NPAIHB POLICY BRIEF

Health Facilities Construction Priority System

PREPARED BY: NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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An Update on the IHS' Health Facilities Construction Priority System

Portland, OR — The FY 2000 Interior Appropriations Conference Report[1] directed the Indian Health Service (IHS) to work with Tribes to make "needed" revisions to its Health Facilities Construction Priority System (HFCPS). Almost eight years after Congress directed the Agency to revise its priority system, IHS is finally at a decision point on how it will respond to the Congressional directive. A set of recommendations, developed by the Facilities Advisory Appropriations Board (FAAB), have been provided to the IHS Director who will decide on how to implement the FAAB recommendations into a new construction priority system. This brief provides an overview of the FAAB recommendations and concerns associated with revising the construction priority system.

Background

The authority for the IHS to establish a health facilities priority system is included at Section 301 of the Indian Health Care Improvement Act (IHCIA). The HFCPS serves as the mechanism to evaluate and rank the facility construction projects for the Indian health system. Those projects that score high enough are provided funding for construction and a recurring staffing package by Congress. The previous priority system—established in 1980—was replaced with the current system which was developed in 1991 and has been locked ever since.

The Interior Conference managers were concerned about the inequities associated with the allocation of health facilities construction resources. The managers identified five areas for the IHS to address in revising the priority system: (1) projects funded primarily by Tribes, (2) anomalies such as remote locations, (3) recognition of projects that involve no or minimal cost increases; (4) alternative financing, and (5) modular construction options. The managers further instructed that issues do not need to be limited to the items they presented. The managers indicated that their intent was for the Agency to develop a more flexible and responsive system that would accommodate the wide variances in Tribal needs.

The reauthorization bills for the IHCIA include a "grandfathering" provision at Section 301(d)) to protect all facility construction

[1] FY 2000 Interior Conference Report (H.R. 2466), October 20, 1999.

The Current HFCPS

The Health Facility Construction Priority System (HFCPS) ranks proposals based on the total amount of space needed; age and condition of the existing facilities; the degree of the isolation of the population to be served, and; availability of alternate health care resources. There are three phases to the current HFCPS process, summarized as follows:

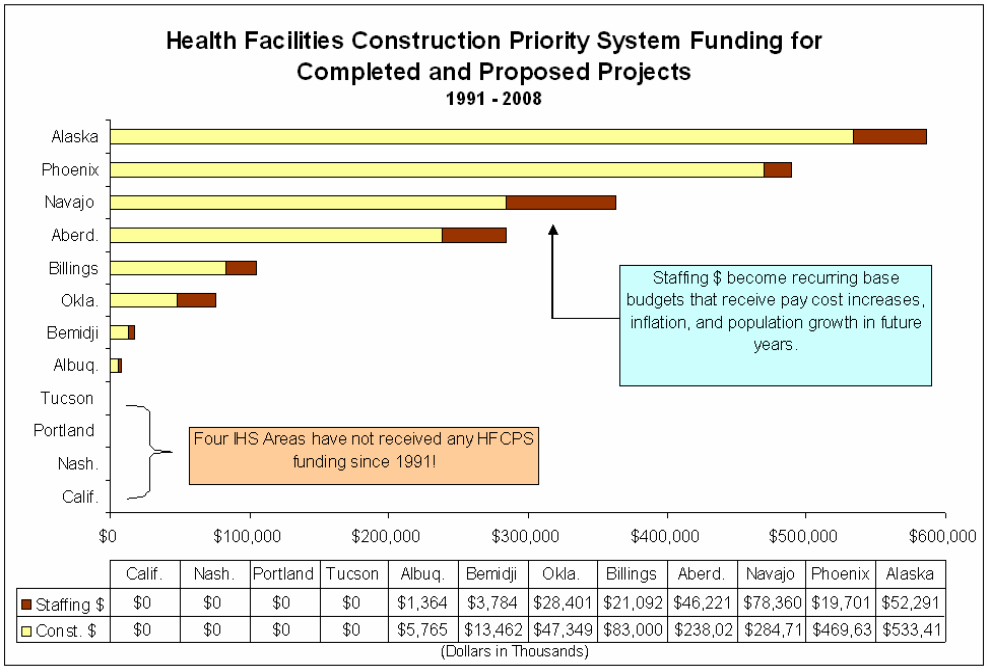
Phase I: In 1991, the HFCPS methodology was applied to 149 IHS Area-generated proposals to construct new or replacement health care facilities. Proposed project data were evaluated on facilities deficiencies, health status, isolation, and facility size. Based on the Phase I results, IHS selected 28 projects to proceed to Phase II.

