HEALTH CARE AND RELATED FACILITIES

INFORMATION SHEETS

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Health Care and Related Facilities
Information Sheets

Office of Environmental Health and Engineering
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Health Care and Related Facilities
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Public Law 94-437 Program Responsibilities

The Indian Health Service (IHS) Office of Environmental Health and Engineering is responsible for administering the planning, design, and construction of hospitals, health centers, substance abuse treatment centers, and staff quarters as authorized by the Snyder Act, 25 U.S.C. 13; and The Indian Health Care Improvement Act, Public Law (P.L.) 94-437. Below, listed by section number, are the programs specifically authorized by P.L. 94-437 related to health care facilities construction.

Section 301: Inpatient Facilities program for new construction, modernization, and/or major renovation of inpatient facilities.

Section 301: Outpatient Facilities program for new construction, modernization, and/or major renovation of outpatient facilities.

Section 301: Staff Quarters program to provide housing for IHS staff in remote locations.

Section 305: Non-IHS Funds Renovation program in which a Tribe renovates an existing IHS facility, with IHS approval, and IHS provides the additional staff and equipment needed.

Section 306: Small Ambulatory Health Center Grants program providing grants to Tribes that present acceptable proposals to construct, expand, or modernize tribally-operated non-IHS facilities.

~~Section 307: (EXPIRED) Indian Health Care Delivery Demonstration program providing contracts with or grants to Tribes that develop and present acceptable plans for demonstration projects for alternative and innovative means of providing health care services.~~

Section 704: Youth Regional Treatment Center program for the construction, renovation, purchase, etc. of a youth regional alcohol and substance abuse treatment center in each IHS Area.

Section 818: Joint Venture Demonstration program for Tribes that develop an acceptable plan to construct a facility and lease it to the IHS for 20 years at no cost. IHS equips, staffs, maintains, and operates the facility. Implementation of this program is based on Congressional funding fro equipment, staffing, and operating expenses.

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Health Facilities Construction Priority System

Section 301 of The Indian Health Care Improvement Act, Public Law 94-437, directs the Indian Health Service (IHS) to identify planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority outpatient care facilities and to submit those needs through the President to the Congress.

In response to this directive, the IHS developed the Health Facilities Construction Priority System (HFCPS) methodology. This methodology is a two-phase process in which Phase I is implemented every 5 years to rank facilities need in Indian Country. The Phase I results are used to identify projects for detailed analysis and prioritization in Phase II.

The HFCPS Methodology

The HFCPS formula The HFCPS formula differs between Phase I and Phase II in that two additional criteria are used in Phase II. These criteria,

Phase I

Phase I is initiated every 5-years to update the ranked and categorized listing of facilities need using the Area Health Services Master Plans. Prior to this update, the IHS Area Offices are notified of the pending update so that they can review their Master Plans and update them if necessary. All IHS and Tribal health care facilities identified on Area Health Services Master Plans are reviewed, ranked and categorized using the Phase I methodology.

Phase II

Phase II is applied as needed to determine those proposals placed on the Priority List as authorized under Section 301 or to prioritize projects that meet the requirements of other authorized facilities construction programs, such as the Joint Venture Program, the Small Ambulatory Program, etc. A limited number of the highest ranking Phase I facilities meeting the requirements of the authorized construction program are selected for Phase II review.

During Phase II, the IHS, in consultation with affected Tribes, conducts a facilities planning review of the highest ranking Phase I facilities. When this review is complete, a PJD is developed that describes the health program requirements as well as the facilities needed to provide access to those health programs. Data from the PJD is applied to the methodology formula to prioritize projects.

The IHS Headquarters reviews each PJD. If the PJD justifies construction, it is approved and the project ranked with all other projects approved in the same fiscal year. The approved projects are placed on the appropriate priority list below those already listed. Proposed projects that have been approved and placed on a priority list remain on the list until they have been fully funded by congressional appropriations or other funding mechanism.

5-Year Planned Construction Budget

After projects are placed on the Priority Lists, the IHS updates its 5-year healthcare facilities construction plan. That plan is updated yearly and used as the basis for requests.

Next Implementation

The IHS anticipates implementing the HFCPS again when the facilities on the Priority List have been substantially funded or when directed by the Congress.

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Present Health Facilities Priority Rankings

February 2008

Inpatient	Outpatient
Phoenix, AZ*	Fort Yuma, CA
South East*	Eagle Butte, SD*
South West*	Kayenta, AZ*
North East*	San Carlos, AZ*
Central – Hospital *	Rapid City, SD
Barrow, AK	Winslow/Dilkon, AZ
Nome, AK	Alamo Navajo, AZ
White River AZ	Pueblo Pintado, NM
Gallup, NM	Bodaway-Coppermine, AZ
	Albuquerque, NM
	Albuquerque West
	Albuquerque Central
	Sells, AZ

March 11, 2008

* Partially Funded
** Fully Funded for Construction

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Proposals Considered During Phase III of the 1991 Implementation of the Health Facilities Construction Priority System

Proposals Considered in Phase III

In 1991, the Indian Health Service (IHS) implemented an application of the HFCPS, completing Phase I and Phase II by December 1992. At that time, IHS Area Offices were asked to prepare and submit Program Justification Documents (PJD) for the proposed projects listed below.

