House Natural Resources Committee
Subcommittee for Indigenous Peoples of the United States
Oversight Hearing

Examining Federal Facilities in Indian Country
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Good afternoon Chair Leger Fernandez, Ranking Member Young, and the Members of this Subcommittee. Thank you for the opportunity to testify on the Indian Health Service's (IHS) Federal facilities in Indian country.

The IHS is an agency within the Department of Health and Human Services (HHS) and our mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. This mission is carried out in partnership with American Indian and Alaska Native Tribal communities through a network of over 687 Federal and Tribal health facilities and 41 Urban Indian Organizations (UIOs) that are located across 37 states and provide health care services to approximately 2.6 million American Indian and Alaska Native people annually.

Current Status of IHS Facilities

Indian health care services are provided in over 687 IHS owned, leased, and/or Tribally owned health care facilities, located mostly in rural and isolated areas and 41 UIOs operated out of 77 locations. Total space in the Real Property Inventory, including office and staff quarters, is just over 25 million square feet, of which the government owns or leases approximately 60 percent and the Tribes own approximately 40 percent. The IHS also operates approximately 2,200 staff quarters units to support health care services in remote locations. For many American Indian and Alaska Native people, IHS-supported programs are the only source of health care. Few, if any, non-IHS alternative sources of medical care are available in many cases, especially in isolated areas.

Disparities in the health status of American Indians and Alaska Natives are directly affected by access to health care services. Health care services are constrained by the limited capacities of existing Indian Health Service and Tribal health care facilities. There is a significant need for expansion, renovation, or replacement of many buildings.

The average age of IHS health care facilities is greater than 37 years, compared to nine to ten years in the private sector. Because of increasing user population and insufficient space, many facilities are severely overcrowded. This impedes American Indians and Alaska Natives' access to health care and precludes increasing the number of health care providers. When a facility is replaced, the new one is typically three to four times larger than the old one. This expansion

provides access to health care for the 10-year projected user population and space for additional staff and some new services.

Total need for the Health Care Facilities Construction (HCFC) Program is approximately $14.5 billion for expanded and active authority facility types according to the 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress.[1] An update to the needs assessment report to Congress is in progress. Early drafts report an increase in the need up to approximately $22 billion amount.

The Healthcare Facilities Construction Priority System (HFCPS) is the methodology that the IHS uses to identify and prioritize the need for IHS and Tribal healthcare facilities. In 1993, the IHS, in collaboration with Tribal representatives, used the HFCPS to prioritize major health facilities' needs. Projects were ranked based on the population served, the condition of health care facilities, remoteness, and barriers to care.

The reauthorization of the Indian Health Care Improvement Act (IHCIA), requires the IHS to complete the 1993 Health Care Facilities Construction Priority list before spending appropriated funding on additional construction projects. IHS has completed 37 projects with another 12 projects remaining on the list. All of the remaining projects have received some funding. Approximately $2.1 billion remains to be funded for these 12 projects as of FY 2020. This cost estimate does not consider the staffing and operating costs for each of the facilities on the 1993 Health Care Facilities Priority List.

In accordance with the IHCIA, Section 141, the HFCPS methodology was revised in 2015. The new methodology determines need based on:

1. The size of the American Indian and Alaska Native population requiring access to services,
2. The size of the existing facility compared to the size of a facility required for the population,
3. The population's health status,
4. The isolation of the population,
5. The social and economic factors that hinder access to services at existing facilities,
6. The size of the required facility, and
7. Tribal innovations for construction and/or operation of a facility.

These criteria were developed with the Facilities Appropriation Advisory Board (FAAB), which is composed of Tribal representatives from each of the 12 IHS Areas and IHS leadership representatives. As the projects on the 1993 Healthcare Facilities Construction Priority List are completed, the new methodology for determining the HFCPS will be used to continue the HCFC Program.

The IHS effort to improve its electronic health record system underscores the need to replace outdated facilities. Aging medical facilities impede medical innovation and modern hospitals

[1] Available on the IHS Website: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf.

contain an extensive amount of complex equipment with high electrical requirements. One difficulty in retrofitting older hospitals with modern technology is that the massive concrete structure tends to absorb Wi-Fi signals, representing a significant challenge to wireless equipment.

