CHAPTER 70-6 MAINTENANCE AND IMPROVEMENT FUNDING ALLOCATION

70-6.1 INTRODUCTION

A. PURPOSE

Detail the Indian Health Service (IHS) Office of Environmental Health and Engineering (OEHE) guidelines for the objectives, appropriate use, allocation formulas, and the obligation/transfer of the IHS Facilities Appropriation Maintenance and Improvement (M&I) funding.

B. BACKGROUND

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

Maintaining reliable and efficient buildings is an increasing challenge as existing health care facilities age and IHS and Tribal Health Programs add additional space into the real property inventory. The average age for IHS-owned health care facilities is over 40 years, whereas the average age, including recapitalization, of private-sector hospital plants, is 11 to 12 years.[1] Many IHS and Tribal health care facilities are operating at or beyond capacity, and their designs

[1] American Hospital Association Trends Affecting Hospitals and Health Systems Chartbook (2018 edition): https://www.aha.org/system/files/2018-06/2018-AHA-Chartbook.pdf

are not efficient in the context of modern health care delivery. In addition, as existing health care facilities continue to age, the operational and maintenance costs increase. IHS hospital administrators have reported that old or inadequate physical environments challenged their ability to provide quality care and maintain compliance with the Medicare Hospital Conditions of Participation. Further, the administrators reported that maintaining aging buildings and equipment is a major challenge with over one third of all IHS hospital accreditation citations have been found to be related to facilities/building condition.

The physical condition of IHS-owned and many tribally owned healthcare facilities is evaluated through routine observations by facilities personnel and by in-depth condition surveys to identify facility, fire-life-safety, and program deficiencies. OEHE uses these observations and surveys to annually develop the IHS Backlog of Essential Maintenance, Alteration, and Repair (BEMAR). BEMAR is a measure of the condition of health care facilities in the Indian health system and establishes priorities for larger M&I projects. Currently, the BEMAR for all IHS and reporting Tribal health care facilities is over $1 billion and increases annually. BEMAR funding started in FY2018.

The IHS receives an annual IHS Facilities Appropriation of which a sub activity item is specifically for the M&I activities in federally owned buildings and where tribally owned space that is used to provide healthcare services pursuant to contract or compact arrangements executed under the provisions of P.L. 93-638, the Indian Self Determination and Education Assistance Act (ISDEAA). M&I funding support and enhance the delivery of healthcare services to American Indians and Alaska Natives and to safeguard the interests in IHS real property. The IHS Area Offices are encouraged to develop spending plans and project priority lists to maintain, repair, and improve their associated facilities.

Allocation of M&I funding is divided into four categories:

Routine M&I. These funds support activities that are generally classified as needed to maintain and complete minor repairs at the IHS and Tribal healthcare service units. Routine M&I funding allocation is formula calculated annually.

BEMAR Project. These funds are allocated to reduce the BEMAR, a list of deficiencies that must be addressed to repair and improve the condition of a healthcare facility. The BEMAR project funding allocation formula; if M&I funding is available after fully funding Routine M&I, Environmental Compliance and Demolition; is based on a 50-50 proportional share of the Area Routine M&I Allocation and total Area BEMAR deficiencies.

Environmental Compliance.
Environmental compliance and funds are available for IHS and Tribal healthcare facilities on a competitive/project basis. IHS uses these for environmental remediation actions, abatement of hazardous materials (e.g., asbestos contained material, lead-based paint, mercury, radon, petroleum leakage/contamination, etc.), fund environmental audits and correct findings, improve

water consumption to protect the environment, and implement other environmental compliance and remediation initiatives. The IHS OEHE Environmental Steering Committee reviews and approves the allocation of this project funding. The IHS Environmental Steering Committee solicits funding requests from the Area Offices and prioritizes per OEHE Technical Handbook Chapter 75-5 *Prioritization and Funding of Environmental Remediation Activities*.

Demolition Funds. Demolition funds are available for demolition of IHS-owned buildings on a competitive basis. The IHS OEHE Environmental Steering Committee reviews and approves the allocation of this project funding. The IHS Environmental Steering Committee solicits funding requests from the Area Offices and prioritizes per OEHE Technical Handbook Chapter 75-8 *Prioritization and Funding of Demolition Activities*. Demolition funds are available of IHS-owned buildings only.

