Facilities Appropriation Advisory Board
For the
Indian Health Service

July 3, 2024

The Honorable Roselyn Tso
Director
Indian Health Service
5600 Fisher Lane
Rockville, MD 20857

Dear Director Tso:

On behalf of the Facilities Appropriation Advisory Board (FAAB), I want to thank you for participating in our meetings held in Sacramento on March 12-13, 2024 and also in Anchorage on June 11-12, 2024. It was indeed a pleasure to meet with you to hear your updates concerning many of the FAAB related issues and the on-going work of the Agency. We also appreciated the opportunity to discuss a number of issues that the FAAB has been analyzing. Following our discussion, the FAAB continued to deliberate on a number of issues we discussed with you. I am transmitting to you the salient points of our discussion and the recommendations we made on these issues. All recommendations received full consensus from the quorum of FAAB members at this meeting.

Joint Venture Construction Program Recommendations

The FAAB was very appreciative to hear that the Indian Health Service (IHS) will soon be announcing a new solicitation of the Joint Venture Construction Program (JVCP). We were excited to hear about the opportunity to allow the new Indian Health Care Improvement Act (IHCIA) facility types to be eligible to compete in the upcoming solicitation for the JVCP. During our meeting we discussed how this process could be managed and whether there should be two phases for the JVCP solicitation. The first phase might include those projects that are eligible under the current eligibility criteria. The second phase might include those new facility types authorized under the IHCIA.

Following our meeting with you, the FAAB discussed at length the solicitation of the JVCP in two phases and also other related JVCP issues that the FAAB has deliberated over the last year. Based on this discussion the FAAB developed several recommendations to help improve the upcoming JVCP solicitation. These recommendations were mindful of many of the past FAAB recommendations to improve JVCP. The FAAB recommendations were also made in recognition of the significant increasing costs of the grandfathered project list and likelihood that it will take in excess of 20-25 years to complete these projects. This leaves the JVCP as the only viable option for Tribes to meet their health facility needs with a staffing package. Thus, our recommendations are also intended not only to improve the JVCP, but to also modernize it to meet the current needs of Tribal health programs more effectively.

1. JVCP Solicitation Recommendation

Our first recommendation is that you should announce both opportunities in one JVCP solicitation. Doing so would allow facilities under the existing eligibility criteria, and also allow those under the new IHCIA authorities identified during the IHS Tribal consultation process (completed in 2017) to be eligible for JVCP funding. This recommendation assumes that the existing HSP planning and scoring criteria are established to review and evaluate the new authorities.

The FAAB discussed this first recommendation at length. The FAAB discussed the Agency's proposal to separate projects under the existing eligibility criteria into a phase one process and a separate phase two process for the new IHCIA authorities. The concern with this approach is that the first phase solicitation would result in only those construction projects being awarded and there would never be a second phase for new IHCIA authorities. This is because there would not be enough budget authority, or Congress may not want to fund a second phase for the new IHCIA authorities. Therefore, including facilities under the existing eligibility criteria and new authorities would be a more equitable approach recognizing that Congress or the Administration might limit the amount of JVCP funding for a new solicitation.

2. JVCP Recommendations #1a and #1b[1]

Over the last year, the FAAB's Facility Needs Assessment Workgroup (FNAW) has been analyzing the JVCP Phase I scoring methodology to evaluate issues associated with why small sized Tribes do not compete on the same basis as larger populations. The 2020 JVCP data demonstrates the majority of awards go to a small number of Areas and that some awardees take years to complete projects, delaying the opportunity for others to participate in the JVCP. There are also needless limitations on facility types.

The FNAW evaluated the 2020 JVCP data and determined that the scoring methodology provides greater weighting to remote populations and favors Tribes with larger user populations. To address this the FAAB requested hypothetical scoring evaluation using the Revised-Health Facilities Construction Priority System (*R-HFCPS*) Phase I and the 2020 applicant data. The FNAW adjusted weighting for remote populations, and this resulted in increasing smaller user populations from more Areas among the Phase I group. The FAAB makes the following recommendations based on this analysis.

The FAAB recommends (#1a) that IHS eliminate the Phase I score reduction created by Tribally constructed healthcare facilities.[2] The above analysis demonstrates that Tribes who have constructed facilities without IHS support currently receive reduced Phase I scores. Their health facility need has been reduced making them less competitive to receive a staffing package through JVCP. This change would only consider existing space constructed with IHS support as "existing space" when determining a facility need score.