In addition, the COVID-19 pandemic highlighted some of the difficulties that older facilities pose to delivering health care services. It is the IHS' policy to use the physical environment to help prevent and control the spread of infection. The pandemic has shown that outdated facilities' patient flow often did not allow for social separation and that waiting areas are not sized or structured for social distancing. Optimally, the infected and non-infected patients would be separated, and patients would flow in one direction through the facility. This is not possible in some IHS facilities, which resulted in limiting appointments, required renovation of existing space, or the provision of temporary space outside of the facility in order to separate patients.

In addition to these difficulties resulting from limited space, two of the largest IHS facilities that remain on the 1993 Health Care Facilities Construction Priority List – Phoenix Indian Medical Center (PIMC) and Gallup Indian Medical Center (GIMC) –face challenges incorporating improvements in health care delivery models and medical technology. The PIMC and GIMC's aging facilities are limited in meeting compliance, procuring new technology, and providing specialized services.

PIMC's annual M&I appropriation is insufficient to meet the needs of an aging health care facility and the compounding funding shortfall creates an increasing backlog of deferred maintenance projects. Until the PIMC replacement facility is complete, capital improvement projects will be required to maintain operations and avert service disruptions. The PIMC Backlog of Essential Maintenance and Repair (BEMAR) need is over $120 million in the following areas: life safety compliance, environmental compliance, Americans with Disabilities Act compliance, patient care space improvements, medical gas systems, and architectural, structural, civil, mechanical, electrical and utility systems repairs. The fifty-year electrical and less than fifty-year-old sewer systems at PIMC are a continuous concern for patient and staff safety, but have been updated and repaired over the years.

They need constant repair as it impacts infection control (infection prevention) accreditation and regulatory requirements, and limits opportunities for medical service expansions and improvements.

The long-term replacement of the PIMC hospital is critical. IHS estimates total construction cost for a replacement facility to be approximately $674 million. Planning documents for the PIMC replacement facility are in development and outline the services, staff, and space requirements, and parallel the development of a Phoenix Area Health Services Master Plan, which engages with and seeks Tribal leadership input. IHS has engaged a vendor to create a facility master plan that will also identify an on-site construction option for the hospital replacement.

Providing clinical services from the 50-year-old GIMC facility continues to be challenging due to inadequate building infrastructure and space. M&I appropriated funds do not meet the need to keep up with repairs necessary to provide an adequate and safe health care environment for IHS

patients and employees. Until the GIMC replacement facility is built, capital improvement projects are needed to avert service disruptions. The GIMC BEMAR need is over $135 million in the following areas: life safety compliance, general safety, environmental compliance, Americans with Disabilities Act compliance, patient care, and architectural, structural/civil, mechanical, electrical, and utility repairs. The current electrical and sewer systems at GIMC are of particular concern given the impact they have on limiting medical services expansion and meeting infection control (infection prevention) accreditation and regulatory requirements.

In partnership with the Navajo Nation, site selection for the new GIMC facility continues without major challenges and is making progress. The new GIMC facility is in the planning phase and has been allocated $2 million for planning. The total estimated cost of the new facility is currently $552 million. The Site Selection Evaluation Report Phase II is expected to be completed no later than October 2022. The scope of work for the new GIMC Master Plan is finalized and the contract for the master plan will be awarded soon. The information from the master plan will be used to develop the Program Justification and Program of Requirements documents.

Maintenance and Backlog

When the IHS lacks sufficient resources to address ongoing facility operation and maintenance needs, these deficiencies, which could compromise health care, must be added to the maintenance backlog each year. The current backlog (IHS and Tribal) is approximately $945 million. The reliability of building systems and mechanical/electrical equipment becomes severely compromised with age and new health care accreditation/regulatory requirements, and the potential consequences are compounded by the isolated, rural settings of most facilities.

In terms of medical equipment, the IHS and Tribal health programs have not been able to keep pace with the ongoing changes in medical practices over the years. Medical and laboratory equipment, which has an average useful life of 6 to 8 years, generally is used at least twice that long in Indian health care facilities. Accurate clinical diagnosis and effective therapeutic procedures depend in large part on health care providers using modern and effective medical equipment/systems. The IHS and Tribal health programs manage approximately 90,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $700 million. Regularly replacing medical and laboratory equipment that is at or beyond its useful life would cost at least $100 million per year, growing at an approximate 2 percent inflation rate per year.