C. OBJECTIVES

The M&I funding objectives include:

- Providing routine maintenance and repairs to upkeep facilities.
- Ensuring that healthcare facilities meet building and fire-life safety codes and standards.
- Achieving and maintaining hospital and health center accreditation[2] or certification standards of The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), Patient-Center Medical Home (PCMH)[3], or other applicable healthcare accreditation standards.
- Providing improvements to facilities for enhanced patient access to care.
- Ensuring compliance with executive orders and public laws relative to building requirements, e.g., sustainability, energy conservation, seismic, environmental, handicapped accessibility, historic preservation, and security.
- Meeting program priorities to address the condition of facilities.
- Demolishing Federal buildings when excess to the needs of the Service or a liability to health and safety.

70.6.2 USE OF M&I FUNDING

In consultation with the IHS Federally operated healthcare sites and Tribal Health Programs, IHS allocates funding to the IHS Area Offices for routine maintenance and repair, and to complete projects to maintain, repair, improve, and modernize the healthcare facilities to support and expand access to quality health care services.

Older IHS healthcare facilities may have insufficient space for modern health care delivery needs and outdated infrastructure that can fail and lead to facilities closures. Facility deficiencies/BEMAR and medical equipment are complex and involve many variables such as accreditation standards, healthcare patient satisfaction, changing healthcare delivery standards, building codes, old building equipment/system, IT interface, and telemedicine medical

[2] IHS Special General Memorandum 17-01, *Patient-Centered Medical Home Designation in Ambulatory Care*: All IHS ambulatory care facilities, including hospital-based ambulatory care health centers, excluding health stations, will attain PCMH certification/designation.
[3] A model of primary care that may be referred to as Primary Care Medical Home (PCMH) by The Joint Commission (TJC), PCMH by Accreditation Association for Ambulatory Health Care, or other state recognized Health Care Home standards.

devices/equipment used by healthcare professionals. As such, Area M&I BEMAR projects and medical equipment procurements need to be prioritized to the right projects/procurements that reduce the highest risk at the IHS healthcare sites.

IHS Area Offices and Tribal Health Programs may use M&I funding for the following typical facilities maintenance, repair, alteration, and improvement activities:

- Maintenance and repair activities of real property such as service contracts, parts, bench stock (e.g., supplies and materials for repairs), and expendable tools required to perform the duties by the IHS facilities staff.
- Preventive maintenance, unscheduled repairs, and regular building upkeep activities.
- Replacing building service equipment such as new circulation water pumps, new air conditioning air handler, etc.
- Public-Law compliance projects to meet mandated code.
- Program-related improvement and alterations to a building for the delivery of 21st century healthcare services.
- Facilities engineering expertise that is not available at the local facility.
- Improvement projects that upgrade or expand real property building equipment/systems; e.g., electrical, plumbing, fire protection, lighting, building automation, fire alarm, ventilation, etc.
- Complete on five-year cycle Facilities Condition Surveys. See OEHE Technical Handbook Chapter 73-1 *Facilities Condition Assessment Program Overview*, Chapter 72-2 *Facilities Condition Assessments*, and Chapter 73-3 *Facilities Engineering Deficiency System*.
- Environmental remediation projects.
- Demolition of Federal building projects.
- Repair by Replacement projects. See OEHE Technical Handbook Chapter 74-1 *Repair by Replacement Projects*.
- Quarters/Housing repairs to augment Quarters Return rent collections to keep quarters/housing units up to date at an acceptable level for occupancy. See OEHE Technical Handbook Chapter 70-7 *Maintenance Standards*.
- Network cabling infrastructure that is directly linked to major building installed equipment (e.g., HVAC digital control systems), major digital medical equipment that interconnects with electric health systems/records, “magnetic” door security/locks, etc., and
- Pharmacy space improvement project for new electronic pharmacy equipment, meet new code requirements, improve ventilation, upgrade security and video surveillance, etc.

