Committee on Natural Resources
Subcommittee for Indigenous Peoples of the United States
Oversight Hearing on "*Examining Federal Facilities in IndianCountry*"
Randy Grinnell, Deputy Director for Management Operations, Indian Health Service
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Questions from Rep. Leger Fernández:

1. **Briefly, can you reiterate how the limited capacities of IHS facilities have constrained IHS' health care services?**

Space and layout limitations in older IHS facilities impede delivery of modern health care services. The IHS's aging network of facilities were designed and sized for the American Indian/Alaska Native (AI/AN) population and health care practices of the time. Over the intervening years, AI/AN populations have substantially increased. This typically results in severely undersized facility capacity relative to the larger actual population, especially capacity to provide contemporary levels of outpatient services. Consequently, the older facility is incapable of handling the needed levels of services whether fully staffed or even supplemented by additional staff. The facility capacity bottleneck restricts services well below the current needed level for the population, and provides challenges for infection control.

Older IHS facilities were constructed before the advent of contemporary patient care models and require modernized internal layouts. New facilities benefit from decades of credible research, evidence-based design, and a host of other advances yielding improvements across a spectrum of clinical, productivity, satisfaction, and cultural measures. The new IHS replacement facilities opened since 2010 experienced an average increase of 42 percent in Outpatient Provider Visits (OPVs) compared to the years before the facility replacement. The existing space of IHS health care facilities is approximately half of that required for serving the AI/AN population

1a. In turn, how does the limited capacity issue affect IHS' patient population relyingupon those facilities?

Limited capacity limits the type of services as well as the number of patient visits. The absence of an adequate facility frequently results in either treatment not being sought or sought later prompted by worsening symptoms and/or referral of patients to outside communities which significantly increases the cost of patient care and causes travel hardships for many patients and their families. Reduced access results in lower health status and a failure to reduce and eliminate persistent health disparities that burden AI/AN population.

It is common for the current user population of an older IHS facility to be 50 to 75 percent greater than the existing population when it was originally constructed. The IHS network is older and replacement and expansion are not keeping up with population growth. Facilities constructed 25-45 years ago and sized for the population at that time are now significantly undersized.

The pandemic has 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. This year has shown that that outdated facilities' patient flow often does not allow for adequate isolation of contagious patients, thereby creating infection control challenges.

Our findings identify an aging infrastructure where many facilities were constructed before the advent of contemporary health care delivery models and modern building codes and standards. The aging network escalates maintenance and repair costs, risks code noncompliance, lowers productivity, and compromises service delivery. Facility space capacity is inadequate for actual and projected AI/AN user populations. The shortage is a consequence of the demographic trends of AI/AN people, modern facility codes/standards, and gradual obsolescence of older space and equipment. The problem will worsen if current demographic trends continue in future years.

1b. In your opinion, do you believe that IHS' facilities needs fall under the prioritiesof the President's American Jobs Plan?

Yes. The IHS facilities projects fall under and contribute to the following priorities of the President's American Jobs Plan:

- Rebuild clean drinking water infrastructure;
- Upgrade and modernize America's drinking water, wastewater, and storm water systems, tackle new contaminants, and support clean water infrastructure across rural America;
- Ensure clean, safe drinking water is a right in all communities;
- Create jobs building and modernizing affordable, accessible, energy efficient, and resilient buildings all over the country, while also improving our nation's Federal facilities;
- Create caregiving jobs and raise wages and benefits for essential home care workers;
- Partner with rural and Tribal communities to create jobs and economic growth in rural America;
- Create good-quality jobs that pay prevailing wages in safe and healthy workplaces while ensuring workers have a free and fair choice to organize, join a union, and bargain collectively with their employers;
- Remediate and redevelop idle real property, and spur the buildout of critical physical, social, and civic infrastructure in distressed and disadvantaged communities;
- Invest resources wisely to deliver infrastructure projects that produce real results;
- Make our infrastructure more resilient;
- Expand access to long-term care services under Medicaid;
- Safeguard critical infrastructure and services, and defend vulnerable communities; and
- Protect Americans from future pandemics.

2. Your testimony references the 1993 Health Care Facilities Construction Priority list, which IHS is required to complete before spending appropriated funding on other construction projects.

2a. How many projects remain on this list, and approximately how much additional funding will be needed to complete them?

There are 12 projects on the Current Priority List. Six Projects are fully funded and six are partially funded. To fund all projects completely would take $2.07 billion.