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[1] See FAAB meeting materials and March 2024 Synopsis. Refer to recommendations #1a, #1b, and #2 in the "Joint Venture Construction Program" PowerPoint dated December 2023/March 2024.

[2] The FAAB refers to this recommendation as Recommendation #1a in the above PowerPoint.

The FAAB further recommended (#1b) replacing the existing Phase I JVCP methodology with the *R-HFCPS* Phase I scoring methodology.[3] This recommendation addresses a long-standing concern that the JVCP favors large sized Tribes as discussed above. This recommended change will provide a scoring factor that weights smaller projects more. The FNAW's scoring analysis for this change indicates that there would be a greater representation of JVCP applications across the Areas during the Phase I scoring process. This recommendation also aligns with multiple FAAB recommendations to implement the *R-HFCPS*, most recently discussed in our May 5, 2022, letter to the IHS Director.

3. JVCP Recommendation #2

The FAAB discussed the recommendation (#2) that the IHS utilize the JVCP to implement and support the new facility authorities included in the IHCIA.[4] This recommendation aligns with the FAAB recommendations discussed in our letter to the IHS Director on April 24, 2023, and are also consistent with the Director's response dated June 24, 2023. The FAAB understands that there may not be a mechanism to competitively score different facility types against one another. However, as we discussed above under the JVCP Solicitation Recommendation section, any new facility type should be allowed if the existing HSP planning and scoring criteria are established to review and evaluate the new authorities.

4. Additional JVCP Policy Improvements

Lastly, the FAAB discussed a number of policy options that would help improve the JVCP for Tribes and that are also consistent with the mission of the IHS to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level. The attached PowerPoint presents these recommendations. The FAAB felt strongly that theses recommendations are within the authority of the IHS Director to implement administratively and would not trigger any regulatory or appropriation issues. Thus, the FAAB is hopeful that you will agree and immediately implement at least two of the recommendations in the current JVCP process—and in the upcoming solicitation that IHS will announce shortly. The FAAB will be sending you a separate letter with the remaining three recommended policy changes that will further improve the JVCP for Tribes.

Funding in advance of Beneficial Occupancy

Our first policy improvement recommendation is that the IHS change its current policy/practice that prohibits advanced JVCP staff funding from being dependent on the certificate of beneficial occupancy. When Tribes prepare for implementation of a new JVCP facility, they need staffing and administrative resources to prepare to bring that facility online much sooner than the IHS policy currently allows. Tribes need to ensure operational readiness and require resources for recruitment, staffing, hiring and other administrative functions at least 6-12 months before that facility is issued its certificate of beneficial occupancy. This is certainly the case for a new facility with zero current staffing.

The FAAB assertion is that there is no legislative prohibition in place for this policy. The IHS' position is that this advanced funding policy was previously approved for past Joint Ventures has no legal or regulatory basis. IHS has also defended this policy explaining there is appropriations report language in the explanatory statements that accompany the appropriations bill that prohibits IHS from allocating

[3] The FAAB refers to this recommendation as Recommendation #1b in the above PowerPoint.
[4] The FAAB refers to this recommendation as Recommendation #2 in the above PowerPoint.

new staffing funds to facilities prior to them achieving beneficial occupancy. The FAAB underscores that Congressional Report language is not law, but it is considered a congressional directive. IHS could ask for a change in this policy and the FAAB recommends that IHS do so.

Modernize the RRM Budget Process

Our second recommendation to improve the JVCP process is that IHS must adopt a more transparent approach to collaborate with Tribes in developing staffing and salary packages in the JVCP. The FAAB recommends that Tribes be allowed to participate alongside the IHS Headquarters and Area staff when developing Resource Requirements Methodology (RRM) budgets for a new facility. The FAAB further recommends that Title 38 compensation scales for physicians, dentists, pharmacists, podiatrist, and other health providers be utilized in the RRM system.

The healthcare industry is in high demand for qualified professionals, intensifying competition for top talent. Tribes and facilities are committed to quality healthcare, requiring an equitable and competitive compensation structure to attract and retain highly skilled professionals. An open and well-informed approach to determining local compensation rates will enable facilities to attract and retain the finest healthcare professionals, thus enhancing the quality of care delivered to First American patients.

