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MEMORANDUM

July 12, 2012

TO: Tribal Clients

FROM: HOBBS, STRAUS, DEAN & WALKER, LLP

RE: ***IHS Consultation on Health Care Facility Construction Issues***

Indian Health Service (IHS) Director Dr. Yvette Roubideaux has written to tribal leaders soliciting comments on health care facility construction matters – priorities, methodology, innovation, and demonstrations. This solicitation is made in light of the new language in the reauthorized Indian Health Care Improvement Act (Affordable Care Act; PL 111-148). The Director's letter and its three page summary of IHS construction programs are attached as one document.

There are two deadlines with regard to this solicitation:

- Nominations for the new Facilities Appropriation Advisory Board are to be submitted to your IHS Area Director by July 31, 2012. The Board will consist of twelve members representing Indian tribes and two members representing the IHS.

- Health care construction recommendations are to be submitted in writing to Dr. Roubideaux by August 31, 2012.

There will be a workshop on this matter at the upcoming Tribal Consultation Summit in Denver, on August 7-8, 2012.

While the IHS letter summarizes some of the new facilities provisions, see below the summary of them that we prepared for tribal clients following the enactment of the Affordable Care Act.

Sec. 301 – Health Care Facilities Priority System. Requires IHS to develop, in consultation with tribes and tribal organizations, a priority system which allows IHS and tribes/tribal organizations to nominate projects at least every three years. Noteworthy features include:

- Grandfathered-in projects listed in FY 2008 budget request as top 10 inpatient, outpatient, staff quarters and YRTC projects that have completed Phases I and II under the current priority system, or projects selected by the Secretary.

- Within one year after enactment, IHS must submit a comprehensive report to Congressional committees ranking facilities construction and renovations needs of IHS, tribes and tribal orgs for –
  - Inpatient facilities;
  - Outpatient facilities;
  - Specialized facilities such as for long-term care and drug abuse treatment;
  - Wellness centers; and
  - Staff quarters.
- An annual report is required describing the priority system; facilities lists (which may include the top 10 inpatient, outpatient and specialized facilities and staff quarters projects); the justification for the rankings; and projected costs of the projects.
- Authority for IHS to establish an area distribution fund sought by several tribes.

Sec. 307 – Indian Health Care Delivery Demonstration Projects. This provision encourages IHS, tribes and tribal organizations to test alternative means of delivering health care through facilities or other methods. The revised provision retains priority for several expressly named projects that were also recited in the prior law but which have not yet been funded.

New Sec. 309 – Tribal Management of Federally Owned Quarters. This new provision authorizes a tribe/tribal organization to elect to directly operate and to establish rental rates for federally-owned staff quarters associated with a facility operated under an ISDEAA agreement, and to directly collect rents from any federal employees who occupy such quarters.

New Sec. 311 – Other Funding, Equipment, and Supplies for Facilities. This new provision has several features:

- It authorizes other federal agencies to transfer funds for Indian health care and sanitation facilities to the Secretary and authorizes the Secretary to accept such funds to construct and operate such facilities, including under ISDEAA agreements.
- It requires IHS to establish by regulation standards for the planning, design, construction, and operation of Indian health and sanitation facilities.

New Sec. 312 – Indian Country Modular Component Facilities Demonstration Program. This new provision requires IHS to establish a grant program for purchase, installation and maintenance of modular component health facilities. At least three grants must be awarded.

- A modular component is one constructed off-site using prefabricated components for subsequent transport to the end site, and represents a more economical method for providing health care facilities than traditional construction.
- IHS must give priority to projects already on the priority list in selecting the projects to be funded under the demonstration program.

- A tribe may apply for a grant whether or not it is operating an ISDEAA agreement. At the grantee's election, the funds provided shall be subject to the ISDEAA.
- $50 million is authorized for the first five years of the demonstration program.

New Sec. 313 – Mobile Health Stations Demonstration Program. This provision establishes a demonstration program for tribal consortia to apply for mobile health station funding. At least three grants must be awarded.

- An eligible tribal consortium is one comprised of two or more service units between which a mobile health station can be transported by road in up to eight hours. IHS- and tribally-operated services units are equally eligible for participation in a consortium.
- A mobile health station is a unit transported by semi-trailer truck, is equipped to provide one or more specialty health services, and can be equipped to be docked at a stationary health care facility.
- Specialty services include dialysis, surgery, mammography, dentistry and other specialty care.
- $5 million is authorized for each of the first five years of the program

Dr. Roubideaux's letter lists specific questions on which the IHS welcomes recommendations, although comments may expand beyond those specific inquiries. The letter references a March 23, 2011 *Report to Congress on Estimated Need for Tribal and IHS Health Facilities* as required by the newly reauthorized Indian Health Care Improvement Act; to our knowledge that report has not been made public.