The remaining projects on the List, Stage of project and Estimated Completion Date:

PIMC NE Scottsdale, AZ	Construction	Oct-21
Rapid City, SD	Design/Const	Jan-24
Dilkon, AZ	Construction	Sep-21
Alamo Navajo, NM	Planning	Jun-24
Pueblo Pintado, NM	Design	Jun-24
Bodaway Gap, AZ	Planning	Jun-24
Albuquerque Health Care System, NM		
Albuquerque West	Planning	Aug-24
Albuquerque Central	Planning	Aug-26
Sells, AZ	Planning	Mar-28
Whiteriver, AZ	Planning	Jun-28
PIMC Central, Phoenix AZ	Planning	Jun-29
GIMC, Gallup NM	Planning	Jun-30

2b. Of IHS' annual appropriated funds, how much is dedicated to this construction priority list?

Of the ~$260 million appropriated for Health Care Facilities Construction (HCFC), ~$210 million went to the priority list, $10 million for quarter construction, $25 million for the Small Ambulatory Program and $5 million for green infrastructure. In the last five years IHS has received approximately $194 million for the Health Care Facility Construction Program per year.

2c. Given the amount of funding Congress passed, did IHS dedicate any Coronavirus relief funds towards this list?

No. Congress intended for the funds to be distributed widely as possible. Funding the priority list project(s) would have reduced the distribution to one or two locations. The Facilities Coronavirus relief funding was used for sanitation projects, medical equipment, and renovation/alteration projects directly related to Coronavirus virus treatment/prevention. The small individual project or equipment costs allowed for widespread distribution. The Coronavirus Relief Funds were used to upgrade current facilities to treat patients and respond to the pandemic. The Priority List projects take several years to plan and construct and would not have contributed to the immediate response to the Coronavirus.

2d. After the completion of all priority construction projects, what will be next? DoesIHS have a plan of action for other facilities construction?

The IHS has developed a new Priority system, which has yet to undergo Tribal consultation, that evaluates the facility health care needs across the country. The plan evaluates the health care needs of the American Indian and Alaska Natives and the status of the current facilities (Federal and tribal). A priority list is developed from that evaluation. When we are close to possibly receiving funding beyond the grandfathered list, we will prioritize newly submitted projects and post a short list of the top-ranking projects in consideration of the amount Congress appropriates. Every few years as needed, we will run the system and rank submitted projects.

Questions from Rep. Grijalva

1. Your written testimony notes that, as of 2016, the estimated total need for IHS' Health Care Facilities Construction (HCFC) Program is approximately $14.5 billion. An update to this estimate is in progress. However, IHS currently estimates the total need tobe around $22 billion.

1a. Generally, what do these figures represent? Can you elaborate on IHS' calculationof its total estimated need for Facilities Construction?

The IHS Health Care Facilities Construction (HCFC) Program develops estimated total need for direct service, tribal and tribal organization health care facilities. Estimated total need includes the amount of physical space and capital resources required to uphold the Federal Government's obligations to provide access to comprehensive, high quality, and culturally competent care.

Currently, the existing space of IHS health care facilities is approximately one-half of what is required for serving the AI/AN population. Estimated costs to construct the replacement and new space total $23 billion in 2021 compared to $14.5 billion reported five years ago, an increase of 59 percent.

Since the last report (2016 to 2020), funding for facility construction has averaged only about $194 million annually. This rate, while higher than the last report period, remains disproportionately low. The overall facilities space need has accumulated over many years. The accelerating obsolescence will further compromise services as the AI/AN population continues to grow faster than the facility capacity to serve it.

The estimated cost and space requirements were determined using the IHS standard planning criteria, detailed tribal and IHS planning documents, and IHS Facilities Budget Estimating System (FBES). The scope of the report was expanded to all health care facilities line items in the Facilities Appropriation. For direct service unit (SU) facilities, the estimated total need is determined by the amount of required space to deliver services to IHS's user-population using data from approved planning documents or detailed master plans. This space was reduced by the current "usable space" that is currently in the system. There are also add-ons for sustainability, quarters, and alternative energy.

1.b. Why do the Health Care Facilities Construction estimates get to be so high?