Maintenance and Improvement (M&I) funds are the primary source of funding to maintain, repair, and improve existing IHS and Tribal health care facilities. M&I funding supports federal, government-owned buildings and Tribally-owned space where health care services are provided pursuant to contracts or compacts executed under the provisions of the Indian Self-Determination and Education Assistance Act (P.L. 93-638). M&I funds are necessary to achieve and maintain accreditation, to meet building codes and standards, to maintain and repair the physical condition of health care facilities, to modernize existing health care facilities to meet changing health care delivery needs, and to implement mandated requirements (e.g., energy conservation, seismic, environmental, handicapped accessibility, security). Efficient and effective buildings and

infrastructure are vital to delivering health care in direct support of the IHS mission and priorities.

Maintaining reliable and efficient buildings is an increasing challenge as existing health care facilities age and additional space is added into the real property inventory. Many IHS and Tribal health care facilities are operating at or beyond capacity, and their designs are not efficient in the context of modern health care delivery. In addition, as existing health care facilities continue to age, the operational and maintenance costs increase.

IHS hospital administrators have reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. Further, the administrators reported that maintaining aging buildings and equipment is a major challenge. Over one third of all IHS hospital deficiencies have been found to be related to facilities with some failing on infection control criteria and others having malfunctioning exit doors. Out of date facilities and equipment also create challenges for recruitment and retention of high-quality health care professionals.

The physical condition of IHS-owned and many Tribally-owned healthcare facilities is evaluated through routine observations by facilities personnel and by in-depth building condition surveys. These observations and surveys identify facility, fire-life-safety, and program deficiencies, and are used to develop IHS' estimate of the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). The BEMAR is a measure of the condition of health care facilities in the Indian health system and establishes priorities for larger M&I projects. The BEMAR for all IHS and reporting Tribal health care facilities as of October 1, 2020, is $944.9 million. When IHS replaces an older, obsolete hospital or clinic with a new facility, all deficiencies associated with the old facility are removed from the backlog.

Funding for Facilities

The table below provides the funding history for HCFC funds.

Fiscal Year	Amount
2018	$243,480,000
2019	$243,480,000
2020	$259,290,000
2021 Enacted	$259,290,000
2022 President’s Budget	$525,781,000

The FY 2021 breakdown of the HCFC allocation is as follows:

- $100 million is allocated to partially fund three inpatient facilities: Phoenix Indian Medical Center, AZ; Whiteriver Hospital, AZ; and Gallup Indian Medical Center, NM. Some of these funds will be used to purchase land for the Phoenix and Gallup facilities.
- $119.29 million is allocated to partially fund four outpatient facilities: Bodaway Gap health Center, AZ; Albuquerque West Health Center, NM; Albuquerque Central health Center, NM; and Sells Alternative Rural Health Center, AZ.

- $25 million is allocated for Small Ambulatory Program projects. These funds are competitively distributed to Tribes who are building facilities to provide health care.
- $10 million is allocated to Staff Quarters Program projects. These funds provide new or replacement staff quarters near existing facilities.
- $5 million is allocated to Green Infrastructure projects. These funds are competitively distributed to Tribal and Federal facilities to reduce energy and water consumption.

The table below provides the funding history for M&I funds.

Fiscal Year (FY)	Amount
2018	$167,527,000
2019	$167,527,000
2020	$168,952,000
2021 Enacted	$168,952,000
FY 2022 President's Budget	$222,924,000

The FY 2021 breakdown of the M&I allocation is as follows:

- Approximately $96 million is the projected amount for routine maintenance and repair to sustain the condition of Federal and Tribal healthcare facilities. These funds will support facilities activities that are generally classified as those needed for 'sustainment' of existing facilities and provided to the IHS Area Offices and to Tribes for daily maintenance activities and local projects to maintain the current state of health care facilities. These *Routine Maintenance Funds* may be used for Area and Tribal M&I projects to fund smaller elements of the backlog of work to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR) and program enhancements.
- Approximately $69.4 million would be available for major Area and Tribal M&I projects to reduce the BEMAR deficiencies and improve healthcare facilities to meet changing healthcare delivery needs. The FY 2021 allocation continues funding approximately 400 critical projects to address the old and antiquated facilities plant infrastructure (e.g., mechanical and electrical BEMAR), accreditation standards, and program enhancements, all of which are essential to support health care delivery.
- Approximately $3 million would be available for environmental compliance projects. The IHS places a high priority on meeting federal, state, and local legal/regulatory environmental requirements, including allocating funding to address findings and recommendations from environmental audits. The IHS has currently identified approximately $7.6 million in environmental compliance tasks and included them in the BEMAR database.
- $500,000 of M&I funding are retained by Headquarters for the demolition of IHS facilities that are no longer needed. The IHS has approximately 120 Federally-owned buildings that are vacant, excess, or obsolete. Many of these buildings are safety and security hazards. IHS plans for orderly demolition of some of these buildings, in concert with transferring others, reducing hazards and liability. Demolition Funds may be used in concert with environmental compliance funds as available for demolition of the Federal buildings to the extent that the proposed action reduces hazards, environmental concerns, or liability to the Indian Health Service. Since FY 2000 when funds were first