Examples of activities that are <u>not</u> be funded using M&I funds:

- Maintenance and repair of personal property equipment.
- Salaries of permanent and temporary staffing.
- Expenditures of operational activities.
- Construction to add additional space to an existing building or construct/acquire a new building.
- Replacement and repair of biomedical equipment.
- Purchase, installation, and upgrades of communication systems, telephones, computers and

associated hardware.
- Information Technology (IT) equipment such as network switches, routers, uninterruptable power supplies.
- Program required systems and equipment such as security surveillance systems, kitchen equipment (refrigerators/ freezers, stove, ovens), network equipment, etc.
- Utility costs.
- Rent for leased space.
- Demolition of buildings/facilities replaced by a Health Care Facilities Construction funded project.

70-6.3 ALLOCATION FORMULA

After budgetary set-asides and rescissions, the remaining M&I funding is allocated to the Area Offices as Routine M&I first and then BEMAR project funding as available. When BEMAR project funding levels are nominal, these funds will be distributed as Routine M&I.

Routine M&I Allocation Formula: The allocation to Area Offices is equal to the summation of the Routine M&I values of the individual buildings in the Area.

Routine M&I = [space] x [quarters]/4 x [construction index] x [intensity] x [location index] x [replacement cost]

Where:
- Space = square meters of IHS-funded program supportable space
- Quarters = number of full quarters the facility is in open/use for the fiscal year
- Construction Index = a percentage factor dependent on the types of materials used in the construction of the building
- Intensity = percentage factor dependent upon hours of operation
- Location Index = percentage factor that adjusts replacement cost based on a specific geographic location
- Replacement Cost = cost to replace one square meter of the facility type

Construction Index reflects a "maintenance and repair factor" based on the type of building construction. This percentage factor is dependent on material type used in the construction of the building. The maintenance factor values are:
- 0.0110 - 1.10%, Fire resistant building, Class A
- 0.0130 - 1.30%, Masonry and wood building, Class B
- 0.0175 – 1.75%, Wood frame building, Class C
- 0.0200 – 2.00%, Temporary structure, trailer, Class T

Intensity is another "maintenance and repair factor" that is a percentage factor dependent upon the use and occupancy of the building. The maintenance factor values are:
- 0.25 (25%): Buildings of minimal use such as warehouses, less than five-day-a-week clinics, vacant or excess buildings in the first year that the facility is vacant/excess, etc.

- 1.0 (100%): Buildings with normal intensity of use of occupancy such as health centers and offices which are used typically 8 hours/day, 5 days/week and multi-story parking garages that may be used 24 hours/day and 7 days/week
- 1.5 (150%): Buildings such as hospitals and service buildings used intensively for 24 hours/day, 7 days/week
- 0.0 (0%): Vacant or excess buildings after the first year that the facility is vacant/excess

Location Index is a factor used to adjust cost based on a specific location. The location index factors are updated annually to reflect current national industry location cost data.

Replacement Cost is the unit cost to replace one square meter of a type of building. Replacement costs are updated annually to reflect current national industry data for the construction costs associated for various types of facilities:

- Hospital
- Health Center, Health Station, Laboratory, Dental Clinic, Outpatient Clinic, etc.
- Youth Regional Treatment Center (YRTC), Alcohol and Substance Abuse Program (ASAP), etc.
- Office and Service Buildings (e.g., Area, service unit, or OEHE offices; hospital support offices; facility management buildings; heating plants; educational, counseling, child care center, and cafeteria buildings; storage buildings; etc.) and multi-level parking garages[4]

BEMAR Project Allocation Formula: BEMAR Project allocation per Area is formula based:

Area BEMAR Project Allocation = [(Area BEMAR total / IHS BEMAR total) x 50% + (Area Routine M&I total / IHS Routine M&I total) x 50%] x National BEMAR Project Funding[5]

Area Offices shall develop a process for determining the distribution of Routine M&I and BEMAR Project funding using spending plans, Facilities Engineering Program Plan (FEPP), holding annual Area Facilities Committee Boards, Tribal consultation, etc.