Aberdeen Area
- Rapid City, South Dakota*
- ~~Sisseton, South Dakota*~~
- Eagle Butte, South Dakota*

Alaska Area
- Barrow, Alaska*
- ~~Metlakatla, Alaska**~~
- Nome, Alaska**
- ~~St. Paul, Alaska*~~

Albuquerque
- Alamo, New Mexico*
- Albuquerque, New Mexico**
- ~~Dulce, New Mexico*~~

Oklahoma City Area
- ~~Clinton, Oklahoma*~~
- ~~Pawnee, Oklahoma**~~
- ~~Talihina, Oklahoma**~~

Navajo Area
- Bodaway - Gap, Arizona**
- Pueblo Pintado, New Mexico**
- Gallup, New Mexico**
- Kayenta, Arizona*
- Winslow - Dilkon, Arizona*

Phoenix Area
- San Carlos, Arizona*
- Whiteriver, Arizona*

Tucson Area
- Sells, Arizona**
- ~~Kerwo, Arizona*~~

Projects with approved PJDs are placed on the Priority Lists in the order in which they are approved. All of the twenty-two projects considered during phase III have approved PJDs, and eight, indicted by strikeout, have been fully funded.

February 27, 2008

*****PJD approved

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Joint Venture Demonstration Program

Section 818 of The Indian Health Care Improvement Act, Public Law 94-437, authorizes the Indian Health Service (IHS) to establish joint venture demonstration projects under which Indian Tribes or tribal organizations would acquire or construct a health facility and lease it to the IHS, at no cost, for at least 20 years. The IHS would not provide planning, design, or construction funding for these facilities; however, it would equip, staff, operate, and maintain them.

Participants in this program would be selected competitively from among eligible applicants who agree to provide an appropriate facility to IHS under a no-cost, 20-year lease.

Proposals considered under this program would be evaluated against the following criteria:

- The need for space at the location is verifiable when evaluated by the Health Facilities Construction Priority System;
- The Tribe is able to fund and manage the proposed project;
- The project is consistent with the IHS Health Facilities Planning Manual; and
- The project is consistent with the IHS Area Health Facilities Master Plan.

In fiscal years (FY) 2001, 2002 and 2005 Congress appropriated approximately $5,000,000 to equip facilities acquired by Tribes under this program. In language accompanying these appropriations, the Congress indicated that IHS should give priority to outpatient projects on the Health Facilities Construction Priority List.

Status

Funding for the Joint Venture Construction Program varies from year to year. But since 2001, when the Congress first appropriated funds for this program, the IHS has entered into agreements to lease and staff seven tribally constructed facilities. Two of these facilities were on the Healthcare Facilities Construction Priority List.

Most recently, in FY 2007 the Congress appropriated $4,000,000 to equip up to two projects through the Joint Venture Construction Program. The Congress indicated that these funds could be used for either hospitals or outpatient facilities and that preference should be given to Tribes that provided funding for equipment. The IHS has entered into an agreement with the Chickasaw Nation for a hospital and is working to identify a second qualifying applicant.

Because the Chickasaw Nation agreed to equip as well as construct their hospital, funds appropriated in FY 2007 to purchase equipment remain unexpended. As a result, the Congress indicated, in the FY 2008 the Interior Appropriations language, that funds remaining from 2007 should be used to fund equipment for up to two additional projects. No additional funds were appropriated in FY 2008.

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Non-IHS Funds Renovation Projects

Section 305 of the Indian Health Care Improvement Act, Public Law (P.L.) 94-437, authorizes the Indian Health Service (IHS) to accept renovations and modernization of IHS or tribal facilities performed by a P.L. 93-638 contractor. The IHS would not provide planning, design, or construction funding for these facilities; however, it would equip, staff, operate, and maintain them.

- No funds have been appropriated for this program.

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Small Ambulatory Care Facility Grants

Section 306 of The Indian Health Care Improvement Act, Public Law (P.L.) 94-437, authorizes the Indian Health Service (IHS) to award grants to Tribes and/or tribal organizations for construction, expansion, or modernization of ambulatory health care facilities located apart from a hospital. Where non-Indians will be served in a facility, the funds awarded under this authority may be used only to support construction proportionate to services provided to eligible American Indians and Alaska Natives (AI/AN) people.

Participants in this program are selected competitively from eligible applicants that meet the following criteria:

- Only Federally recognized Indian Tribes that operate non-IHS outpatient facilities under P.L. 93-638 contracts are eligible to apply for this program.
- Facilities for which construction is funded under Section 301 or Section 307 of P.L. 94-437 are not eligible for this type of grant.
- Priority will be given to Tribes that can demonstrate a need for increased ambulatory health care services and insufficient capacity to deliver such services.
- The completed facility will be available to eligible Indians without regard to ability to pay or source of payment.
- Adequate financial support will be available for services at the completed facility.
- The completed facility will:
  - Have sufficient capacity to provide the required services.
  - Serve at least 500 eligible AI/AN people annually.
  - Provide care for a service area with a population of at least 2,000 eligible persons.

Since fiscal year (FY) 2001, Congress has appropriated approximately $39,273,000 for this program.

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Indian Health Care Delivery Demonstration Projects
To Test of Alternative Means for Delivering Health Care Services

Section 307 of The Indian Health Care Improvement Act, Public Law 94-437, authorized the Indian Health Service (IHS) to enter into contracts with or make grants to Tribes or tribal organizations to carry out demonstration projects that test alternative means of delivering health care services to Indians.

No funds were appropriated for this program and authorization for it expired on September 30, 1995.

