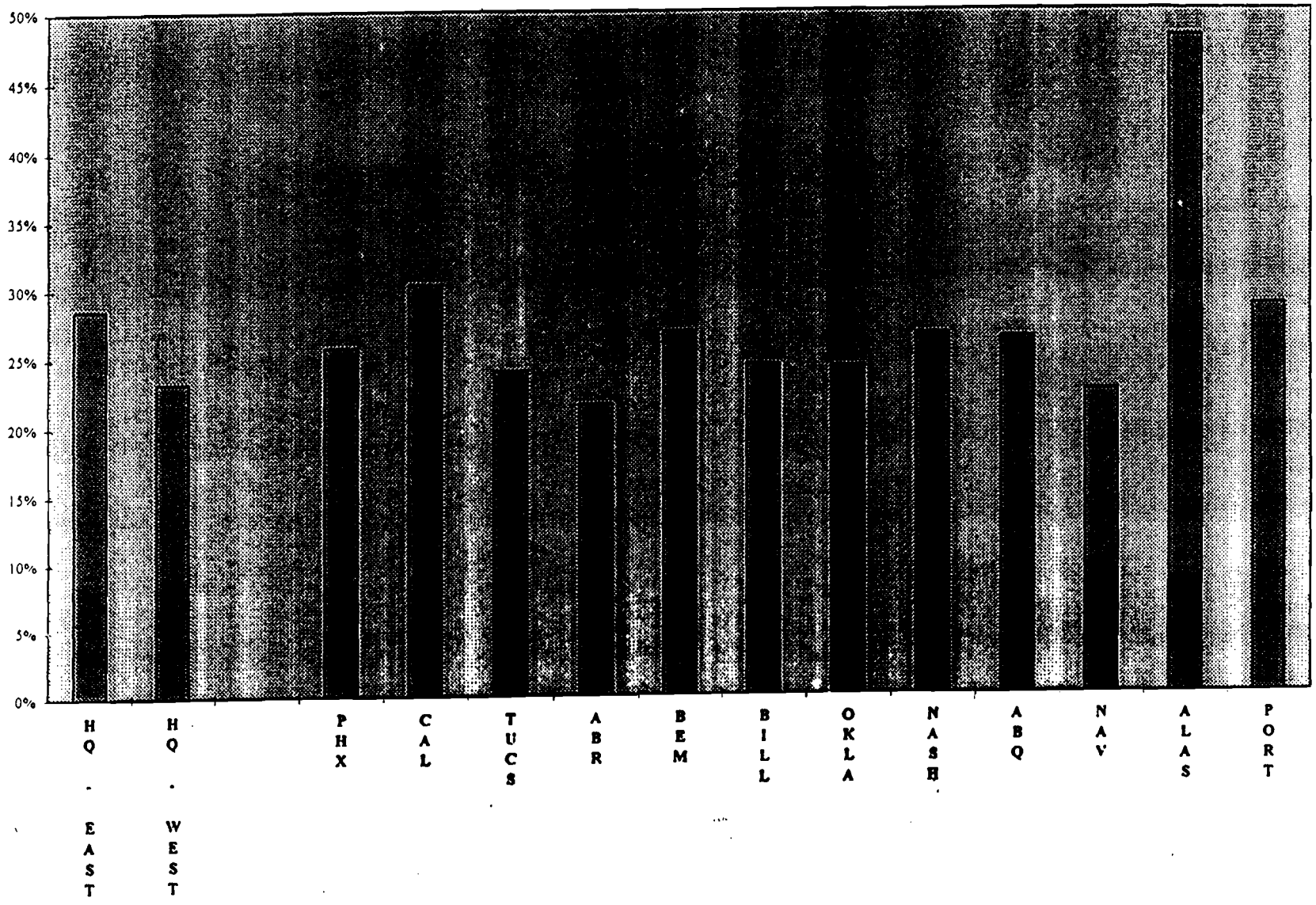

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TABLE 3. SUMMARY OF IHS FACILITIES BY AREA

	# of Service Units	# of Hospitals	# of Health Centers	# of School Health Centers	# of Field Stations & Other
TOTALS	74	42	65	4	31
Aberdeen	13	9	7	1	4
Alaska	3	2	1	0	0
Albuquerque	6	5	8	1	3
Bemidji	3	2	2	0	2
Billings	8	3	8	0	5
California	0	0	0	0	0
Nashville	1	1	0	1	1
Navajo	8	6	8	0	7
Oklahoma	10	5	12	0	0
Phoenix	10	8	6	1	6
Portland	11	0	11	0	2
Tucson	1	1	2	0	1

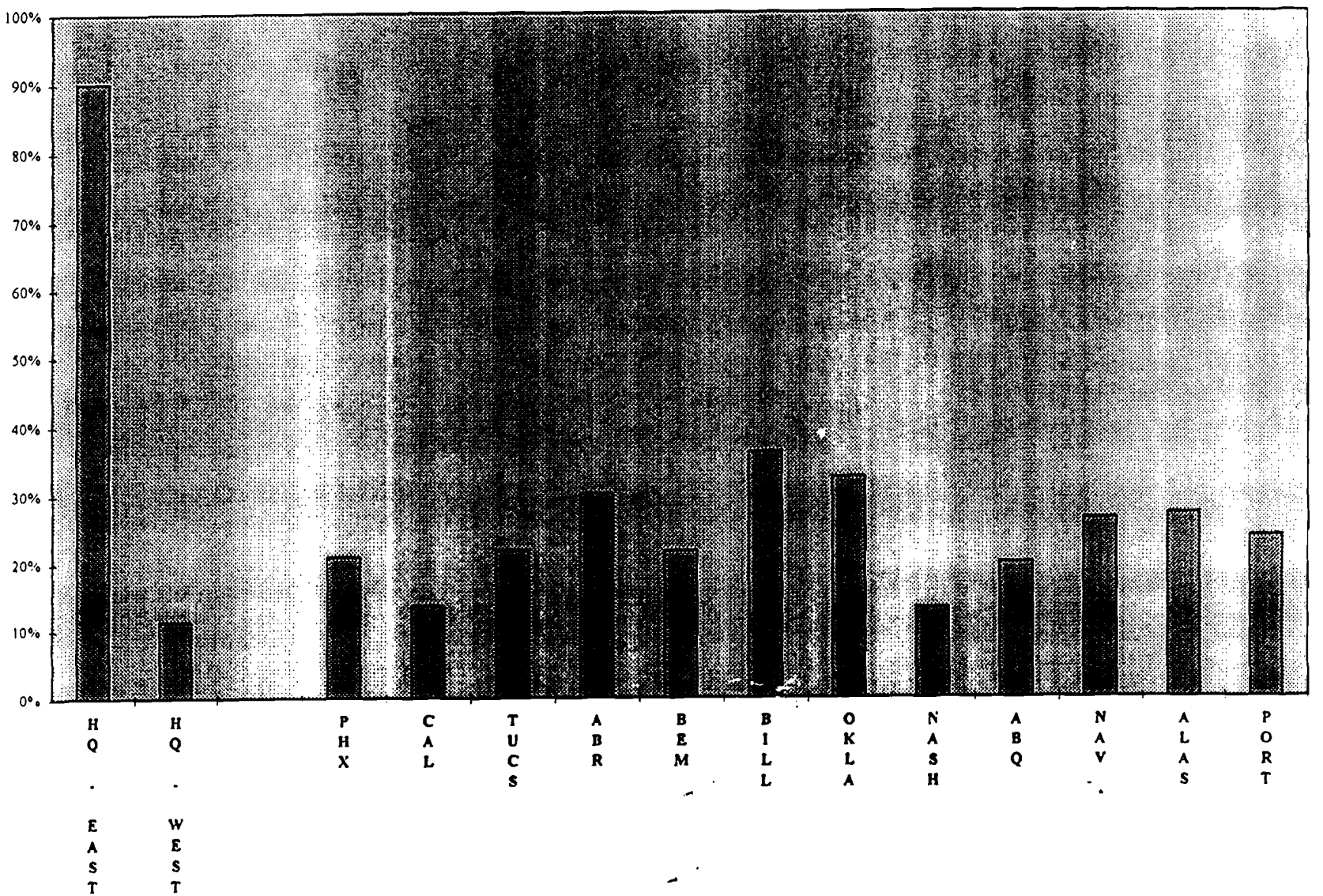
Data Source: Facility counts from data tabulations prepared by IHS Headquarters Patient Care Statistics Branch