Phase II: This phase applies a more detailed analysis to the 28 highest ranked proposals. In FY 1992, the IHS consulted with Tribes about incorporating additional flexibility into the HFCPS in order to consider new concepts. Data requiring analysis in Phase II is subjected to thorough review during development of the Project Justification Document (PJD) which is applied against six criteria: Facility Deficiency, Health Status, Isolation, Barriers to Service, Facility Size, and Innovation. In 1993, 23 of the 28 proposals considered were advanced to Phase III.

Phase III:
IHS Area Offices are to develop PJDs for each of the 23 proposed facilities. As PJDs are approved, projects are added to the respective HFCPS list and included in the IHS Congressional Justification document. This list has remained locked since 1991.

projects that are on currently on a priority list. The language contained in Section 301 was carried over from current law and developed through Tribal consultation, which responded to Tribal needs and concerns in 1999, however given recent changes in the construction priority system, **the language is now out of date**. It is estimated at the current rate of appropriations for facilities construction, it would take 20-30 years to clear the current projects, thus prohibiting a new HFCPS from ever being implemented and prohibiting the IHS from responding to a Congressional directive.

Like Congress, Tribes have also had similar concerns with the facilities priority system. Many Tribes feel that the current system allocates a disproportionate share of federal resources to a select few Tribal communities, which results in gaps in the level of health services provided to Indian people. Only 5 - 6 of the IHS Areas have benefited from the health facilities priority system. At least four IHS Areas have never had an inpatient or outpatient health facility built in 17 years. This makes six Areas that have been disadvantaged under the current priority system. In its directive, Congress recognized that the current system is fundamentally flawed and it needs to be revised. The Agency now has an opportunity to address these issues.



	Calif.	Nash.	Portland	Tucson	Albuq.	Bemidji	Okla.	Billings	Aberd.	Navajo	Phoenix	Alaska
Staffing $	$0	$0	$0	$0	$1,364	$3,784	$28,401	$21,092	$46,221	$78,360	$19,701	$52,291
Const. $	$0	$0	$0	$0	$5,765	$13,462	$47,349	$83,000	$238,02	$284,71	$469,63	$533,41

(Dollars in Thousands)

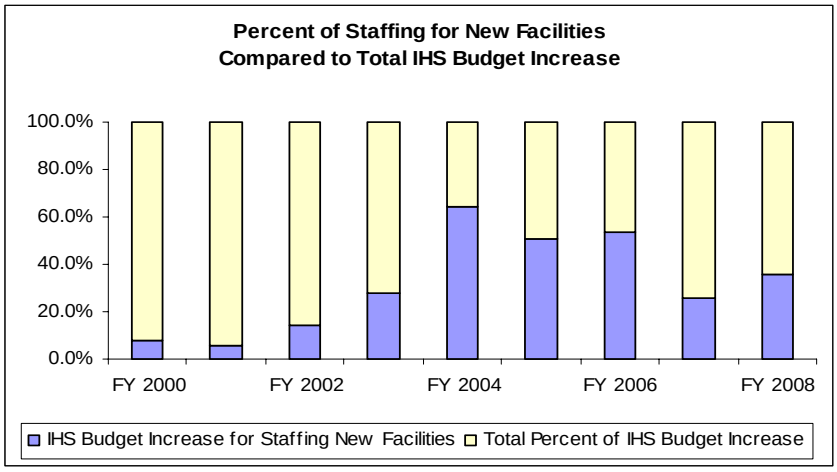
Because of the complexity of the issues, the FAAB appointed a technical workgroup to review the comments and address specific issues identified by Tribes. Members of the FAAB and its technical workgroup included Tribal representatives from each of the twelve IHS Areas and two IHS representatives. The workgroup conducted face-to-face meetings in addition to numerous teleconferences over the next six months on how to revise the priority system. Technical workgroup meetings were held in Portland, Oklahoma City, and Tucson; with additional FAAB meetings held in Rockville and Minneapolis.

Revising the HFCPS

In June 2004—almost five years after Congress directed IHS to revise its construction priority—the Agency sent out for public comment a draft of a revised HFCPS. The IHS received over 1,200 comments during the comment period. The Agency utilized the FAAB to review the comments that were received during the consultation process.