At the Anchorage meeting, the FAAB was presented and discussed a new automated RRM process for developing facility budgets. The new system would be data driven using new up-to-date salary information; use updated Title 38 pay tables for specific professions; allow Area Office and Tribes the opportunities to input specific costs for fringe, COLA, and Commissioned Corps; allow customization for FTEs, salary, and other information; and, most importantly, the updated system would be open and transparent. The benefit of this new automated system is that Tribes will have an opportunity to adjust staffing estimates and seek approval from IHS that they do not have now. Also, IHS will have stronger confidence in staffing budgets and be able to update that estimate yearly as that facility gets closer to construction. The FAAB understand that this new system is in beta-testing and commends the Agency for making these improvements for RRM budgeting. In light of these improvements, the FAAB recommends that the IHS Director implement this new RRM budgeting system as soon as practically possible.

105*(l)* Leases for Joint Venture Construction Projects

During our March meeting, the FAAB discussed a previous recommendation to make facilities constructed under the JVCP eligible for 105*(l)* leases. This recommendation was transmitted to the Director in our letter dated April 24, 2023. In summary, the FAAB recommended that you lift the restrictions that prevent past JVCP facilities to be eligible for a 105*(l)* lease. As we discussed during the March meeting, JVCP leases are intended to facilitate staffing packages to tribes and to allow IHS to take over the use of a facility if a tribe retrocedes the programs back to the IHS. Section 105*(l)* leases are uniquely different and are not traditional leases. As FAAB members explained, 105*(l)* leases are facility cost agreements that transfer funds to tribes to maintain and upkeep facilities.

During our discussion on this issue, you expressed concerns about the costs of implementing the FAAB recommendation to make JVCP facilities eligible for 105*(l)* leases. The FAAB understands your concern and we are aware that Congress is also concerned about the rising costs associated with 105*(l)* leases. However, the FAAB explained that there are a finite number of JVCP leases and that we should not be making policy decisions without data to substantiate decisions. We discussed and recommended that IHS and the FNAW conduct a cost estimate on how much money it might cost to allow JVCP facilities into the 105*(l)* program.

Following our Sacramento meeting, the FAAB requested Headquarters review current 105*(l)* lease costs and JVCP facilities data in the IHS facilities database. The FAAB recommended that this data be used to estimate JVCP facilities' eligibility into the 105*(l)* program. IHS Headquarters staff presented the following information at our meeting in Anchorage. There are currently 33 joint venture facility leases that total 5.75 million square feet. The average lease cost for this square footage in the lower 48 states is $21.48; and the average cost for Alaska is $78.62. Applying these estimates to the existing 105(l) inventory to allow JVCP facilities into the 105(l) program yields an approximate cost of $176 million. We hope this provides you the necessary data to approve the FAAB's recommendation to allow JVCP facilities to be included in the 105(l) program.

Please let us know If there is additional information or data you need to make this decision. We look forward to your favorable decision on this issue.

IHS Conduct FSA Workload Assessment to Determine PSFAs

During our March meeting, the FAAB was provided a presentation on the Facility Support Account (FSA) and how resources associated with this account have an impact on health facilities management activities, operation and maintenance of real property and building systems, medical equipment technical support, and planning and construction management support for new and replacement health facilities projects. The FAAB recognizes that without adequate FSA resources, Areas and tribes may not be able to effectively maintain data and compete for health facilities funding opportunities on a fair basis.

IHS explained that when a new facility is constructed, there are increases to staffing at the Service Unit level, but not at the Area and HQ levels, and when a Tribe chooses to compact, they can take Area and HQ resources. Restated, while there may be new facilities or programs added there are not adequate resources at the HQ and Area levels, to support such activities associated with Small Ambulatory Construction, the JVCP, and other facilities opportunities. The FAAB believes that updating the Programs, Services, Functions, and Activities (PSFA) Manual with an emphasis on FSA residuals makes sense. The FAAB understands that all staffing comes from the Facilities and Environmental Health Support budget line item.