TABLE 4. SUMMARY OF IHS EMPLOYEES BY AREA

	TOTAL STAFF by AREA	Staff at Area Offices	Staff at Service Units & Other	Staff at Hospitals	Staff at Health Centers
TOTALS	15010	2401	995	9852	1762
Aberdeen	1764	225	57	1283	199
Alaska	1467	384	265	818	n/a
Albuquerque	1283	212	7	962	102
Bemidji	415	145	20	201	49
Billings	910	117	21	462	310
California	120	120	0	0	0
Nashville	337	170	13	154	0
Navajo	3256	210	36	2721	289
Oklahoma	2106	319	232	1346	209
Phoenix	2248	194	233	1702	119
Portland	773	218	104	0	451
Tucson	331	87	7	203	34

Data Source: Staff tabulations prepared from PHS Work Force On-Line Data System, as of 8/20/94

Note: Employee counts are from personnel records; staff FTEs are computed from payroll data


100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
HQ - EAST
HQ - WEST
PHX
CAL
TUCS
ABR
BEM
BILL
OKLA
NASH
ABQ
NAV -
ALAS
PORT

APPENDIX B

ORGANIZATION ANALYSIS BY ACCOUNTING POINT

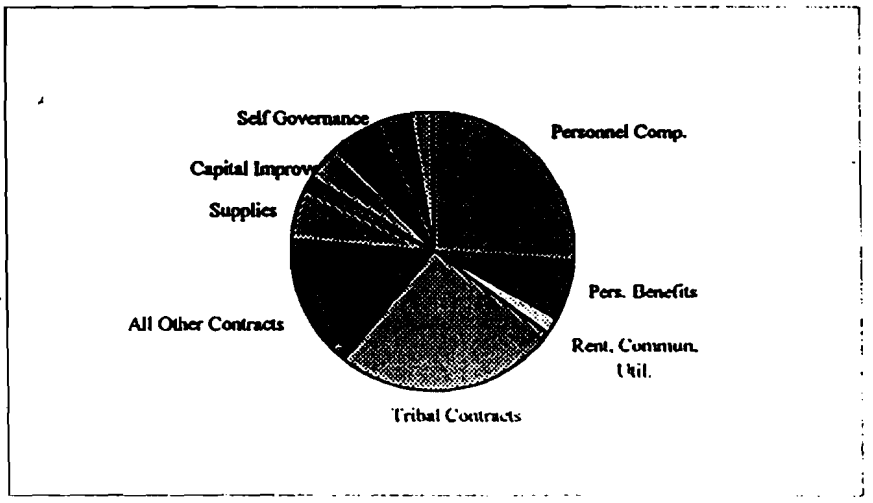
ORGANIZATION ANALYSIS FOR: I H S

Total FTEs: 13.997

Total Budget: $2,155,467,114

BUDGET BY OBJECT CLASS

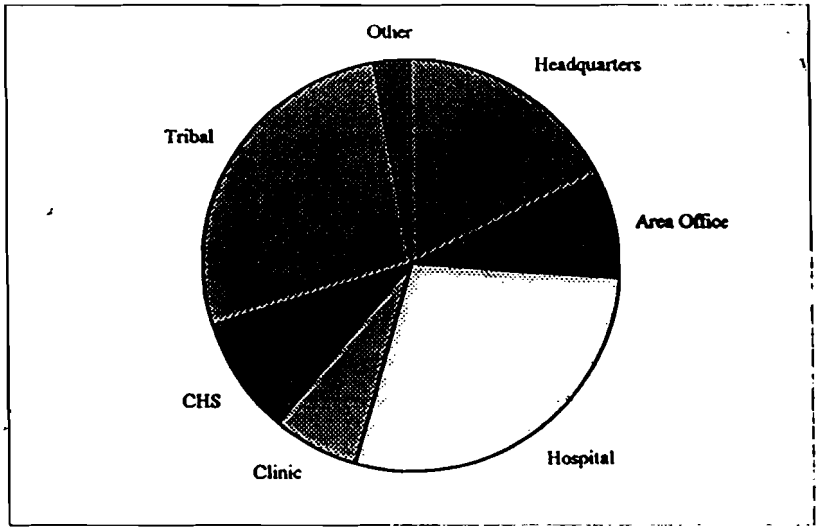
Object Class	Description	Budget $$	%
11	Personnel Comp.	$562,529,459	26%
12	Pers. Benefits	$151,460,836	7%
23	Rent, Commun. Util.	$42,919,378	2%
25.8	Tribal Contracts	$555,495,783	26%
25.X	All Other Contracts	$334,594,754	16%
26	Supplies	$124,302,660	6%
31	Equipment	$36,416,014	2%
32	Capital Improve.	$95,876,174	4%
41	Self Governance	$113,532,580	5%
96	Undistrib. Clrg. Acct.	$83,790,366	4%
XX	Other	$54,549,109	3%



ORGANIZATION ANALYSIS FOR: I H S (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$381,453,166	18%
1	Area Office	$183,228,435	9%
2	Hospital	$607,428,428	28%
3	Clinic	$144,336,102	7%
5	CHS	$199,904,855	9%
8	Tribal	$582,016,163	27%
X	Other	$57,099,966	3%



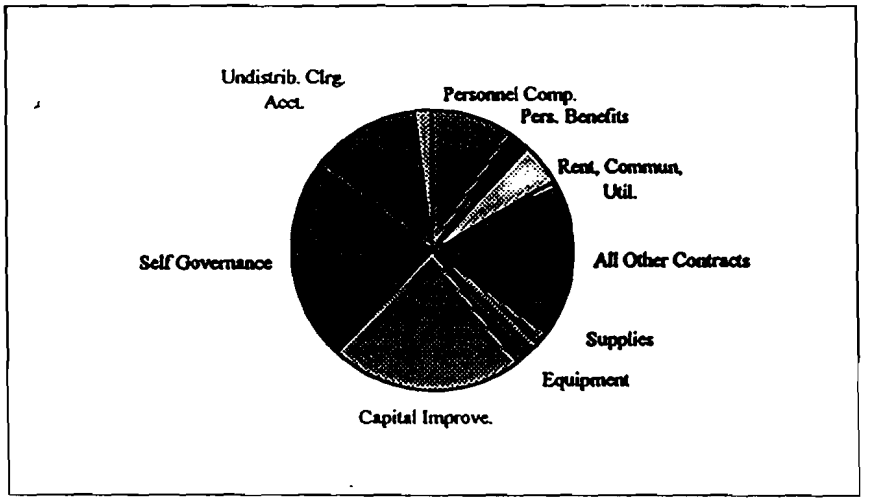
ORGANIZATION ANALYSIS FOR: HEADQUARTERS

Total FTEs: 793

Total Budget: $381,453,166

BUDGET BY OBJECT CLASS

Object Class	Description	Budget $$	%
11	Personnel Comp.	$37,181,509	10%
12	Pers. Benefits	$7,867,319	2%
23	Rent, Commun, Util.	$19,649,374	5%
25.8	Tribal Contracts	$1,665,955	0%
25.X	All Other Contracts	$67,218,651	18%
26	Supplies	$9,580,527	3%
31	Equipment	$8,746,250	2%
32	Capital Improve.	$84,264,270	22%
41	Self Governance	$89,076,558	23%
96	Undistrib. Clrg. Acct.	$48,555,195	13%
XX	Other	$7,647,557	2%