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Quarters Construction Priority System

Section 301 of The Indian Health Care Improvement Act, Public Law 94-437, directs the Indian Health Service (IHS) to identify planning, design, construction, and renovation needs for quarters for personnel working at IHS health care facilities.

In response to this directive, IHS has developed two processes to determine its quarters requirements. At locations being considered during Phase III of the Health Facilities Construction Priority System, IHS assumes there may be a high priority need to construct quarters. Therefore, a Quarters Construction Priority System Phase II data sheet is prepared at the same time as the Program Justification Document for the health facility. If construction of quarters may be justified, a Program Justification Document for Quarters (PJDQ) is prepared and included as a TAB in the health facilities Program Justification Document.

For other existing facilities, the Quarters Construction Priority System (QCPS) is used to determine quarters requirements. Under the three-phase QCPS process, IHS solicits and ranks proposals for quarters according to their relative need for construction. The highest ranking proposals are added to the Quarters Construction Priority List.

Phase I

To assess need for quarters at IHS facilities not currently being considered for replacement or expansion, IHS Headquarters periodically asks each IHS Area Office to submit proposals for Phase I consideration. The IHS uses the QCPS methodology to review these proposals and to determine which will be considered during the more intensive Phase II review.

Phase II

A limited number of proposals that successfully complete Phase I are considered further during Phase II. The IHS examines these proposals in greater detail and applies the QCPS methodology to determine which proposals will be considered during Phase III.

Phase III

During Phase III, appropriate IHS Area Offices prepare a PJDQ for each proposed project successfully completing Phase II of the QCPS. IHS Headquarters reviews each PJDQ.

If the PJDQ justifies construction, it is forwarded to the Director, OEHE, with the recommendation that it be approved. After a PJDQ is approved, those projects not associated with a health care facilities construction project are placed on the Quarters Construction Priority List below those already on it. Those quarters projects approved in conjunction with health care facilities PJDs are included as part of those facilities construction projects on the Health Facilities Construction Priority List. Projects that have been approved and placed on a priority list remain on the list until they have been funded fully by congressional appropriations or other funding mechanism.

5-Year Planned Construction Budget

After projects are placed on the Priority List, the IHS updates its 5-year planned construction budget. That budget is updated yearly and used as the basis for funding requests. Quarters projects associated with facilities are not placed on the Quarters Priority List but are placed on the 5-year Planned Construction Budget with the health facilities construction project.

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Other Funding Program Responsibilities

The Indian Health Service, (IHS) Office of Environmental Health and Engineering, is responsible for administering the planning, design, and construction of health facilities construction projects funded each year by the Appropriation Committees. Below is a list of programs and projects authorized by other than P.L. 94-437, the Indian Health Care Improvement Act.

Medicare/Medicaid: The House/Senate conference report on FY 1993 appropriations for the Department of the Interior and Related Agencies authorizes IHS to spend up to $1,000,000 in Medicare/Medicaid funds for renovation or new construction to correct Joint Commission on Accreditation of Healthcare Organizations deficiencies.

Health Services Carryover Funding: The Department of the Interior and Related Agencies Appropriations Act for FY 1993 permits IHS P.L. 93-638 contractors to use carryover Services funds to purchase, renovate and/or erect modular buildings necessary to provide health care services. The FY 1994 Appropriations Act expanded this permission to include the use of carryover Health Services funds to renovate existing space.

Level of Need Funded: Congressionally mandated expansion of services may also require additional space. If so, the Congress may transfer a portion of the "Services" funds to the "Facilities" appropriations to be used for space improvements or expansions. The IHS and tribal programs must use those facilities funds for additional space or improvements.

Modular Dental Units: In recent years, approximately $1,000,000 annually has been appropriated to replace modular/mobile dental units. In the past, these funds were allocated by the IHS dental program. However, in the FY 1994 appropriations act, the Congress transferred the responsibility to the IHS Facilities Program.

Community Hospitals: P.L. 85-151, permits the use of available appropriations for construction of community hospitals which provide care to Indians and non-Indians.

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Medicare/Medicaid

BACKGROUND

The Congress allows IHS to use Medicare/ Medicaid (M/M) collections for construction to correct accreditation deficiencies in IHS facilities.

The House/Senate conference report on fiscal year 1993 appropriations for the Department of the Interior and Related Agencies contains language that changes how IHS may use M/M collections for construction.

- Increases the amount that may be spent on a project from $250,000 to $1,000,000,
- Provides authority to construct temporary or permanent space, and
- Permits IHS to undertake projects without first obtaining congressional approval. (The IHS will notify the Congress annually of projects approved and completed.)

IMPLEMENTATION

Congressional intent in authorizing use of M/M funds for construction primarily is to correct JCAHO deficiencies. The IHS has established guidelines to ensure that these projects are in accord with this intent, that funds are used appropriately, and that proposed projects are consistent with IHS planning criteria and guidelines.

FUNDING HISTORY

Funds expended for this program come from M/M collections and do not impact the IHS budget appropriations.

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Health Services Carryover Funds

BACKGROUND:

The Department of the Interior and Related Agencies Appropriations Act for FY 1993 permits P.L. 93-638 health services contractors, in limited circumstances, to use health services carryover (HSC) funds for the purchase, renovation, and erection of modular buildings.

In FY 1994, this authorization was expanded to allow use of HSC funds for renovating existing space.