set aside for the demolition of Federal buildings, associated demolition costs have risen significantly due to inflation, environmental regulations, recycling and landfill diversion requirements, and abatement of hazardous material. For example, many IHS locations are very remote which significantly increases the cost to haul the demolition waste off the reservation to approved landfills and recycling facilities.

The table below provides the funding history for Equipment funds.

Fiscal Year	Amount
2018	$23,706,000
2019	$23,706,000
2020	$28,087,000
2021 Enacted	$29,087,000
2022 President's Budget	$100,640,000

Allocation of the IHS Equipment funding in FY 2021 were in four categories:

- New and Replacement Medical Equipment - Approximately $22.6 million was allocated to IHS and Tribal health care facilities to maintain existing and purchase new medical equipment, including the replacement of existing equipment used in diagnosing illnesses. The funding allocation is formula based.
- Tribally Constructed Health Care Facilities - $5 million of medical equipment funds to support the initial purchase of new medical equipment for Tribally constructed health care facilities built using non-IHS funding sources. Tribes and Tribal organizations will use these funds to serve approximately 500,000 patients.
- TRANSAM Program - $500,000 used to acquire new and like-new excess medical equipment from the Department of Defense (DoD) or other sources through the TRANSAM (i.e., Transfer of DoD Excess Medical and Other Supplies to Native Americans) Program and to procure ambulances for IHS and Tribal emergency medical services programs.
- Tribal Emergency Generator - $1 million for competitive awards to Tribal Health Programs located in areas impacted by de-energization events to support the purchase of emergency generators at Tribally-operated health care facilities.

IHS allocates over 75 percent of the annual Medical Equipment funding to IHS and Tribal health care facilities to maintain existing and purchase new medical equipment, including the replacement of existing equipment used in diagnosing illnesses and to enhance telemedicine.

Safe Water and Waste Disposal Facilities

The Sanitation Facilities Construction (SFC) Program is an integral component of IHS disease prevention activities. IHS has carried out the program since 1959 using funds appropriated to provide water and waste disposal facilities for eligible American Indian and Alaska Native homes and communities. As a result, infant mortality rates and mortality rates for gastroenteritis and other environmentally-related diseases have declined. Research supported by the Centers for Disease Control and Prevention states populations in regions with a lower proportion of homes with water service, reflect significantly higher hospitalization rates for pneumonia, influenza, and

respiratory syncytial virus. Researchers associated the increasing illnesses with the restricted access to clean water for hand washing and hygiene.[2] The SFC Program works collaboratively with Tribes to assure all American Indian and Alaska Native homes and communities are provided with safe and adequate water supply and waste disposal facilities as soon as possible.

In FY 2020, IHS funded projects to provide service to 37,771 American Indian and Alaska Native homes. IHS also completed construction on 260 projects with an average project duration of 3.9 years. However, at the end of FY 2020 about 7,140, or 1.8 percent, of all American Indian and Alaska Native homes tracked by IHS lacked water supply or wastewater disposal facilities. About 112,082, or approximately 28 percent, of American Indian and Alaska Native homes tracked by IHS needed some form of sanitation facilities improvements. Many of these homes without service are very remote and may have limited access to health care, which increases the importance of improving environmental conditions.