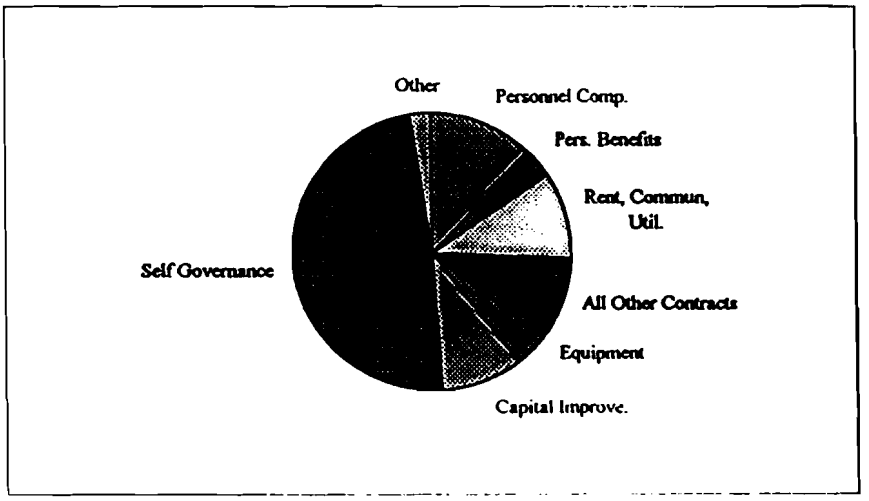


ORGANIZATION ANALYSIS FOR: AP94 - HQ EAST

Total FTEs:	418
Total Budget:	$183,133,143

BUDGET BY OBJECT CLASS

Object Class	Description	Budget $$	%
11	Personnel Comp.	$22,161,700	12%
12	Pers. Benefits	$6,321,296	3%
23	Rent, Commun, Util.	$18,276,551	10%
25.8	Tribal Contracts	$442,078	0%
25.X	All Other Contracts	$17,834,473	10%
26	Supplies	$228,981	0%
31	Equipment	$7,149,089	4%
32	Capital Improve.	$17,108,918	9%
41	Self Governance	$89,076,558	49%
96	Undistrib. Clrg. Acct.	$0	0%
XX	Other	$4,533,498	2%

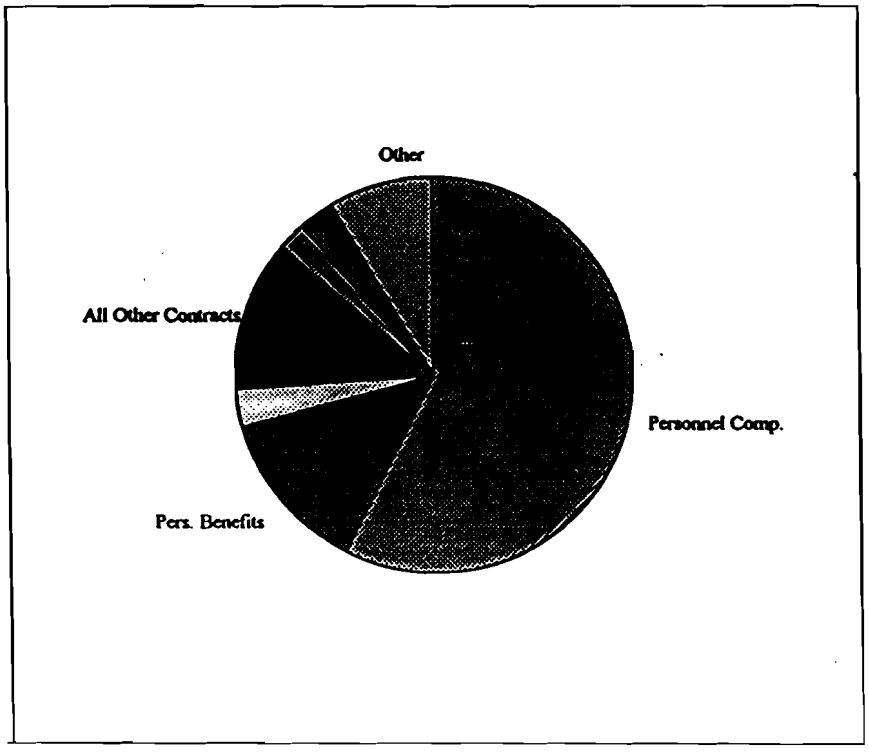


ORGANIZATION ANALYSIS FOR: AP65 - HQ WEST

Total FTEs:	137
Total Budget:	$15,417,328

BUDGET BY OBJECT CLASS

Object Class	Description	Budget $$	%
11	Personnel Comp.	$8,878,874	58%
12	Pers. Benefits	$2,061,284	13%
23	Rent, Commun, Util.	$430,242	3%
25.8	Tribal Contracts	$0	0%
25.X	All Other Contracts	$1,925,426	12%
26	Supplies	$365,692	2%
31	Equipment	$441,394	3%
32	Capital Improve.	$0	0%
41	Self Governance	$0	0%
96	Undistrib. Clrg. Acct.	$0	0%
XX	Other	$1,314,415	9%

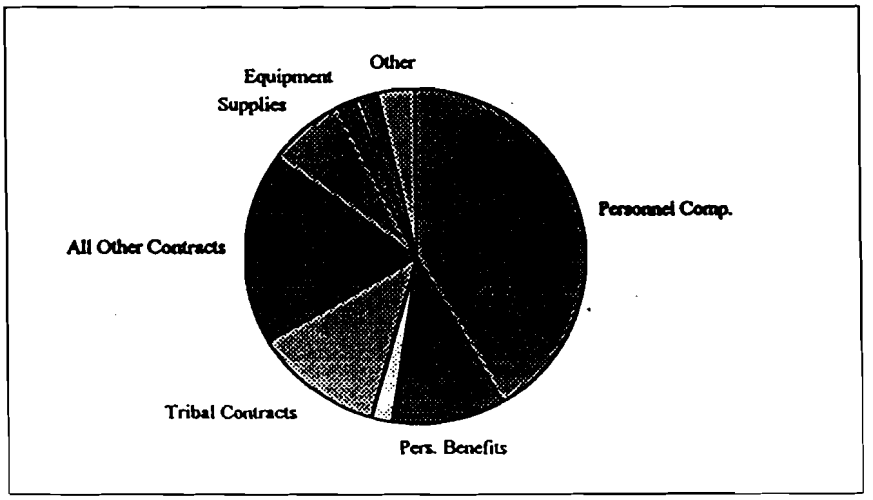


ORGANIZATION ANALYSIS FOR: AP40 - PHOENIX

Total FTEs:	2,041
Total Budget:	$191,577,820

BUDGET BY OBJECT CLASS

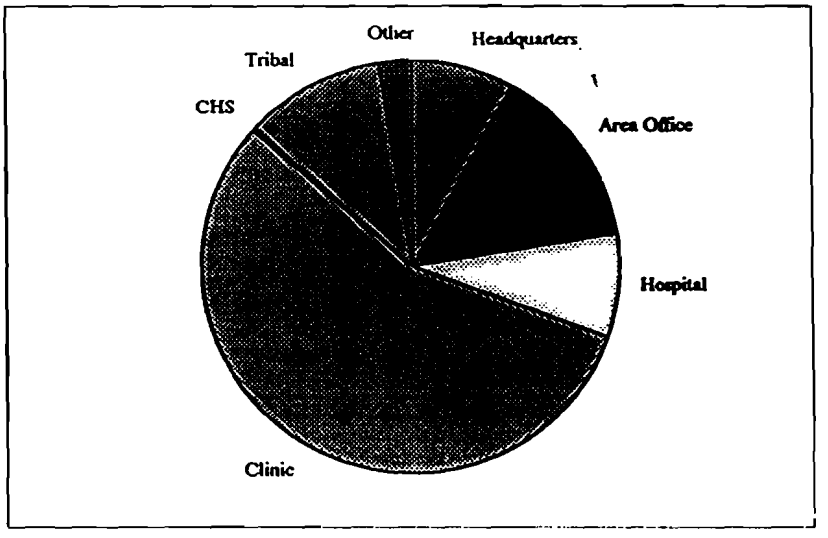
Object Class	Description	Budget $$	%
11	Personnel Comp.	$79,984,753	42%
12	Pers. Benefits	$20,564,950	11%
23	Rent, Commun, Util.	$3,600,870	2%
25.8	Tribal Contracts	$23,514,787	12%
25.X	All Other Contracts	$35,281,482	18%
26	Supplies	$14,430,987	8%
31	Equipment	$2,999,782	2%
32	Capital Improve.	$854,926	0%
41	Self Governance	$0	0%
96	Undistrib. Clrg. Acct.	$3,332,865	2%
XX	Other	$7,012,418	4%



ORGANIZATION ANALYSIS FOR: AP40 - PHOENIX (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$15,256,917	8%
1	Area Office	$28,112,903	15%
2	Hospital	$15,140,685	8%
3	Clinic	$107,219,465	56%
5	CHS	$68,274	0%
8	Tribal	$21,082,616	11%
X	Other	$4,696,961	2%