IMPLEMENTATION:

Any non-construction health care services delivery contracts awarded under authority of P.L. 93-638 which have sufficient carry over funds may use these funds, with IHS approval, to expand, renovate, or purchase modular buildings and to renovate existing buildings needed to provide health care services. The IHS has developed guidelines determining the necessity for proposed construction projects and for processing planning, design, and construction documents for review and approval.

FUNDING HISTORY:

Funds expended for this program come from previously appropriated services funds carried over from one fiscal year to another, and do not impact the IHS budget.

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Modular Dental Units

BACKGROUND

The House/Senate conference report on fiscal year 1994 appropriations for the Department of the Interior and Related Agencies contains language that makes the IHS facilities program responsible for replacement and renovation of existing modular/mobile dental units. In fiscal year 1995 Congress expanded this to include new dental units at new sites.

IMPLEMENTATION

The IHS has developed a methodology that includes guidelines and criteria to allocate these funds where they are the most needed. The evaluation criteria include analysis of the age, condition, and projected workload of the existing facility. It is expected that IHS will be able to replace approximately 2 to 3 modular dental units each year.

FUNDING HISTORY

The Congress has appropriated between $500,000 and $1,000,000 in nine of the last ten years for replacement of existing modular/mobile dental units:

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Community Hospital Construction Funding

BACKGROUND

P.L. 85-151 authorizes the Surgeon General of the United Sates to make funds available for construction of Indian Health facilities to be used in the construction of community hospitals which will serve Indians and non-Indians.

IMPLEMENTATION

The Act does not authorize any new appropriations or expenditure of funds; however, it does permit the use of available appropriations for construction of community hospitals and allows the use of combining these available funds with other funding sources.

It must be demonstrated that construction of a community hospital by one or more public or other nonprofit agencies or organizations is more desirable and effective than direct Federal construction and operation.

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Maintenance and Improvement of IHS Health Care Facilities

BACKGROUND

The IHS and various tribal organizations operate 49 hospitals, 9 substance abuse treatment centers, and numerous health centers and clinics. To ensure that these facilities remain safe and operable, the Congress appropriates a line item for maintenance and improvement (M&I).

IMPLEMENTATION

The IHS allocates funds appropriated by the Congress using a modified University of Oklahoma Formula. This formula uses the building replacement value, the class of building, and the building utilization as major factors to evaluate need and allocate funds. Funds are allocated to most facilities that house IHS-funded programs, whether provided directly or through P.L. 93-638 contracts:

- to perform routine maintenance;
- to achieve compliance with accreditation standards;
- to improve and renovate facilities;
- to ensure that Indian health care facilities meet existing building codes and standards; and
- to ensure compliance with public law building requirements.

FUNDING HISTORY

In fiscal year (FY) 2008, the Congress appropriated $52,889,000 for Repair, Maintenance, and Improvement.

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Environmental Compliance and Remediation

The House and Senate Conference Report on IHS Appropriations for FY 1993 states that $3 million appropriated that year should be included in the IHS base budget for Maintenance and Improvement (M&I) for the purpose of conducting an environmental management program for IHS and tribal health care facilities.

As a result of this direction from the Congress, IHS implemented a comprehensive environmental management program for assessment and remediation of damage to the environment. Assessment consists of formal environmental evaluations at IHS and tribal facilities to determine the nature and scope of environmentally related deficiencies. Remediation consists of construction and other activities to alleviate identified environmental threats and hazards.

Environmental compliance and remediation funds are available for all IHS and tribal health care facilities on a competitive basis, with the most acute environmental threats and hazards having the highest priority. These funds are allocated based on a priority of need and are not distributed as tribal shares.

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Indian Health Service Health Facilities Space Planning Process

For new space planning and design for Indian Health Service (IHS) health care facilities, the IHS is in the process of converting from using the planning guidelines in the Health Facilities Planning Manual (HFPM) to a computerized method, known as the Health Systems Planning (HSP) process. This process develops space planning documents and includes:

- A modular planning system, which allows the IHS to be more effective and efficient in the planning, design, and construction of facilities for the IHS health care delivery process.
- A system that is responsive to future health care needs.
- Templates, which are on computer-aided design drawings (CADD), for 22 departments, including floor plans, ceiling plans, furniture and equipment layouts and lists, and criteria requirements for electrical and mechanical systems.
- Out-of-template space planning criteria for 11 departments that provides design criteria for the space planning of departments not addressed by the standard CADD templates.
- Metric planning and programming module criteria that determines the structural grid for the template.

Currently, the HSP is being implemented for the planning and design of new space for IHS health care facilities, using the HSP CADD templates and/or planning criteria. Through the use of the HSP software, workloads are projected for each medical discipline, which in turn, is used by the software to determine the space requirements for the departments.

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Metrication

Public Law 100-418 designated the metric system as the preferred system of weights and measures for United States trade and commerce. All federal procurement, grants, and business- related activities are to be in metric by September 1992. In July 1991, Executive Order 12770 designated the Secretary of Commerce to direct and coordinate metric conversion efforts of federal agencies, and authorized the development of specific dates for metric conversion in industries where September 1992 was impractical to meet. The revised metric deadline was January 1994 for federal design and construction projects. Additionally, effective no later than January 1, 1995, design and construction of Federally assisted projects, not included as "direct Federal construction projects," shall be done in metric.

The Indian Health Service (IHS) is fully implementing the metric system. In March 1993, IHS directed that the General Services Administration Metric Design Guide be used by the Engineering Services and the Area Facilities Offices as the IHS standard for metrication.