The total sanitation facility need reported through Sanitation Deficiency System (SDS) has increased approximately $0.52 billion, or 20.2 percent, from $2.57 billion to $3.09 billion from FY 2019 to FY 2020. In FY 2020, the IHS was appropriated $197 million to address sanitation deficiencies and support provision of sanitation facilities to eligible American Indian and Alaska Native homes and communities. The magnitude of the sanitation facility needs increase is due to the IHS implementing a revised prioritization system to indicate the level of project planning. A "tier" system was introduced with the publication of the 2019 SDS Guidelines document. Projects considered "ready to fund" are assigned Tier 1, while projects considered "engineering assessed" are assigned Tier 2. Projects considered Tier 3 are those that are only "preliminarily assessed." Previously many of these projects were not reported to Congress. In FY 2020, there was a total of $0.67 billion in Tier 3 projects, resulting in an increase in the total sanitation facility need reported through SDS.

During FY 2020, 373 construction projects to address water supply and wastewater disposal needs were funded with a construction cost of $220 million using IHS and contributed funds. Once constructed, these sanitation facilities will benefit an estimated 143,000 American Indian and Alaska Native people and help avoid over 235,000 inpatient and outpatient visits related to respiratory, skin and soft tissue, and gastro enteric disease over 30 years. The health care cost savings for these visits alone is estimated to be over $259 million. Every $1 spent on water and sewer infrastructure will save $1.18 in avoided direct health care cost.

Adequate staffing resources are needed to ensure SFC projects are designed and constructed within the SFC Program's national average project duration of 4 years. Since FY 2016 the SFC project funding has increased by nearly 100 percent without any increase in staffing resources. Without associated increases in staffing resources the IHS SFC Program is being strained to accomplish the required program statutory obligations of sanitation deficiency needs reporting, project design, planning, and provision of technical assistance, and as such we fully expect our project durations to increase beyond 5 – 6 years. Under the President's proposed FY 2022

[2] Thomas W. Hennessy, Troy Ritter, Robert C. Holman, Dana L. Bruden, Krista L. Yorita, Lisa Bulkow, James E. Cheek, Rosalyn J. Singleton, and Jeff Smith. The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives. American Journal of Public Health: November 2008, Vol. 98, No. 11, pp. 2072-2078.

Budget, the IHS SFC project funds will increase by roughly 60 percent. In addition to the proposed increases in IHS appropriated funds, an assumption is made that the amount of project funds to be directed towards the IHS through appropriations and contributions from other funding sources would double over the FY 2020 levels to $547 million in future fiscal years. The FY 2022 Budget also proposes an increase of +$36 million for the Facilities and Environmental Health Support program to support additional staff to implement the proposed funding increases for SFC, HCFC, M&I, and Equipment.

FY 2022 President's Budget

On May 28, 2021, the White House released the FY 2022 President's Budget, which includes $8.5 billion in discretionary budget authority for the IHS. This funding level is an historic increase of $2.2 billion or 36 percent over FY 2021. These funds will increase access to high-quality health care in Indian Country and begin to remediate the impacts of chronic underfunding of the IHS.

The Discretionary Request also proposes advance appropriations for the IHS to insulate the I/T/U health programs from the impact of potential government shutdowns, and the uncertainty of annual appropriations.

The Budget proposes a $583 million funding increase for IHS facilities programs, bringing total IHS facilities funding to $1.5 billion. This funding increase includes:

- $54 million for Maintenance and Improvement projects, for a total of $223 million,
- $155 million for Sanitation Facilities Construction projects, for a total of $351 million,
- $266 million for Health Care Facilities Construction, for a total of $526 million,
- $72 million for Equipment, for a total of $101 million, and
- $36 million for a total of $300 million for additional facilities support and environmental health activities.

These proposed increases build on the more than $9 billion in COVID-19 supplemental resources that the IHS received over the last year, including $600 million provided for COVID-19 related facilities needs in the American Rescue Plan Act.

Further, advance appropriations would provide predictable funding to enhance facilities project planning, and improve efficiency in project implementation. This new funding approach would also allow the IHS to distribute critical facilities resources to IHS and Tribal Health Programs to the field much sooner than under a Continuing Resolution.

Finally, the President's Budget proposes a legislative change that would permit UIOs to use their IHS resources for much needed facilities improvement projects. Like IHS and Tribally-operated health facilities, many UIO facilities are aging and in need of repair. Providing UIOs with broader authority to improve their facilities will provide parity with other federal contractors, and assist in the provision of high-quality health care for the Urban AI/AN population.

We look forward to continuing our work with Tribal and Federal partners. We are committed to working closely with our stakeholders and understand the importance of working with partners

to address the needs of American Indians and Alaska Natives. Thank you again for the opportunity to speak with you today.