Subcommittee on Indian, Insular and Alaska Native Affairs
Doug LaMalfa, Chairman
Hearing Memorandum

March 6, 2017

To: All Subcommittee on Indian, Insular and Alaska Native Affairs Members

From: Majority Committee Staff,
Subcommittee on Indian, Insular and Alaska Native Affairs

Hearing: Oversight Hearing on "*Improving and Expanding Infrastructure in Tribal and Insular Communities*"

On Thursday, **March 9, 2017, 10:00am in 1324 Longworth House Office Building**, the Indian, Insular and Alaska Native Affairs Subcommittee will hold an oversight hearing on "*Improving and Expanding Infrastructure in Tribal and Insular Communities*."

Policy Overview

- The current average age of Indian Health Service hospitals stands at an abysmal 40 years of age, triple the average age of most U.S. hospitals.

- Despite funding increases by Congress, the Federal Government still spends just $35 per capita on IHS facilities that serve Native people, compared to $374 per capita for the nation as a whole.[1]

- Existing authority provided by Congress should be used by the Indian Health Service to address where the greatest facility needs remain. This hearing will seek solutions for improved accountability of appropriated funds used for building and maintaining IHS infrastructure.

- Capital Improvement Project grants make up the largest combined resource made available to the territories by OIA. Continued fiscal oversight of OIA programs is needed to improve accountability within the CIP grant program for the territories.

Invited Witnesses

The Honorable Herman G. Honanie
Chairman, Hopi Tribe
Kykotsmovi, AZ

Mr. Andy Joseph Jr.
Chairman, Northwest Portland Area Indian Health Board
Member, Colville Business Council
Nespelem, WA

[1] Centers for Medicare and Medicaid Services. National Health Expenditure data. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html

Ms. Victoria Kitcheyan
Great Plains Area Representative
National Indian Health Board
Washington, DC

The Honorable Brian Cladoosby
President, National Congress of American Indians
Washington, DC

Mr. Andy Teuber
Board Chair and President, Alaska Native Tribal Health Consortium
Anchorage, AK

Mr. Nikolao Pula
Acting Assistant Secretary
Office of Insular Affairs
U.S. Department of the Interior
Washington, DC

Background

The Indian Health Service (IHS) is an agency of the U.S. Department of Health and Human Services (HHS) which provides healthcare to approximately 2.2 million American Indians and Alaska Natives (AI/ANs) through 650 healthcare facilities[2] on or near Indian reservations.

The agency is headquartered in Rockville, Maryland and is composed of 12 regions, or "Areas," each with a separate headquarters,[3] which oversee the delivery of health care. Areas are further subdivided into 170 service units which may serve one or more tribes. The agency offers "direct-service" healthcare, meaning care provided by federal employees; it also acts as a conduit for Federal funds for Tribes that have utilized the Indian Self-Determination and Education Assistance Act (ISDEAA)[4] to independently operate their health facilities. The IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive health care in 36 states.

The Snyder Act of 1921[5] provides the basic authority for the federal provision of health services and benefits to Indians because of their status as Indians. The modern statutory basis and framework for the federal provision of health care to Indians is under the Indian Health Care

[2] Facilities include hospitals, health centers, heath stations, Alaska village clinics, and youth regional treatment centers.
[3] The twelve areas of the IHS include: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland and Tucson.
[4] 25 U.S.C. 5301 et seq.
[5] 25 U.S.C. §13

Improvement Act (IHCIA)[6]. This law was permanently reauthorized in Title X of the Patient Protection and Affordable Care Act.[7] As noted, the ISDEAA authorizes tribes to assume the administration and program direction responsibilities that were previously carried out by the federal government through contracts, compacts and annual funding agreements negotiated with the IHS.