On September 28 and 29, 1996, the 104th Congress passed the Savings in Construction Act of 1996. This allows federal agencies to specify both concrete block and lighting fixtures in metric and non-metric units; provided estimated installed costs are less for non-metric products. This applies to federal projects bid after January 1997.

The law also required the appointment by each agency of a Construction Metrication Ombudsman to handle metric related complaints. The IHS ombudsman is located in the Office of Environmental Health and Engineering, Rockville, MD. Also, a follow-up letter sent to all Area Planners stated that metric units must be used in documentation for all projects planned or designed after October 1, 1993. The IHS Technical Handbook for Health Facilities, and Health Facilities Planning Manuals, will be in metric units.

IHS is coordinating with various Federal agencies and the private sector to determine the impact on contractors due to use of the metric system; such as, the availability of construction materials, how construction trades are coping with metric, and impact to construction bids.

The IHS has developed a course to train local contractors and tribal employees on the use of metric. This training covers definitions, style guidelines for writing and reading metric numbers, and differences that might be expected in construction materials.

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Non-IHS Federal Funding for Health Care Facilities Construction

Public Law 94-437, authorizes the Indian Health Service (IHS) to acquire health care delivery space through a variety of cooperative efforts with the Tribes, including entering into joint ventures and accepting required space that, upon prior notification, Tribes have renovated or constructed. These cooperative efforts become more attractive to Tribes as direct federal funding of health care delivery facility construction becomes less available. In most cases these efforts benefit Tribes with the natural resources or businesses that generate income. Many American Indian and Alaska Native groups are not capable of funding expensive renovations or expansions and must rely on grants, gifts, or other contributions to fund their portion of cooperative efforts.

Further information on other federal agencies that might have funds to assist in construction of health care facilities may be available in the Federal Domestic Assistance Catalog. This catalog can be obtained from the Government Printing Office (GPO) for a $53 fee. Call the GPO at (202) 512-1800. Or write to:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954.
The catalog is also available for searching on the Internet at
http://www.cfda.gov/

Tribes, who use non-IHS, federal, and non-federal, sources of funding, should be aware that the laws under which IHS is authorized to accept a facility and/or provide funding for staffing, equipment, and operation and maintenance contain specific language governing the conditions and criteria for IHS participation. In most cases Tribes interested in constructing a facility to house IHS programs, must notify the IHS and receive approval for their facility. The IHS will approve only those facilities that comply with established planning criteria and guidelines. Approval is also dependent on availability of funds to staff, equip, operate, and maintain the facility.

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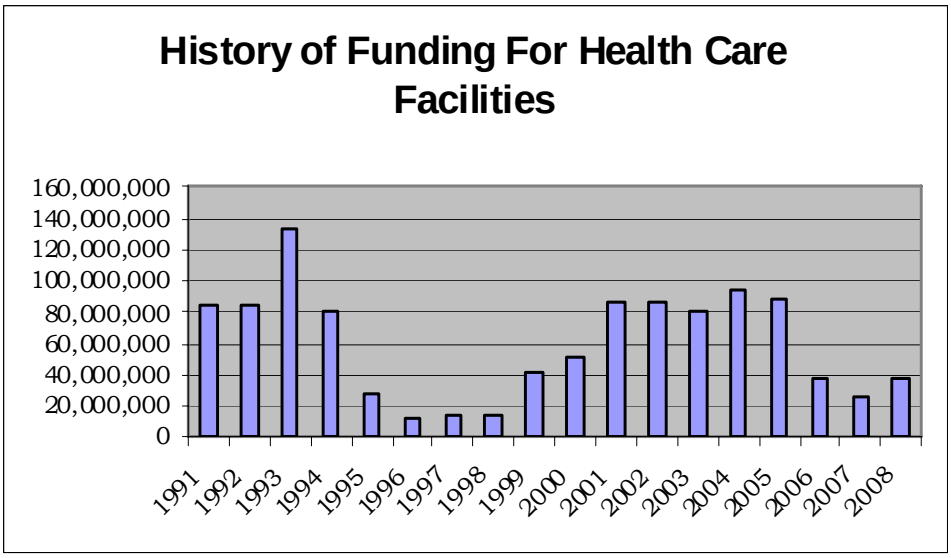
History of Indian Health Service Health Care Facilities Construction Funding

Appropriations for Indian Health Facilities have been erratic over the last 20 years. Funding levels, after rising to a high of approximately $134,000,000 in 1993, decreased sharply to $12,297,000 in 1996. Between FY 2002 and 2008, appropriations have ranged between approximately $86 million and $25 million. The FY 2008 Appropriation was approximately $36.6 million.

1991	$84,595,000
1992	$85,314,000
1993	$134,300,000
1994	$80,184,000
1995	$27,822,000
1996	$12,297,000
1997	$14,500,000
1998	$14,400,000
1999	$41,087,000
2000	$50,393,000
2001	$85,525,000
2002	$86,260,000
2003	$81,585,000
2004	$94,554,000
2005	$88,597,000
2006	$37,779,000
2007	$25,664,000
2008	$36,584,000



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Engineering Services Program

The Indian Health Service, Office of Environmental Health and Engineering, Engineering Services (ES), program provides professional project management and related services for planning, design, construction and leasing of health care facility space. The ES is responsible for the acquisition, award, administration, and closure of contracts for IHS facilities engineering construction projects, including all health care facilities construction, renovation, and modernization projects. The ES staff also conducts facility condition surveys and coordinates planning studies, i.e., site evaluation and housing verification studies, with Area and Headquarters staff.