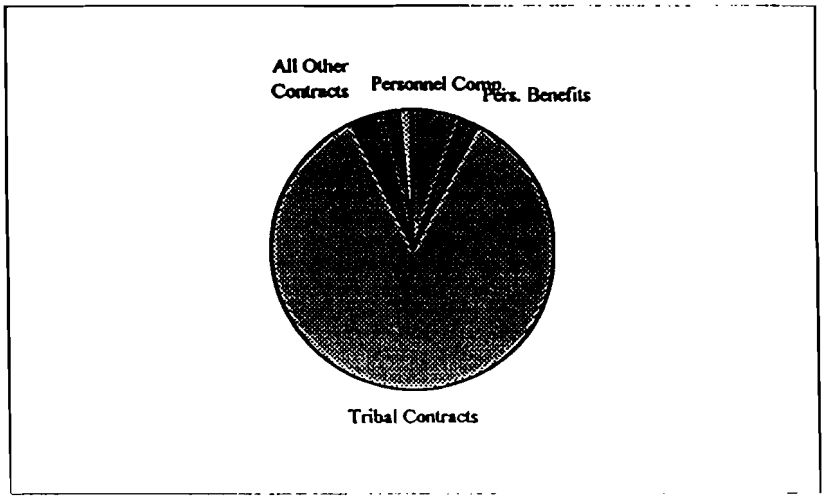


ORGANIZATION ANALYSIS FOR: AP41 - CALIFORNIA

Total FTEs:	75
Total Budget:	$83,806,706

BUDGET BY OBJECT CLASS

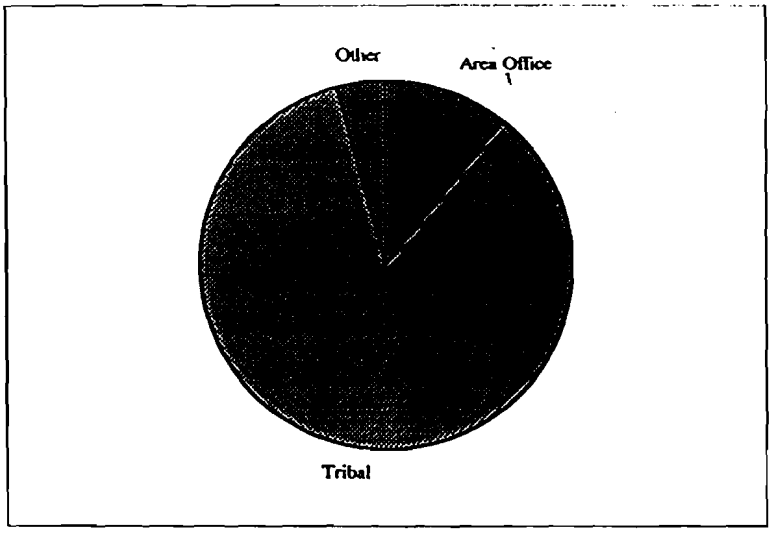
Object Class	Description	Budget $$	%
11	Personnel Comp.	$4,833,787	6%
12	Pers. Benefits	$1,462,753	2%
23	Rent, Commun, Util.	$169,323	0%
25.8	Tribal Contracts	$71,621,674	85%
25.X	All Other Contracts	$1,927,083	2%
26	Supplies	$219,205	0%
31	Equipment	$476,041	1%
32	Capital Improve.	$120,721	0%
41	Self Governance	$0	0%
96	Undistrib. Clrg. Acct.	$1,850,169	2%
XX	Other	$1,125,949	1%



ORGANIZATION ANALYSIS FOR: AP41 - CALIFORNIA (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$5,000	0%
1	Area Office	$9,010,948	11%
2	Hospital	$0	0%
3	Clinic	$0	0%
5	CHS	$107,241	0%
8	Tribal	$71,088,688	85%
X	Other	$3,594,829	4%



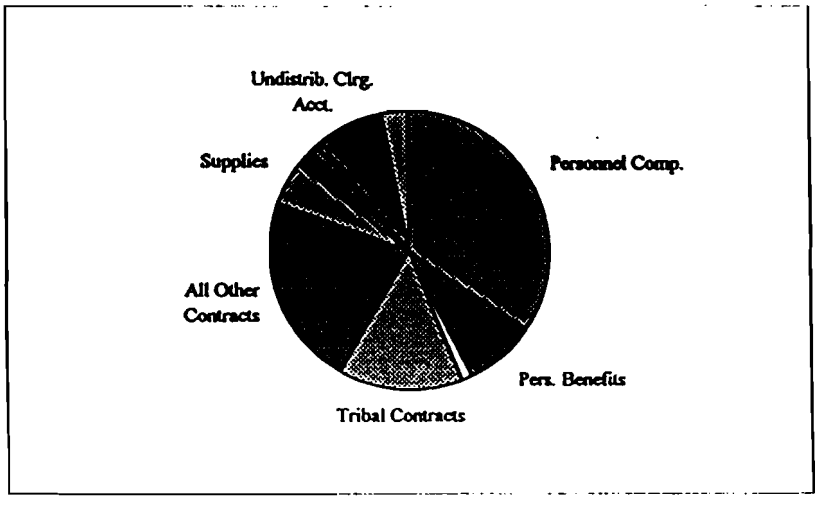
ORGANIZATION ANALYSIS FOR: AP42 - TUCSON

Total FTEs: 322

Total Budget: $37,936,902

BUDGET BY OBJECT CLASS

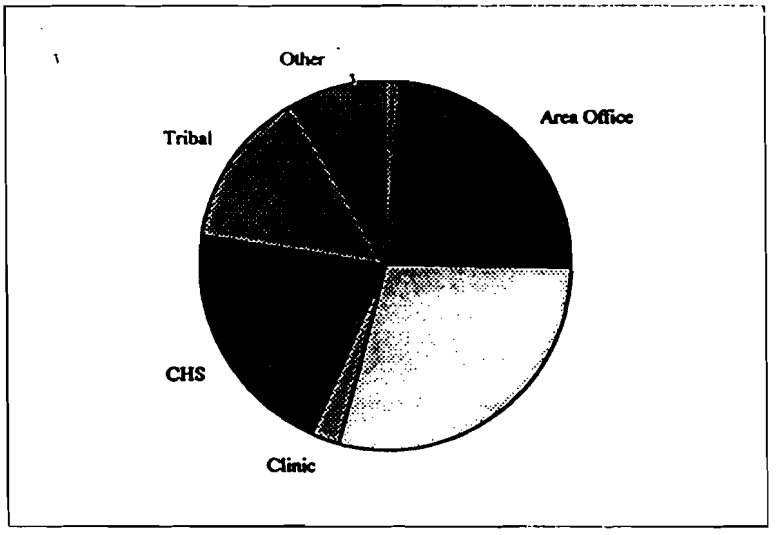
Object Class	Description	Budget $$	%
11	Personnel Comp.	$13,047,947	34%
12	Pers. Benefits	$3,131,732	8%
23	Rent, Commun, Util.	$499,693	1%
25.8	Tribal Contracts	$5,404,703	14%
25.X	All Other Contracts	$8,523,828	22%
26	Supplies	$1,869,690	5%
31	Equipment	$1,168,777	3%
32	Capital Improve.	$232,307	1%
41	Self Governance	$0	0%
96	Undistrib. Clrg. Acct.	$2,913,000	8%
XX	Other	$1,145,227	3%



ORGANIZATION ANALYSIS FOR: AP42 - TUCSON (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$566,489	1%
1	Area Office	$9,003,348	24%
2	Hospital	$11,002,947	29%
3	Clinic	$941,795	2%
5	CHS	$7,856,864	21%
8	Tribal	$5,382,699	14%
X	Other	$3,182,760	8%