There are 4 main contributing factors:

- The amount of space needed depends on the user-population amount. The AI/AN population grows at ~2% annually and Congress only funds ~1% of the total need; therefore the need grows faster than we are providing facilities.
- The cost of construction rises every year (construction inflation).
- The 2010 IHCIA authorized new types of services and facilities including Inpatient Mental/Behavioral Health and Alcohol Substance Abuse Program Facilities, Long-Term Care Facilities, Specialty Medical Services Facilities, and Dialysis Facilities that have added a large amount to the need.
- Existing facilities keep aging and need to be replaced.
    - More space is needed today due to new standards and codes, even if the population was not increasing. Often internal reconfiguration is needed too. Modern codes and standards often require expanded space. However, this is a less significant factor than the growing AI/AN user population. A substantial and growing portion of IHS health care facility space is more than 30 years of age. This space is inefficient and inappropriate for modern medical care.

2. You have provided us with written updates on the Phoenix Indian Medical Center (PIMC) and the Gallup Indian Medical Center (GIMC), both of which remain on the 1993 Health Care Facilities Construction Priority list.

2.a. Can you briefly explain the process of completely replacing an IHS facility andhow the backlog of deferred maintenance impacts this process?

A Facility Master Plan is developed in collaboration with stakeholders and the Indian Health Service for each facility replacement project. Project Planning documents determine the scope of the project including whether a facility should be expanded or replaced, along with site requirements.

Throughout the facility replacement process, the IHS is responsible to provide uninterrupted services to the AI/AN population and maintain the existing facility until the replacement facility is completed. Depending on funding amounts and the project schedule, the existing facilities typically need to be kept operational over several years. Facilities approved for replacement typically lack sufficient space and efficiencies to provide required health care services. They also must be fully maintained to meet health and safety standards to avoid negative impacts on the health outcomes of the service population until such time when patient services can be transferred to the new facility and the current facility can be demolished. Therefore, each phase requires careful planning and oversight to achieve success.

The existing facility BEMAR is completely eliminated once the new replacement facility is operational and the existing facility demolished. It should be many years before the new facility would begin to accumulate BEMAR.

2.b. What role to tribal governments play in this process?

The Tribal role in the health care planning is significant; tribes play a part in Master

Planning effort and in the specific project planning. IHS partners with the Native communities which they serve to ensure that the specific health care needs and culture of the communities are met.

3. **Briefly, can you explain the costs associated with maintaining and replacingIHS' medical equipment?**

The IHS and Tribal health programs manage approximately 100,000 devices consisting of laboratory, medical imaging, patient monitoring, pharmacy, and other biomedical, diagnostic, and patient equipment valued at approximately $700 million. IHS does not have an inventory of Tribal/Tribal Organizations (T/TO) medical equipment. Health care facilities that are independently operated by T/TOs under an Indian Self Determination Education and ISDEAA compact/contract are not required to report this data. However, IHS estimates the number of medical equipment/devices owned by T/TOs based on the same data used to allocate equipment resources and the number of IHS medical devices.

IHS distributes funds for maintaining and replacing medical equipment based on facility type and facility size. The information is maintained in a database and updated annually. Approximately 50% of medical equipment funding goes toward T/TO operated facilities.

With today's medical devices/systems having an average life expectancy of approximately six to eight years and rapid technological advancements, medical equipment replacement is a continual process making it necessary to replace worn out equipment or provide equipment with newer technology to enhance the speed and accuracy of diagnosis and treatment. To replace the equipment at the end of its six- to eight-year life would require approximately $100 million per year, growing at an approximate 2 percent inflation rate each year.

3a. How does aging medical equipment affect patient care?

Typically, the most critical medical equipment is replaced before it could impact healthcare services. However, on rare occasions, major medical equipment failures have required measures, such as closing the emergency room, which results in IHS patient referrals to outside medical facilities for care. IHS has established requirements in policy for IHS facilities to follow in order to manage their equipment inventories effectively and mitigate such risks.

It is imperative that replacement of aging medical equipment be completed within the required timeframe specified by the manufacturer in order to ensure state of the art patient diagnosis and treatment. In addition, aging equipment is more vulnerable to cyber-attacks (e.g., ransomware) as manufacturers are no longer able to provide the required hardware, software upgrades and technical support.

4. Your testimony mentions IHS' effort to improve and update its electronic health records system.

4a. Is it possible to provide us with a brief update on this project?

The IHS is replacing its current Electronic Health Record (EHR) called the Resource

and Patient Management System, or RPMS. Modernizing RPMS represents a once-in-a-generation opportunity to dramatically improve health care in Indian Country and the health status of American Indians and Alaska Natives. RPMS is over 50 years old, and the GAO identifies it as one of the 10 most critical Federal legacy systems in need of modernization.