The ES staff is comprised of licensed architects and registered engineers, certified contracting officers, warranted realty officers and associated support personnel. Project managers serve as a focal point for coordination and implementation project design and construction. The project managers are supported by specialists in architecture; contracting; real property; and electrical, mechanical, civil and structural engineering.

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Health Care and Related Facilities
Information Sheets

Accepting Donated Space

The Public Health Service Act (42 U.S.C. 238) authorizes the Secretary, Department of Health and Human Services (DHHS), to accept gifts of real property under certain circumstances. Before the Indian Health Service (IHS) may accept gifts of real property under this authority, it must ensure that:

- The space is required to house health care services,
- There is no adequate existing IHS or tribal facility and no facility currently being constructed or designed nearby that can house these services,
- The proposed space complies with IHS planning standards and guidelines set forth in the IHS Health Systems Planning Process (HSP) and other guidelines and policies,
- Acceptance of the gift does not obligate the IHS to provide additional staff or services,
- Title to the real property is debt free and the deed contains no restrictive covenants, and
- The land and buildings proposed for donation are uncontaminated.

Tribes interested in donating space should, before beginning detailed planning or design, submit a proposal IHS outlining their general plan for acquiring and donating the space. The proposal must address each of the bulleted items above. The IHS will review the proposal to determine whether it will be able to accept the donation.

If the space is needed, the Tribe will be asked to work with the IHS planning and construction staff to develop and obtain approval of a Project Summary Document for small facilities or Program Justification Document and Program of Requirements for larger facilities. These documents must be consistent with on the HSP and must comply with all applicable laws and regulations.

After planning documents have been approved by the appropriate IHS authority, the IHS will negotiate with the Tribe regarding the details of construction and transfer to ensure the compliance with all applicable general design and construction standards, including the Occupational Safety and Health Administration regulations. Since the facility will be federally owned, metric construction is required unless waived by the Director OEHE. The IHS and the Tribe will also discuss and develop protocols for the inspection processes, right of entry for construction, tort claims and hold harmless provisions, financial reporting requirements, and preparation of the real property report.

Because acquisition of donated space expands the Federal space inventory, specific Congressional authorization is required. In addition to the requirements already described, obtaining Congressional authorization requires that the acquisition meets all requirements for detailed cost accounting of capitalizeable activities.

Transfer of the facility will be handled the same as other DHHS acquisitions. The property must be surveyed by a registered surveyor and appraised by a qualified Member, Appraisal Institute appraiser. The IHS will prepare the necessary transfer documents, including all contracts, deeds, and title policy commitments. These documents must then be submitted to the Department of Justice for an opinion on title. Transfer of the property will be made only after the Department of Justice has advised that the site acquisition documents are complete. Following transfer, title is held by the United States of America.

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Clinical Engineering

Many health care services delivered by IHS require special medical equipment that must be acquired, installed, tested and calibrated, and maintained. Not only must each health care facility be equipped to meet its mission, but IHS continues to explore innovative methods, requiring new electronic technologies, to provide health care in rural settings. IHS acquires medical equipment for IHS and tribal health care facilities either as a part of construction of a new facility or with funds appropriated specifically to purchase equipment.

FUNDS DISTRIBUTION METHODOLOGY

Equipment funds included in funding for specific health facilities construction projects must be used to purchase equipment for the facility for which they are appropriated.

However, the Congress also appropriates funds to modernize or replace existing equipment or provide equipment in facilities acquired outside the Health Facilities Construction Priority System. Of these funds, the Congress directs that $5,000,000 be allocated, on a pro rata share basis, to support tribally constructed health care facilities (see "Equipment Funds for Tribally-Constructed Health Care Facilities" on page 24). In addition, IHS sets aside some funds to procure, transport, and store excess Department of Defense (DoD) medical equipment so that it can be inventoried and provided to IHS facilities and Tribes that need it and to purchase ambulances for Tribal emergency medical services programs. The remainder of the funds appropriated for equipment is allocated among all IHS and tribal health care facilities based on workload using a standard formula.

DOD EXCESS MEDICAL EQUIPMENT

The DOD occasionally makes excess medical equipment available to other federal agencies. To obtain this equipment, IHS need only acquire it (at no or minimal cost) and pay for its transportation and storage. After obtaining the equipment, the IHS inventories it and makes lists available to Tribes and Area Offices. Because the DOD makes this equipment available only to other Federal agencies, any Tribe interested in obtaining equipment through this process must contact the Area Office Clinical Engineer.

Each Area develops a request for equipment based on the needs of Tribes and service units. Since the demand is great and the supply of excess equipment is limited, IHS has established a lottery process for selection of equipment by the Area Offices.

FUNDING HISTORY

During each of the last several years, the Congress has appropriated approximately $21,000,000 to be used in funding replacement equipment. Of this, the Congress directs IHS to allocate $5,000,000 to Tribes that need medical equipment for health care facilities they construct outside the IHS Health Care Facilities Construction Priority System Process. In addition $1 million are allocated to acquire equipment from DoD and to purchase ambulances for Tribal emergency medical services programs.

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Equipment Funds for Tribally-Constructed Health Care Facilities

The Indian Health Service (IHS) allocates approximately $5,000,000 of the annual medical equipment appropriation to support tribally-constructed health care facilities. These funds are available to Tribes and tribal organizations on a pro-rata share basis for equipping tribally-constructed health care facilities or expansions to existing health care facilities that are built using non-IHS funding sources. Awarded funds can be used for purchasing x-ray machines, lab equipment, and other biomedical equipment.