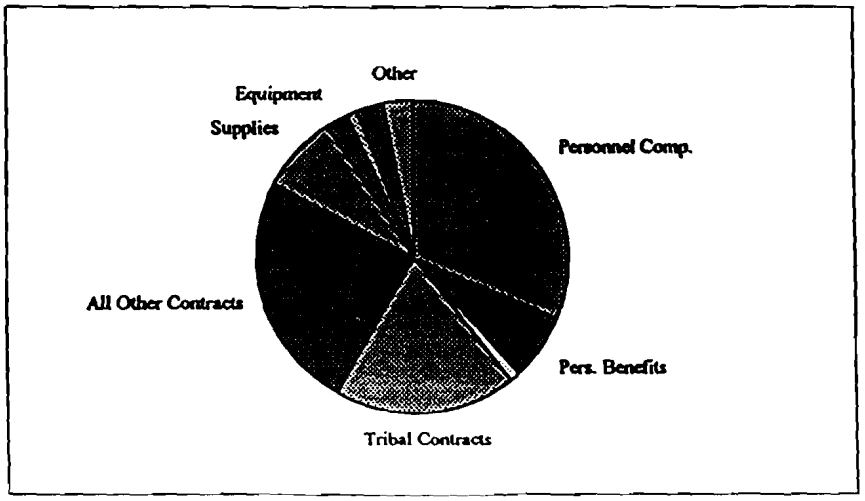


ORGANIZATION ANALYSIS FOR: AP45 - ABERDEEN

Total FTEs:	1,517
Total Budget:	$193,472,026

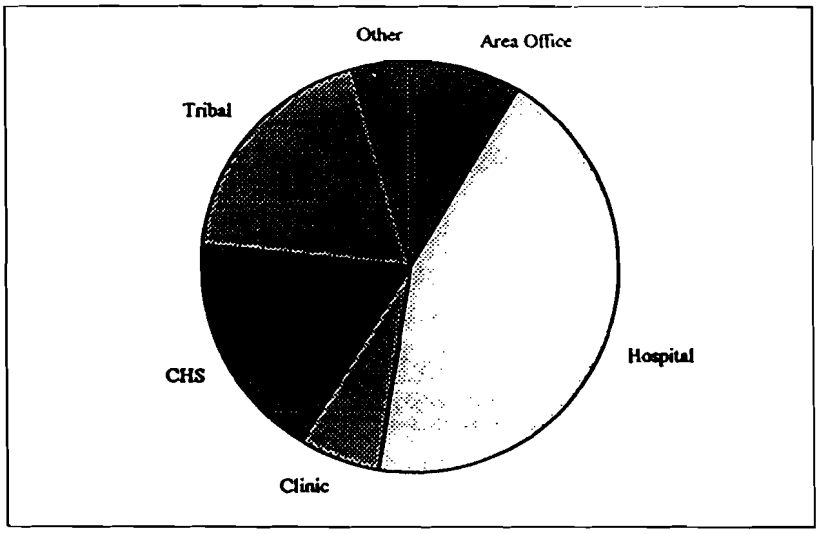
BUDGET BY OBJECT CLASS

Object Class	Description	Budget $$	%
11	Personnel Comp.	$60,903,950	31%
12	Pers. Benefits	$13,123,990	7%
23	Rent, Commun, Util.	$2,199,869	1%
25.8	Tribal Contracts	$36,473,814	19%
25.X	All Other Contracts	$47,241,578	24%
26	Supplies	$15,750,739	8%
31	Equipment	$4,390,023	2%
32	Capital Improve.	$1,926,288	1%
41	Self Governance	$0	0%
96	Undistrib. Clrg. Acct.	$5,611,130	3%
XX	Other	$5,850,644	3%



BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$587,485	0%
1	Area Office	$15,875,405	8%
2	Hospital	$85,059,525	44%
3	Clinic	$12,618,109	7%
5	CHS	$34,098,506	18%
8	Tribal	$36,848,876	19%
X	Other	$8,384,120	4%

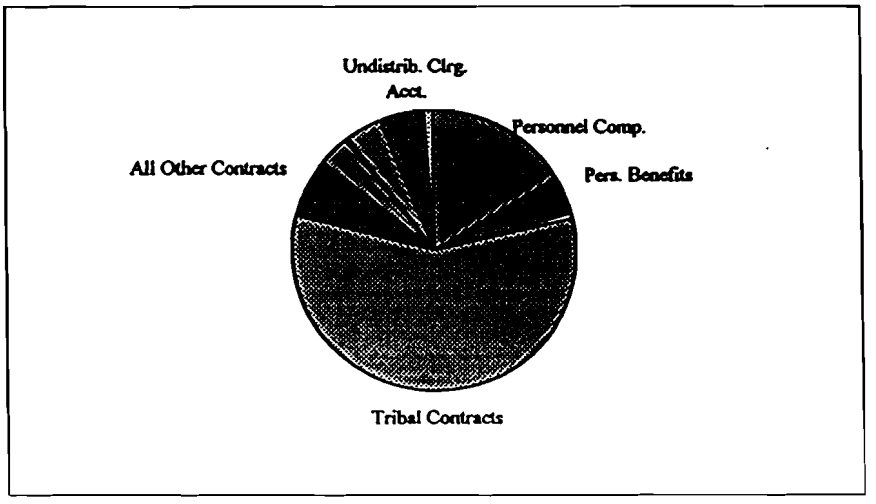


ORGANIZATION ANALYSIS FOR: AP46 - BEMIDJI

Total FTEs:	305
Total Budget:	$93,435,097

BUDGET BY OBJECT CLASS

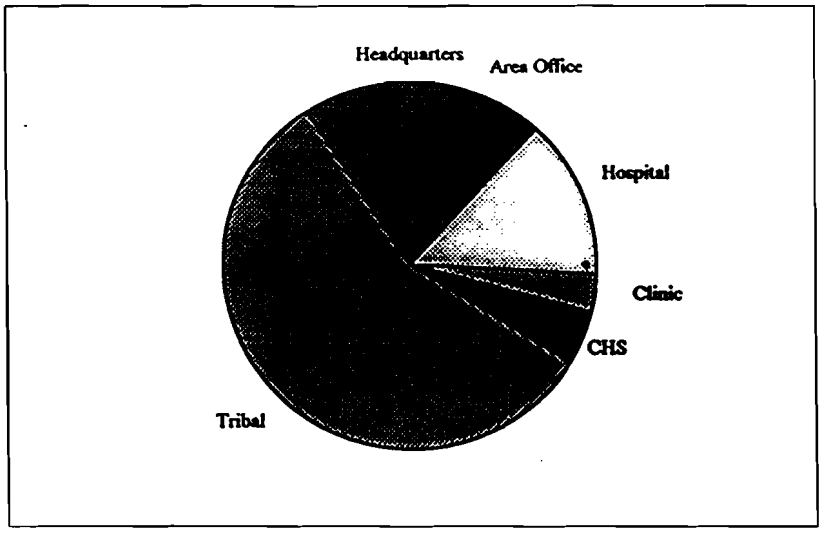
Object Class	Description	Budget $$	%
11	Personnel Comp.	$15,413,130	16%
12	Pers. Benefits	$4,128,877	4%
23	Rent, Commun, Util.	$542,919	1%
25.8	Tribal Contracts	$53,659,136	57%
25.X	All Other Contracts	$6,425,541	7%
26	Supplies	$3,407,098	4%
31	Equipment	$299,784	0%
32	Capital Improve.	$3,746,616	4%
41	Self Governance	$0	0%
96	Undistrib. Clrg. Acct.	$4,691,842	5%
XX	Other	$1,120,155	1%



ORGANIZATION ANALYSIS FOR: AP46 - BEMIDJI (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$7,000	0%
1	Area Office	$10,896,281	12%
2	Hospital	$13,317,549	14%
3	Clinic	$2,991,848	3%
5	CHS	$4,568,224	5%
8	Tribal	$53,080,982	57%
X	Other	$8,573,212	9%