The system uses many of the Veterans Administration's VistA system components, which will soon be replaced by the modernized VA/DoD electronic health record. The IHS is collaborating with the VA and DoD so we can take advantage of their lessons learned and best practices. In addition, the IHS is piloting a key connection to the VA/DoD joint health information exchange, which will support interoperability between the IHS system and the new VA/DoD system.

After significant Tribal Consultation and Urban Confer, the IHS announced the decision to move forward with the Full Replacement of the RPMS and published a request for information to solicit additional information from the health information technology industry. IHS also hosted an industry day in May 2021 to provide the industry with an overview of IHS, the Health IT Modernization Project, and a notional contracting strategy. The information from the industry and Tribal Consultation and Urban Confer sessions support the ongoing development of an acquisition plan.

The IHS recently requested information from Tribal and Urban Indian Organizations about their investments in Health IT infrastructure. The Modernization team is currently analyzing over forty responses. This information will be utilized in a report to Congress and to further inform the IHS modernization project.

The IHS relies on its health information technology system for all aspects of patient care, including the patient health record, prescriptions, care referrals, and billing both public and private insurance for reimbursable health care services. Implementing modern technologies can strain the infrastructure of aging facilities due to the lack of equipment space, network capacity, power, and cooling. The future IHS Health IT system will address compatibility with VA/DoD, Tribal and Urban Health Systems, and community partners to ensure interoperability while leveraging modern technology and tools to provide high-quality care.

4b. What additional resources does IHS need to complete this task?

- Congress has provided critical support for the Electronic Health Record program, including $34.5 million in the FY 2021 appropriation, $65 million in the CARES Act, and $70 million in the American Rescue Plan Act of 2021.

- Estimating the total cost of the modernization project is difficult at this time, due to the early stage of the project.

- As we progress through the initial implementation steps, we expect to refine our estimates.

5. **Your testimony estimates the entire IHS maintenance backlog to be at $945**

million—does this amount include construction projects?
The Backlog of Essential Maintenance, Alteration and Repair (BEMAR) – e.g., "maintenance backlog" is identified by IHS and Tribal Health Programs as the list of building deficiencies requiring repair in existing buildings and structures. BEMAR does not include construction of new space (e.g., an addition to an existing building) or construction of new buildings.

5.a. How does this backlog affect IHS' patient population?
Typically, the most critical BEMAR deficiencies are addressed/corrected prior to affecting healthcare services. However, major building deficiencies could potentially impact services such as closing the emergency room, which requires IHS patients to be referred to outside medical facilities.

6. **Briefly, can you explain IHS' Sanitation Facilities Construction (SFC) program and why it is so vital to disease prevention activities?**
The Division of Sanitation Facilities Construction (DSFC), which administers the IHS SFC Program, is a nation-wide program responsible for the delivery of environmental engineering services and sanitation facilities to tribes through the allocation of available resources to twelve IHS Area Offices. The SFC Program provides AI/AN homes and tribal communities with essential water supply, sewage disposal, and solid waste disposal facilities through funded SFC projects. Residents in homes without adequate sanitation facilities are at a higher risk for gastrointestinal disease, respiratory diseases, and other chronic diseases. Many of these homes without service are very remote and may also have limited access to health care which increases the importance of improving environmental conditions in which residents may live.

6a. Can you also address how the SFC program contributes to money saved down theline in patient care?
During FY 2020, 373 sanitation facilities 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 AI/AN people and help avoid over 235,000 inpatient and outpatient visits related to respiratory infections, skin and soft tissue infections and gastro enteric disease over 30 years. Health care cost savings for these visits alone is estimated to be over $259 million, according to a SFC performance indicator, which was developed in collaboration with the CDC and review by John Hopkins University. Every $1 spent on water and sewer infrastructure improvements will save $1.18 in averted direct health care cost[1].

7. The President's budget proposes advance appropriations for IHS. This has been a priority of the Committee's for some time now and we are pleased to see its inclusion in the budget.
   a. **Can you explain why advance appropriations for IHS is ultimately an issue of parity?**

[1] IHS (2020). Estimating the impact of sanitation infrastructure investments on rates of respiratory infections, skin infections, and infectious diarrhea in Indian Country, 2015-2018. Internal SFC report: unpublished.