Please let Geoff Strommer (gstrommer@hobbsstraus.com or 503-242-1745) know if we may provide additional information or be of assistance in drafting comments on IHS facility construction matters.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

JUL 3 2012

Dear Tribal Leader:

As part of the Affordable Care Act, the Indian Health Care Improvement Act (IHCIA) was permanently reauthorized and contains new provisions on health care facility construction priorities, methodology, innovation, and demonstrations. I am writing to request your input on **how to improve the Indian Health Service (IHS) health care facilities construction process**.

Since I have been the IHS Director, the topic of health care facilities construction and the associated staffing and operational needs is mentioned very frequently in my meetings with Tribes. As you may know, the IHS has a priority list for health care facilities construction that has been in place for many years. The ongoing challenge related to this list is that the amount of annual funding for construction, staffing, and operations of new health care facilities is greater than available resources in the IHS budget. In recent years (excluding the Recovery Act), appropriated health care facility construction funding has been between $29 million and $85 million each year.

The IHCIA's Subtitle C, "Health Facilities," authorizes a new Facilities Appropriation Advisory Board (FAAB) to review and revise the IHS Health Care Facilities Construction Priority System and to be "comprised of 12 members representing Indian tribes and 2 members representing the Service, established at the discretion of the Director."

The IHCIA Health Care Facility provisions provide new authorities that:

- Expand the types of health care facilities that must be assessed and prioritized in a report to Congress; in addition to inpatient and outpatient facilities, the IHS must report the priority need for "specialized health care facilities (such as for long-term care and alcohol and drug abuse treatment), wellness centers, and staff quarters."
- Ensure projects on the current priority list will not be affected by any changes in the Priority System.
- Require a report by March 23, 2011 that ranked facility need. A Report to Congress on Estimated Need for Tribal and IHS Health Facilities was submitted on time and described the current priority list and Tribal consultation needed on the new IHCIA authorities.
- Require IHS to establish, by regulation, standards for the planning, design, construction, and operation of health care or sanitation facilities serving Indians.
- Include the authority for other agencies to contribute to the IHS and for IHS to accept contributions for facility planning, design, construction and maintenance. These funds may be placed into Public Law 93-638 accounts and contracts.
- Direct the IHS to establish a demonstration program for modular component construction. IHS requested and received $1 million in the FY 2012 budget to conduct a feasibility study on this provision.

- Authorize a demonstration program "for consortia of two or more service units to access funding to purchase a mobile health station to provide specialty health care services such as dentistry, mammography and dialysis."
- Authorize Indian Tribes to set rental rates and collect rents at federally-owned quarters operated under the ISDEAA.
- Reauthorize the demonstration to test or use alternative means of delivering health care through health facilities to Indians. This authorization includes specific direction to develop new health programs offering care outside of regular clinic operational hours and/or in alternative settings, and to use alternate or innovative methods of delivering health care services to Indians.

I am requesting your input and recommendations on how the IHS should move forward with health care facilities construction in light of the new health facilities construction language in the IHCIA. I have listed some questions for your consideration below and have also enclosed a summary of IHS health care facility construction programs for your reference.

1. IHS plans to proceed with establishing the **FAAB** as authorized by Section 141 of the IHCIA. The IHCIA establishes it as advisory to the IHS Director. Do you have any recommendations on the structure, focus, or composition of the Board? Please also submit nominations for members to your IHS Area Director by July 31, 2012.

2. How should the IHS proceed with establishing the **Facilities Needs Assessment Workgroup** as authorized by Section 141 of the IHCIA? Should this be a separate group from #1?

3. How should the IHS improve our overall **health care facilities planning and construction process** and the way we do business related to health care facility construction?

4. How could the IHS improve our approach to health care facilities construction within the **Budget Formulation process**?

5. Do you have suggestions for **innovative strategies** for health care facilities construction?

6. How could the IHS improve the overall process for determining **staffing and operational costs** related to specific types of health care facilities?

7. Do you have suggestions about how the IHS could change and improve our **small ambulatory program**?

8. Do you have suggestions about how the IHS could change and improve our **joint venture construction program**?

Please submit your health care facilities construction recommendations in writing to me by August 31, 2012, at either of the following addresses:

By e-mail at consultation@ihs.gov; or by postal mail at:

Yvette Roubideaux, M.D., M.P.H.
Director, Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Thank you for your input on this very important program.