To address the issues discussed above, the FAAB recommends that IHS conduct a workload assessment to determine the PSFAs and the number of FTEs needed to perform inherently federal functions in the 12 Areas, for FAAB to review and a future FAAB meeting. The FAAB would use this information to make additional recommendations on FSA workload, and then for IHS to make any necessary adjustments as recommended by the FAAB.

In closing, and on behalf of the FAAB, we want you to know that we value our partnership with you and the rest of your leadership at IHS. We also thank you for attending our FAAB meetings and your commitment to address the FAAB's recommendations. Dates have not been finalized yet but we invite you to our next FAAB meeting which will be held virtually to discuss these and other issues. Thank you for all you do to advance the mission of the IHS and Tribal health programs.

Sincerely,

Charles Grim

Charles Grim, DDS, MHSA
Chairperson, FAAB

Enclosures

Joint Venture Construction Program

FNAW Program Recommendations

For FAAB Consideration

December 2023 / March 2024

Workgroup Members

- CAPT Jason Lovett (FNAW *Co*-Chair)
- Laura Platero / Karol Dixon, Portland Area
- CDR Ali Ali, California Area
- Martin Shutt, Great Plains Area
- Chris Bradley, Albuquerque Area (*No longer with IHS*)

FAAB JV Issues / Concerns

- Small Tribes unable to compete, program favors large populations.
- Majority of awards go to a small number of Areas.
- Some awardees take years to complete project, delaying opportunity for others.
- Limitation on facility types.

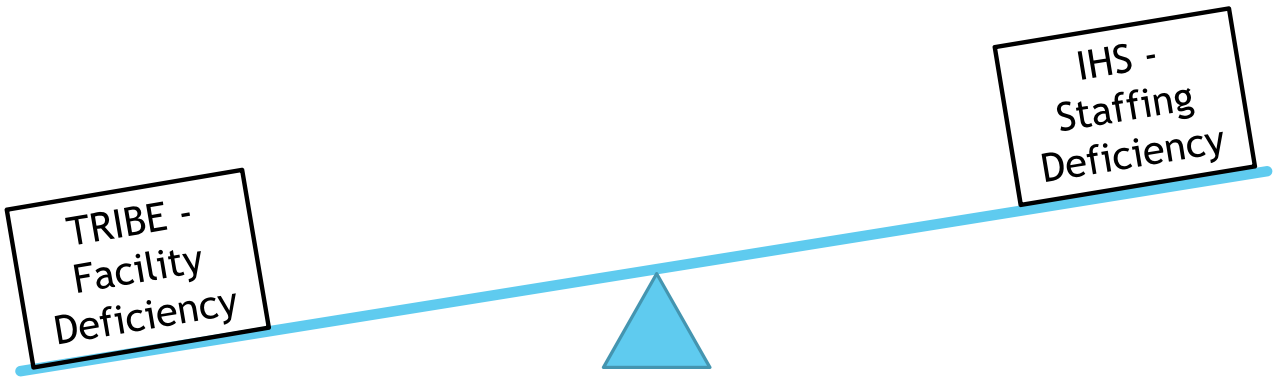
Completed Program Evaluation

- Considered program constraints
  - What is fixed? (Law / Regulation / Other)
  - What could change?
- Evaluated existing JV Phase I scoring methodology using 2020 applicant data.
  - Heavy weighting to remote populations
  - Favors larger user populations
- FAAB requested hypothetical scoring evaluation using the R-HFCPS Phase I and 2020 applicant data.
  - Weighting for remote populations greatly reduced
  - Favors smaller user populations
  - Based on applicant data set, more areas represented among highest Phase I scores

Developed Recommendations

- For FAAB consideration/discussion:
  - Recommendation #1a – Eliminate the Phase I score reduction created by Tribally constructed healthcare facilities.
  - Recommendation #1b - Replace the existing Phase I JV methodology with the R-HFCPS Phase I scoring methodology.
  - Recommendation #2 - Utilize Joint Venture Program to implement IHS support for new facility type authorities.

Background Context



Background Context

- Can JV be an effective tool to address system wide facility and health resource deficiencies?
  - So long as new staffing appropriations remain limited, probably not.
  - The best recommendations for improvement won't change that.
- Recent observation:
  - IHCIA
    - 1680h Demonstration Projects for tribal management of health care services
    - 1680h(e) Joint venture demonstration projects

Recommendation #1a

- **Eliminate the Phase I score reduction created by Tribally constructed healthcare facilities.**

- Tribes who have constructed facilities without IHS support currently receive reduced Phase I scores.
  - Their health facility need has been reduced;
  - Thus less competitive to receive a staffing package through JV.
  - Evident in scoring review.