Healthcare Facilities

To provide primary health care needs for AI/AN communities, the IHS system is a mostly rural outpatient system focused on primary care consisting of the following types of facilities:

	Hospitals	Health Centers	A/N Village Clinics	Health Stations	Total
IHS	28	62	N/A	32	122
Tribal	18	282	150	80	530

Source: U.S. Dept. of Health and Human Services, Indian Health Service[8]

Generally, IHS facilities provide health and health education services that focus on primary and preventive care. Funding for facility construction is provided through the IHS Health Care Facilities Construction (HCFC) program. The HCFC program is funded based on an IHS list of priorities for construction projects. During FY 1990, in consultation with the Tribes, the IHS revised the Health Facilities Construction Priority System (HFCPS). As part of the reauthorization of the IHCIA in the Affordable Care Act, Congress mandated that no changes in the construction priority list shall occur after the date of enactment. The remaining health care facilities projects on the HFCPS list, including those partially funded, totaled approximately $2.2 billion as of April 2015.

To improve oversight of health facilities construction, Congress began requiring quinquennial reports describing the health facility needs.[9] In 2016, the IHS reported to Congress that the current average age of IHS hospitals is 40 years of age, approximately 30 years older than most U.S. hospitals.[10] The increased age of facilities adds to the risk of building code noncompliance and compromises the delivery of healthcare. National benchmarks for operation and maintenance costs show that a 40 year old facility will cost around 26 percent more than a 10 year old facility.[11]

[6] 25 U.S.C. §1601 et. seq.
[7] P.L. 111-48.
[8] https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/factsheets/Profile2016.pdf
[9] 25 U.S.C. §1631.
[10] Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals (2015 ed., pp. 176-179): https://aharesourcecenter.wordpress.com/2011/10/20/average-age-of-plant-about-10-years/
[11] Adams, Tim, et al. Operations and Maintenance Benchmarks for Health Care Facilities. International Facility Management Association, 2010.

The HCFC appropriations between FY 2010 and FY 2016 have averaged $76 million annually, with $105 million in 2016. It is estimated that at the current appropriations rate and existing replacement rate, a new 2016 facility would not be replaced for 400 years.[12]

The cost to increase IHS facilities to needed capacity is enormous, about **$14.5 billion** with expanded and active authority facility types. At current funding rates, the IHS facilities network will continue to age and capacity will decline. Compared to per capita and industry benchmarks of capital investment rates, funding for replacement and expansion is disproportionately low. In 2015, only two-thirds of the 1993 facility priority list was complete. At that pace, even that subset will not be completed until 2041.[13]

Action Needed

In February 2016, the Government Accountability Office (GAO) added Federal Indian healthcare to its biennial "high risk list"[14] of federal agencies and programs at most risk for waste, fraud and abuse. While several Congressional hearings and GAO reports during the past two years have focused on the quality of care being provided at IHS facilities, the Committee is extremely concerned with the contributing role health facility age plays into providing quality care to AI/ANs.