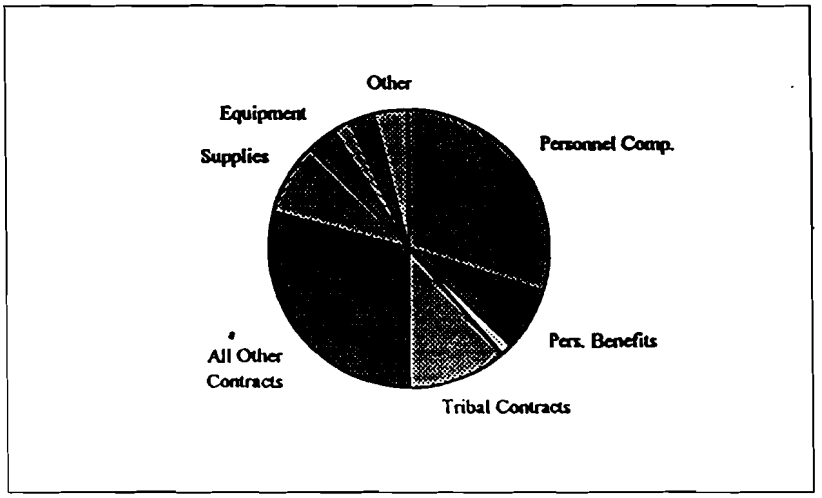


ORGANIZATION ANALYSIS FOR: AP47 - BILLINGS

Total FTEs:	778
Total Budget:	$107,740,769

BUDGET BY OBJECT CLASS

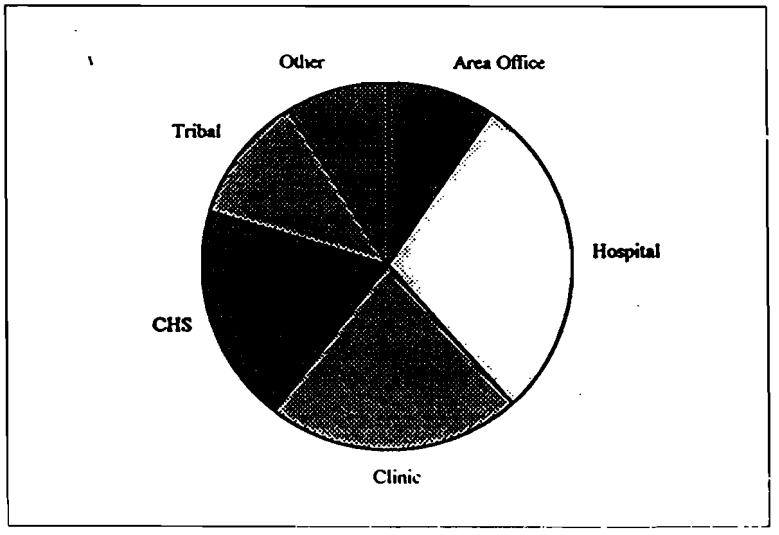
Object Class	Description	Budget $$	%
11	Personnel Comp.	$32,193,511	30%
12	Pers. Benefits	$7,844,789	7%
23	Rent, Commun, Util.	$1,603,349	1%
25.8	Tribal Contracts	$12,147,261	11%
25.X	All Other Contracts	$31,496,405	29%
26	Supplies	$9,364,262	9%
31	Equipment	$3,517,430	3%
32	Capital Improve.	$2,452,599	2%
41	Self Governance	$0	0%
96	Undistrib. Clrg. Acct.	$3,061,234	3%
XX	Other	$4,059,931	4%



ORGANIZATION ANALYSIS FOR: AP47 - BILLINGS (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$439,177	0%
1	Area Office	$9,870,645	9%
2	Hospital	$31,037,869	29%
3	Clinic	$23,771,752	22%
5	CHS	$20,864,791	19%
8	Tribal	$12,106,395	11%
X	Other	$9,650,141	9%

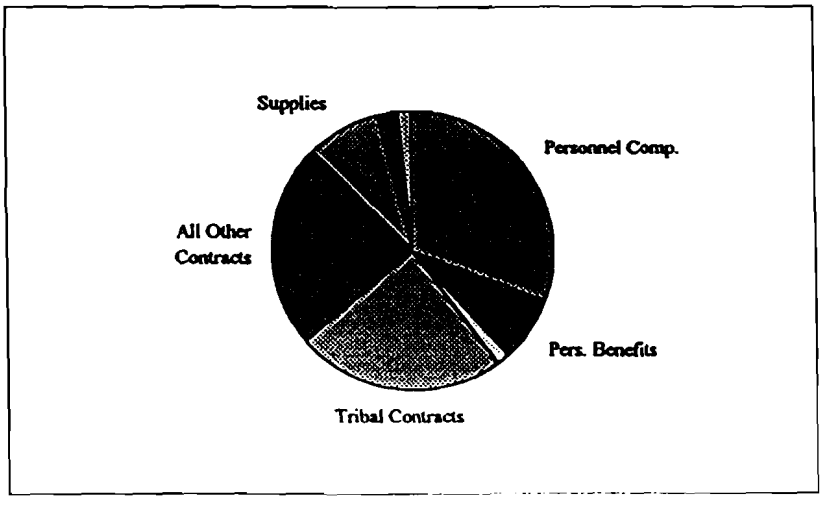


ORGANIZATION ANALYSIS FOR: AP50 - OKLAHOMA

Total FTEs:	1,811
Total Budget:	$232,873,858

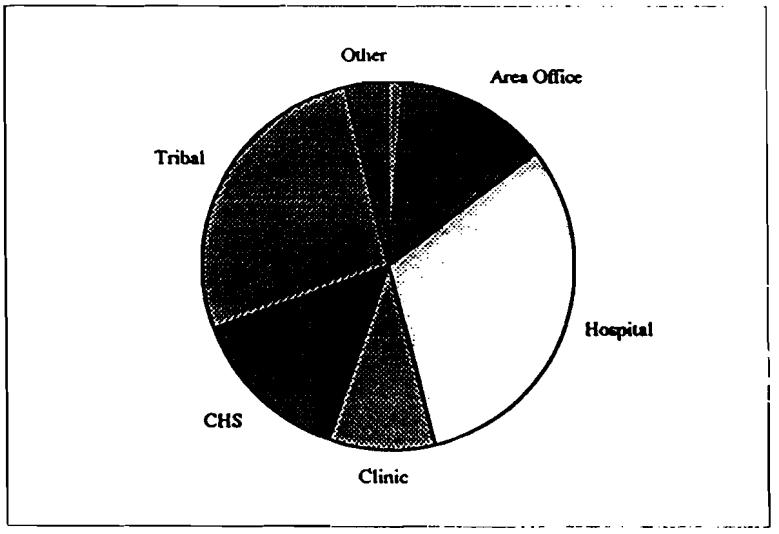
BUDGET BY OBJECT CLASS

Object Class	Description	Budget $$	%
11	Personnel Comp.	$71,825,104	31%
12	Pers. Benefits	$17,414,013	7%
23	Rent, Commun, Util.	$3,370,552	1%
25.8	Tribal Contracts	$56,296,266	24%
25.X	All Other Contracts	$54,620,661	23%
26	Supplies	$20,099,760	9%
31	Equipment	$5,509,981	2%
32	Capital Improve.	$27,034	0%
41	Self Governance	$0	0%
96	Undistrib. Clrg. Acct.	$0	0%
XX	Other	$3,710,487	2%



BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$3,405,081	1%
1	Area Office	$30,229,400	13%
2	Hospital	$73,693,730	32%
3	Clinic	$21,360,700	9%
5	CHS	$33,236,951	14%
8	Tribal	$62,712,105	27%
X	Other	$8,235,891	4%