Sincerely,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director

Enclosure
IHS Health Care Facilities Construction Programs (Summary Description)

IHS Health Care Facilities Construction Program

The Indian Health Service (IHS) Health Care Facilities Construction (HCFC) Program is authorized to construct health care facilities and staff quarters, renovate/construct Youth Regional Treatment Centers for substance abuse, Joint Venture Construction Projects, provide construction funding for Tribal small ambulatory care facilities projects, replace/provide new dental units, and to assist non-IHS funded renovation projects.

Pursuant to the Indian Health Care Improvement Act (IHCIA), Public Law (P.L.) 94-437, the need for construction to provide health care facilities, including specialized facilities, and staff quarters is assessed through application of comprehensive priority system methodologies. The proposals are then evaluated objectively and ranked according to need.

The current IHS Health Care Facility Construction Priority List was last updated in 1991 and, according to the IHCIA, must be completed before new facilities are added. To determine the locations where new and replacement facilities are most critically needed, the IHS uses a comprehensive priority system, including methodologies for health care facilities and staff quarters construction. Projects for other authorized programs are identified in separate processes.

The Health Care Facilities Construction Priority System (HFCPS) is a three-phase process that establishes one national list for funding:

- Phase I: IHS Headquarters solicits proposals from the IHS Areas for urgently needed new or replacement health care facilities and essential staff quarters projects. Area Offices submit proposals and IHS uses the data (which has not yet been validated) in these proposals to apply a formulaic analysis to obtain a short list of proposals for more systematic review.

- Phase II: Area Offices review and update data for proposals identified in Phase I. These data are validated and then reviewed based on formulaic analysis of Facility Deficiency and Isolation criteria:
    - Facility Deficiency is determined using both the difference between the required space and the existing space (absolute need) and the ratio of the existing space/required space (relative need). Since the required space is determined by population and the workload to serve that population, the existing HFCPS is driven strongly by population. Existing space is the space available to support the provision of health care services. This space is adjusted for its condition and age.
    - Isolation is determined using the distance to alternative sources of care.

- Phase III: The HFCPS does not limit the number of projects to be evaluated for prioritization in Phase III. Proposals showing greatest need are evaluated in a detailed planning process that involves development and approval of a Program Justification Document (PJD). Formal justification documents are prepared for those scoring highest. Once justified and approved, projects are placed on the appropriate construction priority list and proposed for funding. The HFCPS establishes one national list that prioritizes funding needs for the top 10 inpatient and the top 10 outpatient facilities. Appropriations

for health care facility construction are allocated only to facilities on the national priority list.

Joint Venture Construction Program

Section 818 of the IHCIA, P.L. 94-437, authorizes the IHS to establish joint venture projects under which Tribes or Tribal organizations would acquire, construct, or renovate a health care facility and lease it to the IHS, at no cost, for a period of 20 years. Participants in this competitive program are selected from among eligible applicants who agree to provide an appropriate facility to IHS. The facility may be an inpatient or outpatient facility. The Tribe must use Tribal, private or other available (non-IHS) funds to design and construct the facility. In return the IHS will submit requests to Congress for funding for the staff, operations, and maintenance of the facility per the Joint Venture Agreement.

Proposals considered under this program are evaluated against the following criteria:

- The need for space at the location is verifiable when evaluated by using the criteria in the IHS planning methodologies;
- The Tribe is able to fund and manage the proposed project using its own (non-IHS) funds;
- The project is consistent with the IHS Health Systems Planning program; and
- The project is consistent with the IHS Area Health Facilities Master Plan.

Additional consideration is given to Tribes that elect to fully fund the equipment for the facility.

Small Ambulatory Program

Section 306 of the IHCIA, P.L. 94-437, authorizes the IHS to award grants to Tribes and/or Tribal organizations for construction, expansion, or modernization of ambulatory health care facilities located apart from a hospital. Where non-Indians will be served in a facility, the funds awarded under this authority may be used only to support construction proportionate to services provided to eligible American Indian and Alaska Native (AI/AN) people. The last year that IHS received appropriations to fund the Small Ambulatory Program was in 2006.

Participants in this program are selected competititively from eligible applicants who meet the following criteria:

- Only federally recognized Tribes that operate non-IHS outpatient facilities under P.L. 93-638 contracts are eligible to apply for this program.
- Facilities for which construction is funded under Section 301 or Section 307 of P.L. 94-437 are not eligible for this type of grant.
- Priority will be given to Tribes that can demonstrate a need for increased ambulatory health care services and insufficient capacity to deliver such services.
- The completed facility will be available to eligible Indians without regard to ability to pay or source of payment.

- The applicant can demonstrate the ability to financially support services at the completed facility.
- The completed facility will:
    - Have sufficent capacity to provide the required services.
    - Serve at least 500 eligible AI/AN people annually.
    - Provide care for a service area with a population of at least 2,000 eligible persons.