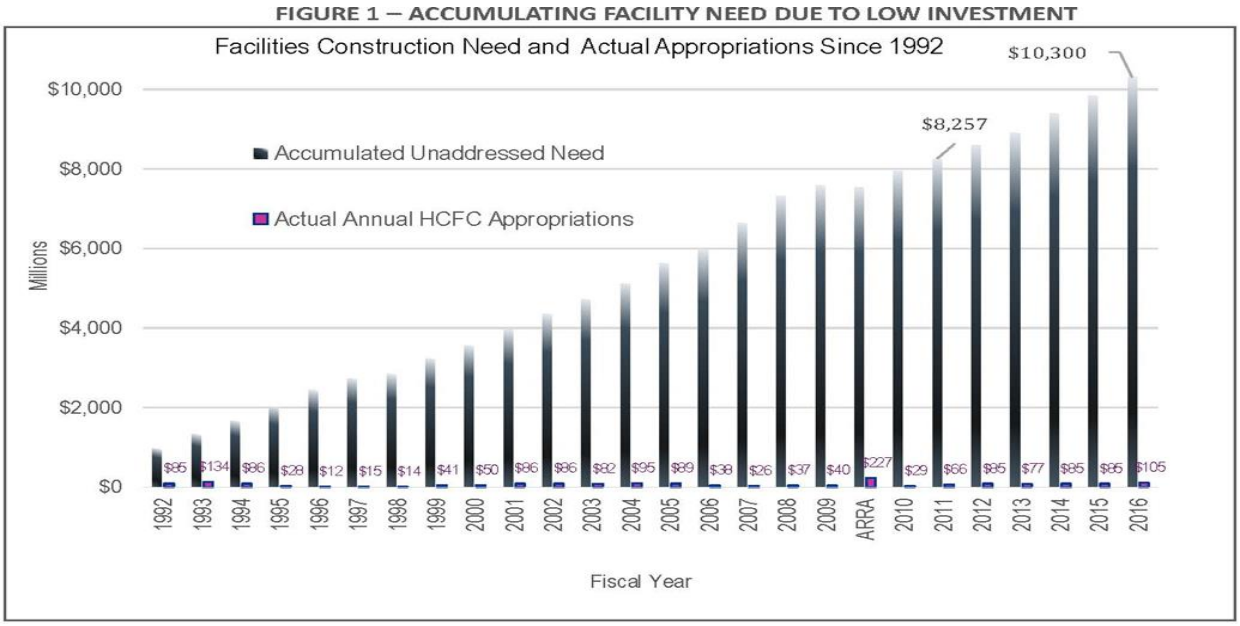


Figure 1: Accumulating Facility Need Due to low Investment
Source: IHS 2016 Facilities Needs Assessment Report to Congress

[12] The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress at 3. https://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/RepCong_2016/IHSRTC_on_FacilitiesNeedsAssessmentReport.pdf

[13] The 2016 Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress at 19.

[14] http://www.gao.gov/highrisk/improving_federal_management_serve_tribes/why_did_study

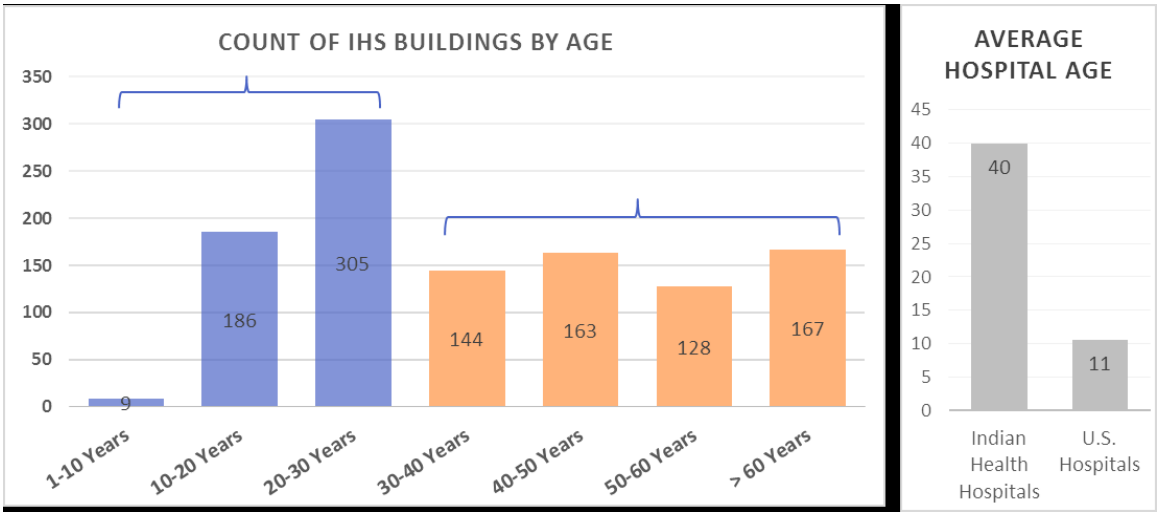


Figure 2: Disproportionally Aged Buildings
Source: IHS 2016 Facilities Needs Assessment

Options for the Future

Area Distribution Fund

When Congress permanently reauthorized the IHCIA in 2010, it included a new section which required the IHS, in consultation with tribes and tribal organizations, to develop innovative approaches to address all or part of the total unmet need for construction of health facilities.[15] That section also provides that IHS may consider establishing an Area Distribution fund (ADF) in which a portion of health facility construction funding could be devoted to all IHS service areas.