The workgroup reported their initial recommendations to the full FAAB on May 11-12, 2005. The technical workgroup report developed specific recommendations to make improvements in the facilities priority system and transmitted them to IHS on July 21, 2005. In October 2005, the workgroup met again in Rockville to revisit its recommendations based on feedback from the IHS' Office of Environmental Health and Engineering. The revised recommendations were transmitted to IHS on February 28, 2006. Shortly after, the IHS Director sent a letter to Tribal leaders requesting additional facility data to assess the impact on projects under the new system. The full FAAB met in October 2006 in Minneapolis to review a "dry run" of facility construction project scores under the new system. There were concerns related to the project rankings, so the FAAB adjusted

their original recommendations which were transmitted to IHS on March 3, 2007. This process culminates over three years of work to revise the facilities construction priority system. If the IHCIA passes as proposed it will prohibit the new system from being implemented today.

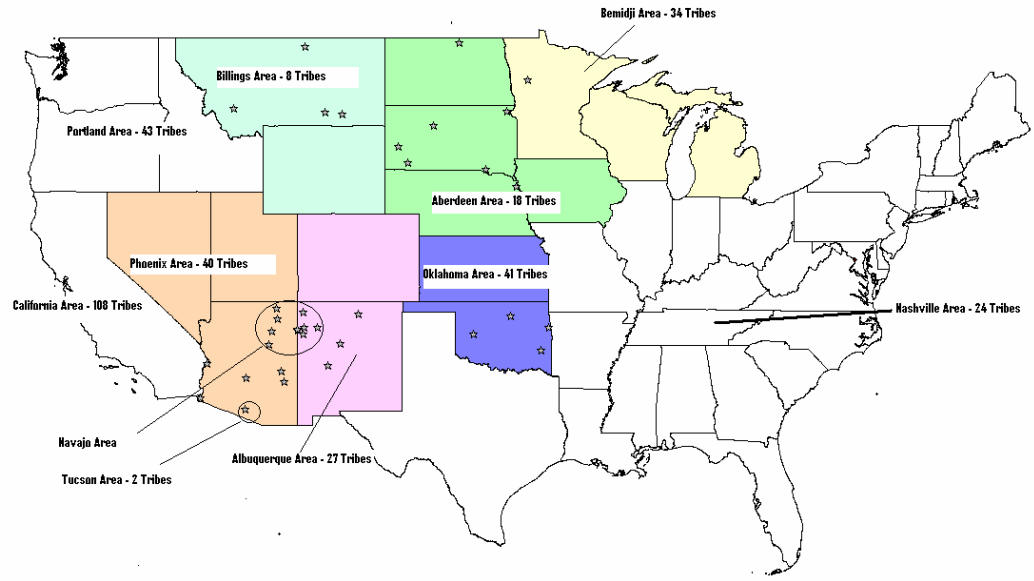


Why is the System Unfair?

Staffing for newly constructed health facilities has always been a concern for Tribes that are dependent on Contract Health Service (CHS) funding to provide health care. The inequities associated with health facilities construction provide a significant amount of resources to one to three Tribes that are fortunate to score well under the priority system and receive a new facility—along with a recurring staffing package. The significance of staffing new facilities is that it removes funds necessary to maintain current services (pay costs, inflation, and population growth) from the IHS budget increase, which then become recurring appropriations. The graph below illustrates, staffing packages for facilities construction cuts considerably into budget increases for the IHS. It provides a disproportionate share of resources to only a few of the IHS Areas. Tribes nationwide ask, "Why did our health program only receive a 1% increase in funding this year when the IHS received a 5% increase in its budget?" The answer to this is due to phasing in staffing at new facilities. In FY 2004, the IHS received a 2.1% increase; however Tribes nationally realized less than a 1% increase in their health care budgets. In 2004, phasing in new staffing was over 60% of the IHS budget increase. In FY 2005 and FY 2006, new staffing costs consumed over 50% of the increase. The graph illustrates, the reason for this gap between the annual approved increases for the IHS accounts and actual program level increases is the cost of staffing new facilities.

Area Distribution Fund

To address the inequities of facilities construction funding, an effort to bring some level of fairness to the process has been proposed in the current reauthorization efforts of the IHCIA. Some Area Indian Health Boards and Tribes support the establishment of an Area distribution methodology for facilities construction projects within the twelve IHS Areas. This proposed concept would provide for a percentage of health facilities construction funds to be used to build health facilities that are not part of the facilities priority system. The proposal would include a 50 percent staffing and equipment package similar to those projects that are funded under the current priority system. The



current priority system projects receive an 85% staffing and equipment package.
Unfortunately, the proposal is not supported unanimously by the IHCIA's National Steering Committee and is a point of controversy in the current reauthorization effort. Those IHS Areas that have projects on the current priority list view any other facilities construction proposals to address the current inequities as competition for limited facilities construction resources. They are not willing to relent that Tribes nationally have been locked out of the current priority system or that there are Areas that have never received a facility under the current system (see map above). The Northwest Portland Area Indian Health Board has negotiated in good faith with representatives of the National Steering Committee to reach a consensus on this issue. However not all Areas have been as willing to reach a resolution.