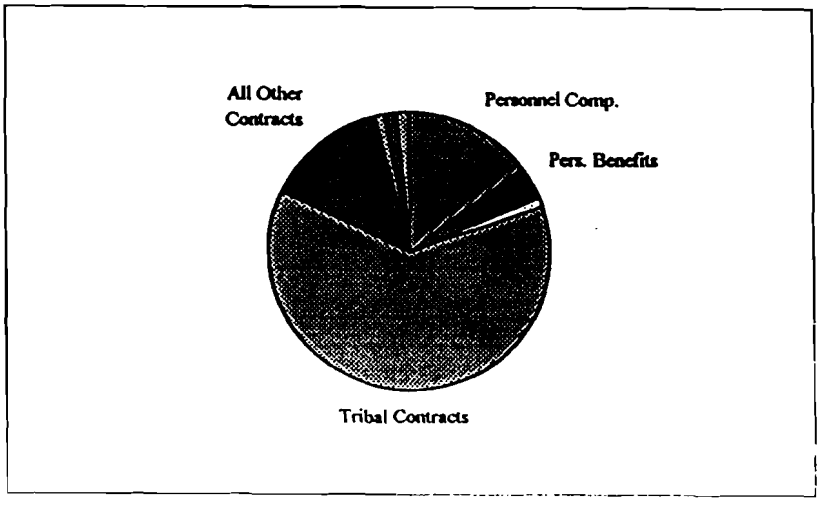


ORGANIZATION ANALYSIS FOR: AP51 - NASHVILLE

Total FTEs:	270
Total Budget:	$80,689,994

BUDGET BY OBJECT CLASS

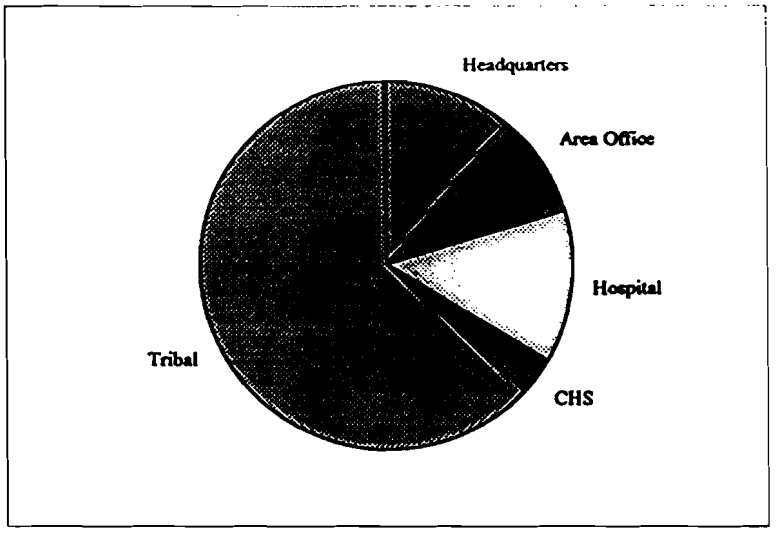
Object Class	Description	Budget $$	%
11	Personnel Comp.	$11,933,212	15%
12	Pers. Benefits	$3,173,739	4%
23	Rent, Commun, Util.	$756,630	1%
25.8	Tribal Contracts	$50,299,226	62%
25.X	All Other Contracts	$11,352,047	14%
26	Supplies	$828,591	1%
31	Equipment	$405,002	1%
32	Capital Improve.	$0	0%
41	Self Governance	$0	0%
96	Undistrib. Clrg. Acct.	$900,268	1%
XX	Other	$1,041,279	1%



ORGANIZATION ANALYSIS FOR: AP51 - NASHVILLE (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$8,996,291	11%
1	Area Office	$7,333,636	9%
2	Hospital	$10,696,071	13%
3	Clinic	$201,343	0%
5	CHS	$2,624,956	3%
8	Tribal	$50,711,470	63%
X	Other	$126,227	0%



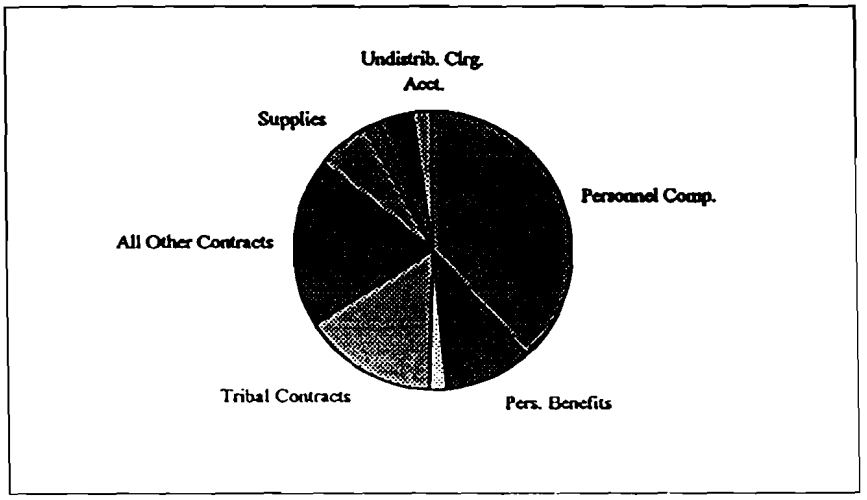
ORGANIZATION ANALYSIS FOR: AP53 - ALBUQUERQUE

Total FTEs: 1,135

Total Budget: $109,435,235

BUDGET BY OBJECT CLASS

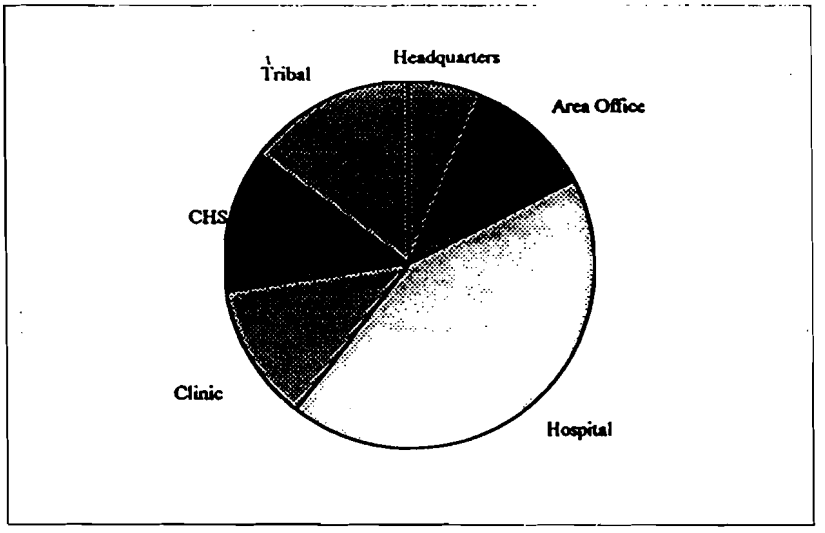
Object Class	Description	Budget $$	%
11	Personnel Comp.	$42,060,425	38%
12	Pers. Benefits	$11,053,345	10%
23	Rent, Commun, Util.	$2,212,192	2%
25.8	Tribal Contracts	$16,930,178	15%
25.X	All Other Contracts	$21,811,603	20%
26	Supplies	$6,894,274	6%
31	Equipment	$1,478,307	1%
32	Capital Improve.	$210,891	0%
41	Self Governance	$0	0%
96	Undistrib. Clrg. Acct.	$4,284,230	4%
XX	Other	$2,499,790	2%



ORGANIZATION ANALYSIS FOR: AP53 - ALBUQUERQUE (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$7,036,143	6%
1	Area Office	$12,216,116	11%
2	Hospital	$47,032,526	43%
3	Clinic	$13,041,373	12%
5	CHS	$14,060,558	13%
8	Tribal	$16,006,503	15%
X	Other	$42,016	0%



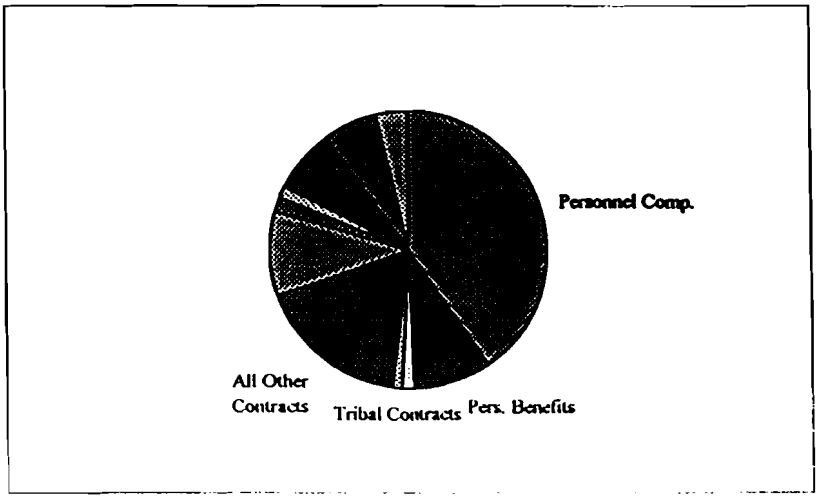
ORGANIZATION ANALYSIS FOR: AP54 - NAVAJO