Tribes constructing new space by replacement, addition, or expansion may apply for these funds. Eligible applicants will be funded on a fair share basis up to 20% of construction costs for outpatient facilities or 17% for inpatient facilities, up to $300,000. Should funds remain after all eligible awards are made, the remaining balance of funds will be distributed on a prorated basis according to unmet need exceeding $300,000, not to exceed the final maximum eligible for each project.

Tribes and tribal organizations are invited to apply for these equipment funds during the application period each year in August. Specific details on the program and application process are available at: https://webehrs.ihs.gov/external/erds/.

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Health Care and Related Facilities
Information Sheets
Real Property Management

SCOPE

The Realty Management Services Program is responsible for managing space and facilities on a nation-wide basis for Indian Health Service (IHS) administrative and health care delivery programs. The IHS programs are provided from:

240 Federally-owned installations
253 Direct-lease sites (Public Law 94-437)
64 GSA-assigned locations
500 Tribal sites (approximately)

Additionally, IHS manages approximately 2,300 Government Quarters units at more than 70 sites.

MANAGING GOVERNMENT-OWNED REAL PROPERTY

The Real Property Management Program implements laws and regulations applicable to Government-owned real property. The program also assists Tribes in acquiring surplus Federal real property via the Surplus Property Program for Public Health Benefit, DoD Base Reuse and Implementation procedures, etc. It assists Tribes in acquiring title to Federal facilities for use in conjunction with health services contracts, per The Indian Health Care and Improvement Act.

IHS LEASING PROGRAMS

The IHS Leasing Programs encompass three major leasing areas:

- Space leased through the GSA-assigned or delegated leasing authorities;
- Space leased by the IHS under authorizations in the Indian Health Care Improvement Act (P.L. 94-437) for directly operated programs; and,
- Space leased by the IHS for tribally operated (contracted) programs through the Indian Self Determination and Education Act.

The Federal Property Management Regulations authorize the IHS to enter into subleases with GSA for space to house Government programs. The regulations also provide HHS limited authority to competitively acquire lease space in private sector markets when suitable Federal space is not available.

Public Law 94-437, authorizes the IHS to enter into leases with Tribes and/or tribal organizations (for IHS operated programs) for periods of up to 20 years. Additional funding authority from the Congress is required before negotiating capital leases and lease/purchase agreements.

Public Law 103-413, provides authority for the IHS to lease tribally owned and operated facilities and to compensate Tribes for the use of their buildings via a lease instrument, rather than through the P.L. 93-638 contract. For IHS to be able to pay these new lease costs requires additional funding from the Congress.

The IHS Lease Priority System (LPS) was established in 1991 and includes multidiscipline reviews of LPS lease applications. The LPS review process ensures funding for necessary programs, staff, and equipment.

The IHS leasing programs assists Tribes in evaluating Federal lease requirements, market survey data, payment structures, and scoring for capital lease/purchases, etc.

QUARTERS MANAGEMENT PROGRAM

In conjunction with 19 other Federal agencies, administers a nationwide program to survey and evaluate private sector rental markets to establish uniform rents for Government quarters.

The Quarters Management Program assists the IHS Areas in establishing and implementing an effective Quarters Management Program.

March 14, 2006

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Health Care and Related Facilities
Information Sheets
Transfer of Real Property

The Federal Property and Administrative Services Act and implementing regulations (41 CFR 101-47) require Federal agencies to evaluate utilization of real property and dispose of the property that is in excess of an agencies needs.

EXCESS REAL PROPERTY - WITHIN A RESERVATION

When excess Federal real property is located within a reservation (or within or adjourning reservation land in Oklahoma), Tribes are offered the excess property pursuit to P.L. 93-599, Federal Facilities on Indian Lands. Transfer actions under this authority do not require screening for reuse by other agencies. The Tribe or tribal organization should submit a tribal resolution requesting the transfer to the Area Office listing the real property, purposed use of the real property, and contract/compact number (if applicable). The actual transfer is without compensation to the Secretary of the Interior through the General Services Administration (GSA). The property is held in trust status under the Bureau of Indian Affairs (BIA).

EXCESS REAL PROPERTY - TRUST LAND

Excess property already held in trust by IHS for a Tribe is transferred to BIA. The P.L. 83-568 [The Transfer Act] transferred health functions and related buildings, lands, and facilities from the BIA to the Indian Health Service (IHS). To facilitate transfers as well as retransfers of real property, GSA developed regulations (41 CFR 101-47.604) to provide the Secretaries authority "to transfer and to retransfer to each other, upon request, any of the property of the agency which is being used and will continue to be used in the administration of any function relating to Indians."

EXCESS REAL PROPERTY - FEDERAL LAND

The Federal Property and Administrative Services Act provides statutory authority for the disposal of excess real property to another executive agency having a need for the property, or, if there is no such need, for its disposal as surplus property in accordance with federal laws and regulations.

The GSA is responsible for the disposal of excess and surplus federal real property that the IHS reports as excess; it is no longer required for health care purposes. These disposal actions generally require screening for reuse by federal agencies, nonfederal recipients, or for donation to eligible state, public, or nonprofit agencies. Property not conveyed to eligible recipients is sold by competitive bid.

TRANSFER OF REAL PROPERTY UNDER A SELF-DETERMINATION CONTRACT OR COMPACT

P.L. 93-638, the Indian Self Determination and Education Assistance Act, §105(f) and §512(c) permits the donation of real property to a Tribe, tribal organization, or urban Indian program for their use in connection with a self-determination contract or compact pursuit to the Act.