A meeting is scheduled with Congressional staff and the National Steering Committee to determine if a resolution can be reached on this issue. If a compromise position can be reached, then the IHCIA can proceed without any controversy. If not, Congressional members will have to weigh the interests of those Areas and Tribes that are supportive of the Area Distribution methodology for facilities construction against those that are not. If consensus on this issue can not be reached, Congress should weigh the efforts made by those Areas to work toward a compromise on this issue, along with those Areas that are supportive and the number of Tribes that they represent, and include the new language in the IHCIA bills.

FAAB Process Recommendations

The FAAB recommended the following process for implementing the new HFCPS. The proposed process incorporates FAAB innovations and builds on the IHS Area Master Planning process:

Process Description:

I. Phase I - Needs Assessment Phase
   a) Every 5 years the IHS and Tribes update Area Master Plans (12-24 months);
   b) Area Offices submit data from Area Master Plans on proposed projects to IHS Headquarters;
   c) Headquarters collects the data and uses it to populate a database that will be used to calculate scores for the HFCPS;
   d) Data is scored using the HFCPS Phase I formula (3-4 months);
   e) IHS publishes Phase I results and letters sent to appropriate Tribes and Area Offices informing them of selection to Phase II. Letter include required timelines, deadlines, and other requirements for Phase II, and;
   f) Every 5 years the Phase I score is recalculated; restarting the process at Step "a" above.

II. Phase II - Project Prioritization Phase – (See *Grandfathering* recommendation below for initial implementation of Phase II)
   a) IHS selects the highest ranked projects in Phase I that could be expected to be funded by Congress in three years, based on historical appropriations patterns and estimates of project costs to be evaluated during Phase II;
   b) Tribes and Area Offices submit documentation for Phase II projects that include: Business Plans, Health System Planning Process (HSP), Draft Program Justification Document (PJD), Resource Requirement Methodology (RRM) and documentation supporting "Innovations" and "Barriers" claims. Basic planning documents are reviewed per items a-c below before the proposed projects are submitted to the Validation Committee (6 months):
      1. HSP output – IHS staff validates and approves.
      2. Draft PJD – IHS staff reviews and comments.
      3. Phase I Site Selection IHS reviews and approves.
   c) IHS completes Phase II site selection, revises, and approves the PJD (6 months).
   d) Validation Committee reviews required data; projects with incomplete documentation, or documentation does not support Phase I ranking are moved back to Phase I.
   e) Projects that do not have completed PJDs are moved back to Phase I; and may compete in subsequent applications of Phase II based on their ranking in Phase I. (2 wks)
   f) Projects that have completed Phase II process are scored and ranked based on validated data and placed on the Priority List in order of ranking.
   g) IHS publishes results of Phase II and notifies appropriate Tribes and Areas.
   h) Annually thereafter, as projects on the Priority List are funded, new projects are pulled off National List of facilities to maintain 3 years worth of projects on the Priority List. This restarts the Phase II process at step "a".
   i) Once a project makes Phase II by completing step "f" above, it stays on the list, until fully funded.
   j) Facilities projects for new Tribes, after they have been incorporated into Area Master Plans, start the process at step B above.

Grandfathering: Facilities that are on the Priority List, or based on previous implementations of the HFCPS, are being considered for placement on the Priority List and that have not received appropriations be evaluated in an "interim Phase II" to determine their priority relative to the highest ranking facilities identified during the initial Phase I implementation of the revised system.

1) Outpatient facilities on the priority list when projects are added to it using the new HFCPS should remain on the priority list, but those that do not have approved PJDs will be re-evaluated in an "interim Phase II" of the revision to the HFCPS.

2) Inpatient facilities in the prioritization pipeline that do not have an approved PJD should re-compete during Phase I of the HFCPS.

3) Projects identified in the prioritization processes prior to 1993, should be scored in Phase I and ranked on the universal national listing of facilities. They should then be marked to indicate they have been identified for priority consideration in earlier versions of the HFCPS.