Total FTEs: 2,982

Total Budget: $285,465,937

BUDGET BY OBJECT CLASS

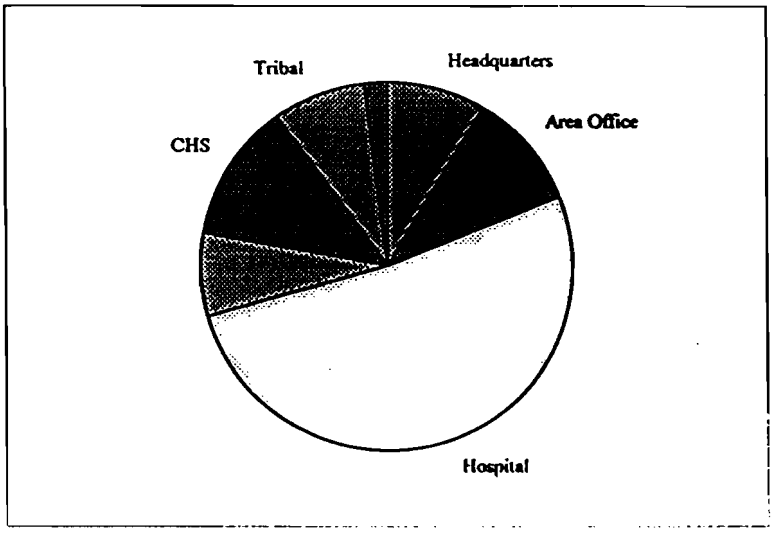
Object Class	Description	Budget $$	%
11	Personnel Comp.	$115,339,237	40%
12	Pers. Benefits	$25,850,733	9%
23	Rent, Commun, Util.	$4,272,546	1%
25.8	Tribal Contracts	$2,880,030	1%
25.X	All Other Contracts	$50,512,440	18%
26	Supplies	$27,696,694	10%
31	Equipment	$5,325,961	2%
32	Capital Improve.	$3,659,888	1%
41	Self Governance	$21,593,378	8%
96	Undistrib. Clrg. Acct.	$18,158,339	6%
XX	Other	$10,176,691	4%



ORGANIZATION ANALYSIS FOR: AP54 - NAVAJO (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$24.359,008	9%
1	Area Office	$29,616,150	10%
2	Hospital	$147,654,543	52%
3	Clinic	$20.431.552	7%
5	CHS	$34.658,100	12%
8	Tribal	$23.155,187	8%
X	Other	$5,591,398	2%

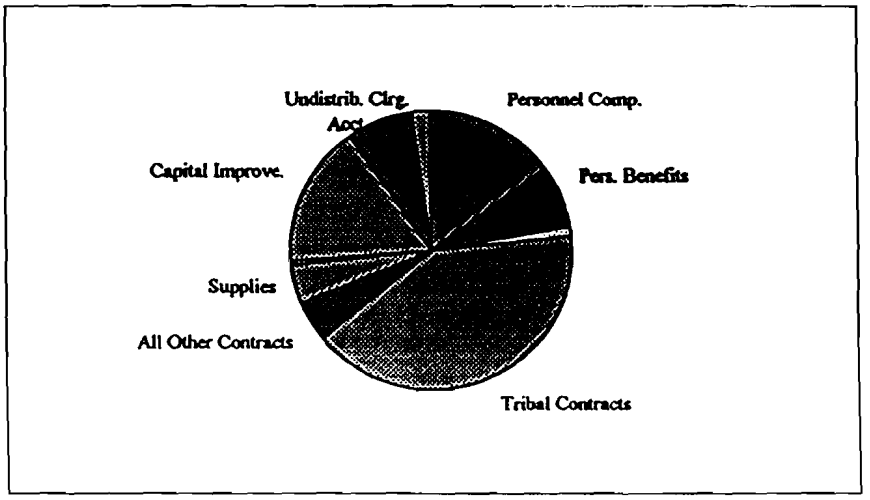


ORGANIZATION ANALYSIS FOR: AP59 - ALASKA

Total FTEs:	1,039
Total Budget:	$387,545,218

BUDGET BY OBJECT CLASS

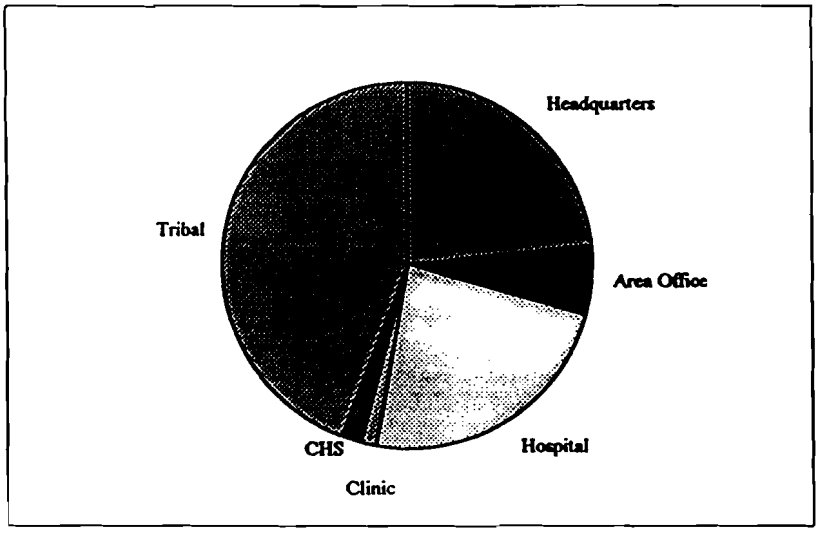
Object Class	Description	Budget $$	%
11	Personnel Comp.	$58,140,087	15%
12	Pers. Benefits	$27,949,144	7%
23	Rent, Commun, Util.	$4,094,461	1%
25.8	Tribal Contracts	$158,398,661	41%
25.X	All Other Contracts	$18,500,202	5%
26	Supplies	$16,867,494	4%
31	Equipment	$2,463,465	1%
32	Capital Improve.	$63,508,770	16%
41	Self Governance	$786,280	0%
96	Undistrib. Clrg. Acct.	$28,729,818	7%
XX	Other	$8,106,836	2%



ORGANIZATION ANALYSIS FOR: APS9 - ALASKA (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$80,714,203	21%
1	Area Office	$21,204,235	5%
2	Hospital	$80,714,203	21%
3	Clinic	$5,082,163	1%
5	CHS	$5,826,097	2%
8	Tribal	$152,315,009	39%
X	Other	$0	0%



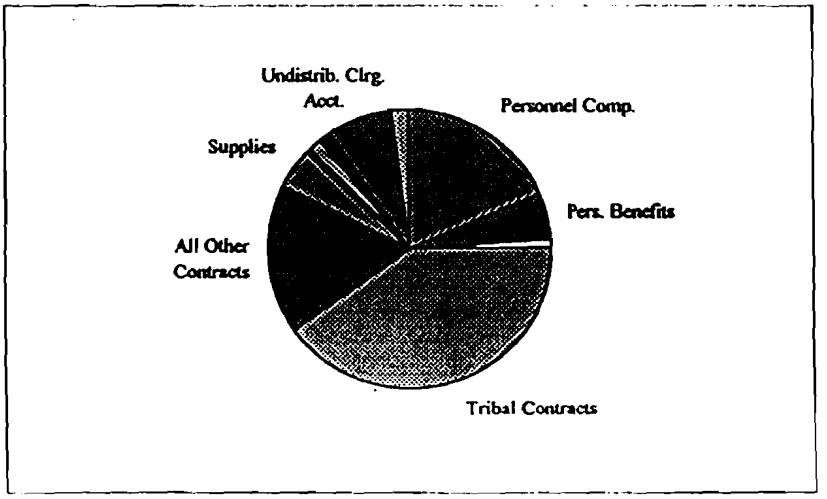
ORGANIZATION ANALYSIS FOR: AP64 - PORTLAND

Total FTEs: 624

Total Budget: $138,440,993

BUDGET BY OBJECT CLASS

Object Class	Description	Budget $$	%
11	Personnel Comp.	$25,801,238	19%
12	Pers. Benefits	$7,379,249	5%
23	Rent, Commun, Util.	$890,180	1%
25.8	Tribal Contracts	$56,296,266	41%
25.X	All Other Contracts	$24,033,815	17%
26	Supplies	$6,213,717	4%
31	Equipment	$790,828	1%
32	Capital Improve.	$1,856,173	1%
41	Self Governance	$2,076,364	1%
96	Undistrib. Clrg. Acct.	$10,257,471	7%
XX	Other	$2,845,694	2%



ORGANIZATION ANALYSIS FOR: AP64 - PORTLAND (Continued)

BUDGET BY COST CENTER PREFIX

Prefix	Description	Budget $$	%
0	Headquarters	$560,810	0%
1	Area Office	$12,690,520	9%
2	Hospital	$0	0%
3	Clinic	$28,754,784	21%
5	CHS	$13,889,663	10%
8	Tribal	$77,525,633	56%
X	Other	$5,019,584	4%