A Tribe or tribal organization should submit a formal written request to the Area Office when they desire to acquire title of Federal real property under the Indian Self Determination and Education Assistance Act.

Prior to transfer, the IHS must perform certain essential actions such as a title search of the land, a metes and bounds survey, environmental assessment, historic evaluation, etc. to comply with real property transfer regulations, laws, and executive orders. Once these actions are completed the transfer of the real property will be accomplished through a quitclaim deed containing required provisions on the use of property, reversionary rights, and environmental covenants.

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Indian Trust Land

Trust land (or land in trust status) is land held in trust by the United States for an individual Indian or a Tribe. The Indian Health Service (IHS) is the trustee for trust lands transferred under the Transfer Act (Public Law 83-568) used for Indian health care purposes.

The Transfer Act (Public Law 83-568) transferred to the Surgeon General of the Public Health Service "... all functions, responsibilities, authorities, and duties of the Department of the Interior (DOI)" relating to Indian health care. Under the Act, the DOI transferred existing hospitals, clinics, health stations, quarters, and associated lands utilized for health care purposes to the IHS. This included in some instances land held in trust status.

TRUSTEE OF TRUST LAND

The IHS trustee responsibilities for the trust lands used to provide health care services nationally to Native American and Alaska Native populations include managing the resources in a way that:

- Reflects our Federal trust responsibility toward Indian Tribes;
- Respects tribal rights;
- Acknowledges the treaty obligations; and
- Protects the resources that the Federal Government holds in trust for Tribes.

LEASEHOLD INTEREST OF TRUST LANDS

As an alternative to transferring trustee responsibilities to the IHS, Tribes in conjunction with the Bureau of Indian Affairs (BIA) may lease these lands to the IHS for construction of new health care facilities. A no-cost lease of the trust land helps to preserve the land for health care purposes, protects it against other encumbrances, and provides a documented agreement of use.

TRANSFER OF EXCESS TRUST LAND

When no longer needed for health care purposes, the trustee responsibility is transferred back to the DOI to continue the Federal trustee responsibilities. The BIA then makes the land available for the use and benefit of the relevant Tribe (40 U.S.C. §523).

ACQUISITION OF TRUST LANDS

The DOI has responsibility to accept land that will be held in trust by the United States for an individual Indian or a Tribe (25 C.F.R. Part 51).

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Lease Priority System

The Indian health Care Improvement Act (IHCIA), Public Law (P.L.) 94-437, authorizes the IHS to enter into leases with tribes and/or tribal organizations.

The IHS Lease Priority System (LPS was established in 1991. The IHS Lease Priority System addresses leases for general purpose space or the expansion of small health care facilities which would not ordinarily be considered under the Health Facilities Construction Priority System (HFCPS).

Lease proposals for health and dental clinics are limited to 2,000 gross square meters or 21,528 net square feet (nsf) provided Area funding is available when the request is made. Leases of larger health care facilities, any capital lease request, or any lease/purchase agreement require advance placement on the Health Facilities Construction Priority List and specific funding.

Nominal cost or rent free space must be approved through the LPS. This assures appropriate space for programs and ensures funding for necessary programs, staff, and equipment.

The IHCIA, as amended by P.L. 102-573, waived the requirement for tribal contractors to obtain advance approval of leasing in Appropriations Acts. However, tribes and tribal organizations need approval through the LPS before acquiring new or expanded leased space when costs for such space are expected to be reimbursed with the IHS contract funds. LPS applications require Area Finance officer certification of sufficient funds to pay additional lease costs without adversely impacting contractor operations.

The Headquarters LPS Committee meets monthly.

TYPES OF LEASES COVERED BY HQ AND AREA LPS COMMITTEES:

- IHS leases with tribes and tribal organizations pursuant to P.L. 94-437 for IHS operated programs.
- Small health and dental clinics, less than 2,000 square meters.
- Nominal Cost/Rent free space, regardless of size.
- Special purpose space (less than 2,500 nsf) for one year or less or any amount of temporary space (less than 180 days).

TYPES OF SPACE LEASED BY IHS:

- Office; storage; warehouses; clinics; other institutional; automated data processing; conference/training; service/maintenance; inside and outside parking; research/development, etc.
- Quarters (after approval and funding of Program Justification Document –Quarters).
- Clinic space > 2,000 square meters (21,258 nsf) once approved through Health Facilities Construction Priority System methodology.

EXCEPTIONS TO LPS:

- Village Built Clinics leased in Alaska (up to 170 locations annually).

LPS APPLICATIONS ARE DUE:

Applications received by Area or HQ LPS Committees by the 15th day of any month will be reviewed at the next monthly LPS meeting.

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Leasing under Indian Self Determination and Education Assistance Act

The Indian Self Determination and Education Assistance Act, Public Law (P.L.) 93-638, as amended (25 U.S.C. 1674) in §105(l) authorizes the Indian Health Service (IHS) to lease space owned by a tribe or tribal organization for tribe or tribal organization to use in the delivery of services under this Act.

Compensation may include rental payments negotiated at fair market rates and/or other reasonable expenses (less any funds provided from other Federal programs; i.e., Federal grants, direct-Federal construction funding, etc.). Funding for the lease would be deducted from the existing P.L. 93-638 program contract funds for rental payments to the contractor or grantee.

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