The Facilities Appropriations Advisory Board, a joint federal-Tribal advisory committee, developed the ADF concept in recognition of the grandfathered status of certain health facilities projects on the priority list, while allowing an innovative and alternative approach for new proposals to be considered and funded. The ADF is intended to allow each IHS Area to improve, expand, or replace existing health care facilities. The Agency could extend the benefits of appropriated funds to a significantly larger number of tribes and communities throughout Indian Country than would be possible by relying solely on funding for line-item projects.

Additionally, the IHS is working directly with tribes to provide technical support for tribes that are seeking alternative non-IHS funding to build or expand health facilities.

[15] 25 U.S.C § 1631.

U.S. Insular Area Infrastructure

Capital Improvement Project (CIP) Grants

A major tool available to the U.S. territories for completing upgrades to infrastructure projects is the Capital Improvement Project (CIP) Grant program. CIP grants help territories make much needed improvements to roads, hospitals, water treatment systems, schools and more. Upgrades to critical infrastructure through CIP grants improve the quality of life of the local communities while providing a basis for attracting new business investment in these remote places.

Office of Insular Affairs (OIA), an agency in the Department of the Interior, determines annual allocation of the available mandatory $27.72 million CIP funding through an established process based on competitive criteria. The territories are scored on their demonstrated ability to exercise prudent financial management practices while adhering to federal grant requirements. The criteria that the territory governments are measured by are ranked giving more weight to more significant criteria. Insular governments that are able to meet the standards receive higher scores and thus can have their annual allocation adjusted to reflect their capacity to manage funding efficiently and effectively.

The list of criteria territories are scored by is as follows:

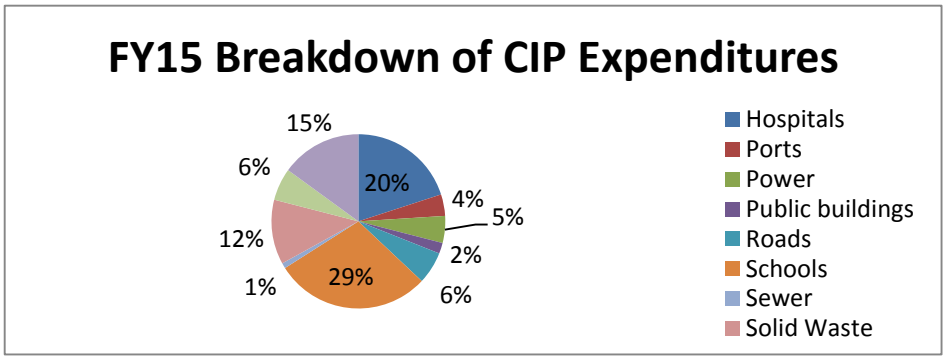
1. The extent to which the applicant is in compliance with completion deadlines established under the Single Audit Act of 1984
2. The extent to which the applicant's financial statements were reliable
3. The extent to which the applicant is exercising prudent financial management and is solvent
4. The extent to which the applicant has demonstrated prompt and effective efforts to resolve questioned costs and internal control deficiencies identified in single audits
5. The extent to which the applicant has responded to recommendations identified in reviews completed by the Office of Inspector General, the Government Accountability Office and other Federal offices
6. The extent to which the applicant has demonstrated effective contract administration and compliance with local statutes and regulations regarding procurement practices and processes
7. The extent to which the applicant's capital improvement application is complete and submitted on time
8. The extent to which the applicant has complied with all reporting requirements applicable to past and ongoing grants in an accurate manner
9. The extent to which the applicant dedicates adequate resources to critical offices to help ensure properly functioning internal controls and efficient operations, including the presence of a qualified independent auditor with an adequately funded office and strong safeguards to its independence
10. The extent to which the applicant is able to successfully expend capital improvement funds within the award period