- Area Offices may retain a percentage of the Routine M&I funding for an IHS service unit level for Area prioritized repair and improvement projects, and emergency projects (e.g. fire or flood). The Area project approval threshold for projects is $3 million via a signed Project Summary Document (PSD). Submit projects greater than $3 million to OEHE Division of Facilities Planning and Construction for review and approval.
- For Tribally operated federally owned facilities, Area Offices should obtain concurrence from the Tribal Health Program to retain a portion of Routine M&I funding for the IHS buildings. Tribes or Tribal Health Programs with Tribally owned facilities may opt to take their portion of Routine M&I funding in their ISDEAA Compact/Contract funding agreements.

[4] Service buildings and parking garages are currently fixed at $1,000 per square meter.

[5] For example, if IHS has $10 Million in BEMAR Project Funding and an Area receives 12% of the total national Routine M&I funding and has 10% of national BEMAR, the Area Office BEMAR project funding is [(12% x 50%) + (10% x 50%)] x $10M = $1.1 million.

70-6.4 ELIGIBILITY

A. M&I ELIGIBILITY

Eligibility to be included in the Routine M&I allocation formula is determined by building ownership and the type of healthcare program operating in the building.

- Government-owned building: M&I eligible if it supports an IHS-approved program.
- Tribally owned or leased (except for the Tribal leased space listed below) building: M&I eligible if it supports an IHS-approved program pursuant to an ISDEAA contract or compact.
- IHS leased buildings for direct IHS healthcare services: M&I eligible only if IHS is responsible for the maintenance and repair under the terms of the lease.
- Joint Venture leases: M&I eligible if it supports an IHS-approved program pursuant to an ISDEAA contract or compact.
- Multi-level parking garages: M&I eligible if in support of an IHS-approved program.
- Village Built Clinic (VBC): Not M&I eligible as direct funded under the VBC lease.
- Land: Not eligible.
- Quarters and other housing related facilities (e.g., garages, storage sheds, carports): Not M&I eligible.
- ISDEAA Section 105(l) Leased Tribal Buildings: Not eligible to receive Routine M&I funding[6].
- Urban Indian Health Program Facilities: Not eligible to receive M&I funding unless otherwise made eligible by Congress.
- Contract Health Services: Not eligible to receive M&I funding.

B. IHS-APPROVED PROGRAM SPACE

Refer to the OEHE Technical Handbook Chapter 77-1 *Facilities Supportable Space* for guidance on IHS approved program space.

C. SUPPORTABLE SPACE

For Routine M&I funding allocation, supportable space is defined at the service unit level not by individual building. The summation of agency-related program space in a service unit may not exceed its maximum supportable space. Each building can be fully, partially, or zero M&I

[6] ISDEAA Lease Provision
25 U.S. Code § 450j. Contract or grant provisions and administration.
(l) Lease of facility used for administration and delivery of services.
(1) Upon the request of an Indian tribe or tribal organization, the Secretary shall enter into a lease with the Indian tribe or tribal organization that holds title to, a leasehold interest in, or a trust interest in, a facility used by the Indian tribe or tribal organization for the administration and delivery of services under this subchapter.
(2) The Secretary shall compensate each Indian tribe or tribal organization that enters into a lease under paragraph (1) for the use of the facility leased for the purposes specified in such paragraph. Such compensation may include rent, depreciation based on the useful life of the facility, principal and interest paid or accrued, operation and maintenance expenses, and such other reasonable expenses that the Secretary determines, by regulation, to be allowable.
25 Code of Federal Regulation, Subpart H - Lease of Tribally-Owned Buildings by the Secretary, § 900.69 to § 900.74.
§ 900.69: Section 105(l) of the Act requires the Secretary, at the request of an Indian tribe or tribal organization, to enter into a lease with the Indian tribe or tribal organization for a building owned or leased by the tribe or tribal organization that is used for administration or delivery of services under the Act. The lease is to include compensation as provided in the statute as well as "such other reasonable expenses that the Secretary determines, by regulation, to be allowable."
§ 900.70: "To the extent that no element is duplicative"

eligible supportable space (by percentage) depending on the maximum supportable space value for the service unit in the Healthcare Facilities Data System (HFDS). The HFDS also contains fields for the Area Offices to code buildings as M&I and Medical Equipment "Eligible": Yes or No. The associated Area Office adjusts the percentage of M&I eligible supportable space for each building within a service unit to ensure the appropriate distribution of Routine M&I funding. Refer to OEHE Technical Handbook Chapter 77-1 *Facilities Supportable Space*.