- For the first time, the FY 2022 President's Budget proposes advance appropriations for the IHS. This proposal is consistent with the feedback we have heard from Tribal and Urban Indian Leaders over the last several years.

- Advance appropriations will ensure a predictable funding source for the Indian health system, avoiding the negative consequences of funding delays under continuing resolutions, and lapses in funding during government shutdowns.

- With advance appropriations, the IHS could disburse funds more quickly, which could enable IHS, tribal, and urban Indian health program managers to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for American Indians and Alaska Natives.

- Advance appropriations would also protect the Indian Health System from lapses in appropriations (government shutdowns).

- Events like the lapse in appropriations experienced in FY 2019 disrupt IHS's ability to fulfill its mission and negatively affect our efforts to recruit and retain a quality workforce and provide the continuum of high-quality care that our patients deserve.

- This planning stability would reduce unnecessary administrative burden and costs.

- Funding continuity could also alleviate concerns from potential recruits, especially health care providers, about the stability of their employment.

Questions from Rep. Gallego

1. Mr. Grinnell, in your testimony you state that "the 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. 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." I have two questions in response:

   1a. First does the $22 billion referenced in your testimony include needs at UIO facilities?

   The assessment of the urban Indian organizations' (UIOs) facility needs is not included in this report. However, on December 27, 2020, the Consolidated Appropriations Act, 2021 (Pub. L. No. 116-260) designates $1 million to conduct an infrastructure study for UIO facilities. This infrastructure study will be the first step towards assessing current UIO health care facilities and development of a comprehensive action plan that will identify the physical space and capital resources necessary to eliminate health disparities and improve access to comprehensive, high quality, and culturally competent care.

   1b. Second, what is the timeline for IHS releasing the report on UIO infrastructure required in the FY21 appropriations package?

IHS estimates the report to be released in January 2023. The estimated date includes the time to confer with urban Indian organizations and solicit input from key stakeholders.

2. It is my understanding that because of the way the Indian health Care Improvement Act is written, some of the COVID-19 relief passed for UIOs – including all of the CARES Act money – was not able to be spent on renovation and construction projects unless it met the narrow accreditation standard in statute. **If the accreditation language is struck from IHCIA as your budget request proposes, will IHS be able to retroactively allow UIOs with unspent funds under the CARES Act or ARPA spend that money on construction projects?**

   The answer would depend on how Congress chooses to amend 25 U.S.C. 1659 if it were to do so. For example, unless Congress unambiguously indicates a retroactive date of applicability, there would be a presumption against retroactivity and the effective date would likely be the date of enactment. Also, since all COVID-19 funding is allocated to the UIO through the IHS IHCIA contract, and assuming the language of the provision still contains "The Secretary may make funds available", it would be within IHS's discretion to determine how it wants to authorize and/or fund such activities through the IHS IHCIA contract. If an amended law is enacted, IHS would have many decisions to make about implementing the new, broader authority.

   Taking into account those considerations, it would probably not be considered "retroactive" to allow the use of unspent ARPA or CARES Act funding for future projects within the scope of section 1659. It would likely be considered retroactive to use unspent funding to reimburse for past projects. Each of the specific appropriations within the ARPA and CARES Act contain specific purpose requirements that would need to be met, the parties would need to agree to amend the IHS IHCIA contract to allow for these types of projects, and the project would need to be approved by the Contracting Officer and follow all other applicable requirements.

3. Thank you for your testimony regarding the needs at Phoenix Indian Medical Center. Your testimony states that the total cost of replacing the facility would be $674 million. **Is there a current timeline for this replacement?**

   Currently in the Annual Construction Plan the Phoenix Indian Medical Center (PIMC) will be fully funded in FY 2025 and the facility completed in FY 2029. This is assuming that the IHS construction program will be funded at a rate in excess of $500 million per year in FY 2022 through FY 2025. If funding is delayed, project schedules will be delayed. Currently the planning for this facility is proceeding and scheduled to be complete in FY 2022.

4. Your testimony also mentions $120 million in Essential Maintenance and Repair backlog at PIMC. **If PIMC were replaced sooner rather than later, would these costs be saved?**

   When an old building is replaced by a new building, the Backlog of Essential

Maintenance, Alterative, and Repair (BEMAR) is "deleted" since the building is typically demolished or transferred from IHS real property inventory and the new building has in perfect condition with $0 of BEMAR.