Allocation of CIP funds will shift year to year, reflecting the insular governments' individual performance compared to one another. Governments that increase their performance and score higher based on the above criteria receive a higher share of mandatory available CIP funds.

The list below ranks the territories in terms of their FY 2017 total CIP funding out of the available $27.72 million available.[16] For comparison on how the U.S. Territories preformed, it also lists the (+/-) in funding from their previous allocation in FY 2016 (in $ thousands):

1. American Samoa: $9,613,000 (+108)
2. Commonwealth of the Northern Mariana Islands: $9,082,000 (-524)
3. Guam: $6,578,000 (+908)
4. U.S. Virgin Islands: $2,447,000 (-492)

The graph below gives a breakdown of which types of infrastructure projects received the most funding throughout the territories during FY 2015.[17] The majority of funding went to projects for schools and hospitals throughout the insular areas.



Territory Performance Overview FY 2017

American Samoa

In FY 2017, American Samoa received $9.6 million to continue meeting critical infrastructure needs. The LBJ Tropical Medical Center underwent an expansion and renovation of the dialysis unit and the forensic psychiatric unit. Other noteworthy construction projects include a new ferry boat to provide transportation to the Manu'a Islands by the Port Administration, a new inmate building at the Tafuna Correctional Facility to alleviate overcrowding, and a new Multipurpose Building at the American Samoa Community college.

Fiscal Oversight within CIP

One example of proper fiscal oversight being carried out by OIA is their current designation of American Samoa as a "High Risk" grantee as provided for in 43 CFR 12.52, and as recommended by the GAO and Office of the Inspector General (OIG). The designation requires American Samoa grantees to comply with special conditions for future or existing grants some of which include: payment of grant funds on a reimbursable basis and withholding of

[16] Office of Insular Areas, FY 2017 Budget Justification. CIP Grants p.25.
[17] Office of Insular Areas, FY 2017 Budget Justification. CIP Grants p.26.

approval to proceed from one project phase to another until receipt of acceptable evidence of current performance. The designation may be removed if special conditions are met by the American Samoa government including completion of Single Audits, achieving balanced budget requirements and compliance with their current Memorandum of Agreement and Fiscal Reform Plan, both established under Public Law 106-113 (H.R. 2466) Park 5, Section 125(b)(3).

Commonwealth of the Northern Mariana Islands (CNMI)

In FY 2017, the CNMI received $9 million to continue their critical infrastructure needs. Top priorities included HVAC replacement at the Commonwealth Health Center and the Garapan Revitalization Drainage project. It is worth noting that since the beginning of the CIP program in 1978, the Federal government has granted the CNMI over $400 million in funds to improve their capital infrastructure.

Guam

In FY 2017, Guam received $6.5 million to continue their critical infrastructure projects. Priority projects focused on Public Health and Public Safety and include the Guam Power Authority Wind Turbine project, the Public Health Mosquito Laboratory and the Public Library renovation.

U.S. Virgin Islands (USVI)

In FY 2017, the USVI received $2.4 million to continue their critical infrastructure needs. Priorities included upgrades to a convenience center at Mandahl, St. Thomas by the VI Waste Management Authority. The Schneider Regional Medical Center completed an information technology network upgrade through replacement of eighty-five percent of their existing servers. The VI Water and Power Authority also made substantial progress in upgrading their automated grid capability, focusing on making a transition to more intelligent Distribution Automation switches that will improve the electrical distribution system operation and increase reliability.