70-6.5 BEMAR PROJECT FUNDING TRANSFER

To request Area BEMAR project funding, IHS Area Offices must submit a prioritized BEMAR project list that improves IHS facilities and reduces BEMAR to OEHE Division of Facilities Operations (DFO). OEHE DFO will review the project list and then approve the transfer the M&I BEMAR project funding to the perspective Area Office. The Area Office shall then coordinate with OEHE Division of Engineering Services to award the construction project contract to execute the project scope of work.

Tribal Health Programs using Federal or Tribally owned healthcare facilities are also eligible. The Tribal Health Program is to furnish their M&I BEMAR project list to the Area Office for submission to OEHE Division of Facilities Operations. Once the M&I BEMAR funding is transferred to the Area Office, the Area Office shall then coordinate with OEHE Division of Engineering Services to issue either the ISDEAA Title I Subpart J Construction Contract or ISDEAA Title V Construction Project Agreement to the Tribal Health Program. Only OEHE Division of Engineering Services may award the agreement to transfer the M&I BEMAR project funding for major repair construction projects[7] using either an ISDEAA Title I Construction Contract or a Title V Construction Project Agreement (TVCPA). However if the Tribal project is estimated at $150,000 or less, the project funding may be transferred by an ISDEAA Annual Funding Agreement amendment.[8]

70-6.6 TIMELINE

The Maintenance & Improvement and Medical Equipment (M&I-E) data in HFDS are reviewed annually during the fiscal year concluding in September when the M&I-E allocations are finalized for allocation at the start of the fiscal year in October.

OEHE Division of Facilities Operations will prompt the Area Offices with steps involved in reviewing the data. Area Offices must confirm the accuracy of the data in the tables by September 1. Below are the key timeline steps/dates:

- April - Area Offices, in consultation with Tribal Health Programs, review M&I-E data in HFDS to validate existing buildings and projected buildings.

[7] Per the Code of Federal Regulations, Title 42, Chapter I, Subchapter M, Part 137, Subpart N - Construction, Section 137.280 - Construction Definitions, construction project means "An organized noncontinuous undertaking to complete a specific set of predetermined objectives for the planning, environmental determination, design, construction, repair, improvement, or expansion of buildings or facilities described in a project agreement."

[8] Generally, projects at or below the $150,000 threshold are not typically considered to have a significant affect. This threshold aligns with the Federal Acquisition Regulations (FAR) simplified acquisition threshold.

- April - Review medical workload data for Hospital Admissions, Inpatient Days, Outpatient Visits, and Community Health Aide Practitioner visits and user population data by service unit from the Office of Public Health Support (and uploaded into HFDS). For non-reporting Tribal Health Programs, confirm workload data with Area statistician and report the information to OEHE Division of Facilities Operations[9].
- May - OEHE Division of Engineering Services updates the Replacement Index and Locality Index factors used in the Routine M&I-E allocation formula.
- July - Area Offices evaluates and verifies M&I eligibility and the maximum supportable space value for all IHS and Tribal service units. Area Offices coordinate with OEHE Division of Facilities Planning and Construction for updates to the maximum supportable space value. Based on the maximum supportable space value, adjust the percentage of supportable space within the service unit to ensure no service unit exceeds the maximum supportable space value.
- August - Area Office complete the final review, including coordinating with Tribal Health Programs and via Tribal consultation, of the projected Routine M&I-E allocations for accuracy and appropriateness. Provide feedback and proposed edits to OEHE Division of Facilities Operations.
- October - OEHE finalizes the Routine M&I-E allocations and Area M&I BEMAR project funding for the fiscal year. First based on the IHS Advance Appropriation leveling level and then adjusted once the IHS Appropriation is enacted.
- October - OEHE publishes the annual IHS BEMAR report.

[9] Division of Facilities Operations email at IHSDFO@ihs.gov