- Many tribes in this situation have never received IHS staffing packages.

#1a – Eliminate Tribal Space Score Reduction

- What is this intended to do?
  - Put Tribes who have not received a staffing package on a level playing field for Phase I scoring.
  - Change the primary driver of Phase I Score from facility deficiency to something else.
    - Discussed as part of Recommendation #1b.
  - Address concern that a majority of awards go to a small number of Areas.

- Note: There likely still needs to be a construction project.
  - Need to provide a properly sized leasable building meeting all current facility codes and standards.
  - Likely involves renovation and expansion.
  - Proposals are further evaluated under Phase II.

#1a – Eliminate Tribal Space Score Reduction

- How could this recommendation be accomplished? One possible approach:
  - During Phase I scoring, omit existing healthcare space that was
    1. Constructed by Tribes with eligible Joint Venture funding sources and
    2. Was not part of a previous Joint Venture Project.
  - In other words, only consider existing space constructed with IHS support as "Existing Space" when determining facility need score.

#1a – Eliminate Tribal Space Score Reduction

- Concerns Raised During Review Discussions
  - Fundamentally, should a Tribe that does not have any health facilities be considered to have a similar need as a Tribe with health facilities available?
  - Would this provide an added advantage to wealthier Tribes who have more financial resources available?

Recommendation #1b

- **Replace the existing Phase I JV methodology with the R-HFCPS Phase I scoring methodology.**
- Provides a scoring advantage for smaller projects, addressing a FAAB concern.
- Scoring analysis indicates greater representation across Areas among top Phase I scores, addressing another FAAB concern.
- Aligns with multiple past FAAB recommendations to implement R-HFCPS, most recently the May 5, 2022 letter to the IHS Director letter.
  - Not full implementation, use of scoring criteria only.
  - The FAAB recommended consultation on isolation factor (July 31, 2023 letter) could be completed prior to use.

#1b – Replace Existing Phase I Methodology

- Recommendation #1b may be implemented as a standalone recommendation.
- However, recommendation #1a is NOT standalone. If implemented, then Recommendation #1b should be implemented as well. Because:
- Recommendation #1a would eliminate facility need as a primary differentiator among many applicants.
  - Under existing Phase I scoring, the Isolation Factor would become even stronger Phase I differentiator.
  - Under R-HFCPS Phase I, the **health status** of the population served and facility size (weighted toward smaller facilities) would become the strongest Phase I differentiators.
  - **Health status** could be a preferable criteria to prioritize staffing funds.

Recommendation #2

- **Utilize Joint Venture Program to implement IHS support for new facility type authorities.**
- Aligns with FAAB recommendation on April 24th, 2023 and consistent with IHS Director response on June 24th, 2023.
- Better program alignment if JV is a tool to implement “demonstration” projects.
- Challenge: There is not a mechanism to competitively score different facility types against one another.

#2 – Implement New Facility Types

- How could this be accomplished? One approach:
  - Focus the next JV round on the highest priority new facility type, based on tribal consultation. (Recall previous result of a similar consultation)
    - Facilities of the same type can be competitively scored against one another.
    - Would create a focus and urgency to finalize associated planning criteria.
    - Provides real data to validate planning criteria and support master planning.
    - If focused on a single new facility type, a rotational approach could optimize the number of Areas benefitting from new resources and services.

#2 – Implement New Facility Types

- Recommendation #2 could be implemented as a standalone, or in conjunction with Recommendations #1a and #1b.

- Concerns Raised During Review Discussions:

  - Should new facility types be considered when there are so many basic outpatient facility needs that are unaddressed?

  - How can a rotational approach be done fairly given great differences in geographic size and population across Areas?

Thank You

Final Thoughts?

- Recommendation #1a – Eliminate the Phase I score reduction created by Tribally constructed healthcare facilities.
- Recommendation #1b - Replace the existing Phase I JV methodology with the R-HFCPS Phase I scoring methodology.
- Recommendation #2 - Utilize Joint Venture Program to implement IHS support for new facility type authorities.