National Indian Health Board
National Congress of American Indians
National Council of Urban Indian Health
Alaska Native Health Board

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE
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November 15, 2019

The Honorable Julia Brownley
Chairwoman
House Committee on Veterans' Affairs
Subcommittee on Health
B234 Longworth House Office Building
Washington, D.C. 20515

The Honorable Neal Dunn
Ranking Member
House Committee on Veterans' Affairs
Subcommittee on Health
B234 Longworth House Office Building
Washington, D.C. 20515

Re: House Committee on Veterans' Affairs Subcommittee on Health Oversight Hearing Entitled "Native Veterans' Access to Healthcare"

Dear Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee:

On behalf of the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), the National Council of Urban Indian Health (NCUIH), the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), and the Alaska Native Health Board (ANHB) – whose organizations collectively serve the sovereign, federally-recognized Tribal Nations and Urban Indian Organizations (UIOs) – we thank you for the opportunity to testify on Wednesday, October 30, 2019, during the House Committee on Veterans Affairs Subcommittee on Health oversight hearing entitled, "Native Veterans' Access to Healthcare".

Compared to their non-Native counterparts, Native Veterans are underrepresented among other Veterans that are able to access Veterans Administration services and benefits. The disproportionate barriers Native Veterans experience neither honors nor respects what they have sacrificed to protect Tribal communities and the United States. Health care for Native Veterans is rightfully owed to them because of the federal government's promise to service members and its treaty obligations and trust responsibility to the Tribal Nations. The demonstration of your commitment to serving the health interests and needs of American Indian and Alaska Native (AI/AN) Veterans is crucial to ensuring that that the federal government upholds its trust responsibility and treaty obligations for healthcare. We thank you for your attention to Native Veteran health disparities, and to assist your work, this letter provides additional information and answers regarding following collective hearing testimony.

<u>Supporting Legislation That Improves Healthcare for Native Veterans</u>
As mentioned during the hearing, there are several ways the Subcommittee can work to improve healthcare delivery to Native Veterans. We urge the Subcommittee to support, and encourage their respective colleagues to support three bills which affirm the federal government's dual responsibilities to Native Veterans. If passed, these bills will greatly expand health services for

American Indian and Alaska Native (AI/AN) Veterans, and therefore, improve the United States Department of Veterans Affairs' (VA) ability to provide quality care:

- H.R. 2791 — The Department of Veterans Affairs Tribal Advisory Committee (VATAC) Act of 2019, to create a Tribal Advisory Committee at VA;
- H.R. 4908 — The Native American Veteran Parity in Access to Care Today Act, to exempt Native veterans from copays when accessing VA services; and
- H.R. 4153 — The Health Care Access for Urban Native Veterans Act, to authorize Urban Indian Organizations (UIOs) and VA to enter into agreements for the sharing of medical services and facilities and other purposes.

Reaffirming the VA 's Treaty Obligations and Trust Responsibility

We were encouraged that the purpose of the oversight hearing included an examination of VA's ability to uphold the federal government's trust responsibility and its treaty obligations to Tribal Nations. We respectfully remind the Subcommittee that the treaty and trust relationship applies to every federal agency, including VA. Holding VA accountable for this obligation is a necessary step to improve the health status of Native Veterans who benefit from coordinated care. Moreover, this federal obligation, such as federal fiduciary responsibilities, includes the provision of culturally competent health care which takes into account a Native Veteran's traditions such as language, barriers, and customs.

Therefore, the following recommendations are being made in the interest of improving the health status of Native Veterans and strengthening the federal government's relationship with the Tribal Nations:

- *Increase Native Veterans' access to culturally competent services:* The VA must increase outreach and education efforts to improve care coordination and improve the healthcare status of Native Veterans. The Tribal Nations have consistently stressed the need for AI/AN toolkits and guides to assist Native Veterans in navigating care access. This work is essential and requires a culturally competent workforce with knowledge and the earned respect of the community to adequately connect a Native Veteran to their services. Further, Native Veterans require assistance with benefits claims and accessing other VA services which could be accomplished through access and support for Tribal Veterans Service Organizations (TVSOs). We urge this Subcommittee to examine ways which ensure Tribal Nations are able to establish TVSOs to assist Native Veterans with the preparation, presentation, and prosecution of benefits claims.

- *Exempt Native Veterans from co-pays, in fulfillment of the trust responsibility:* In recognition of the federal treaty obligations and trust responsibility, VA should eliminate all deductibles and co-pays for Native Veterans. Neither the Native Veteran nor the IHS should be responsible for any co-payments for healthcare services provided to Native Veterans because the services being accessed have been pre-paid by Tribal Nations. Also, neither the IHS nor Tribal Nations charge co-payments or deductibles to AI/AN beneficiaries because of the federal treaty obligations and the Federal trust responsibility to provide for AI/AN healthcare.

- *Ensure parity between the VA and appropriations to Indian Country:* In order for the federal government to effectively leverage its resources and successfully coordinate care for Native Veterans, it must also consider funding and additional resource disparities between the departments and agencies expected to collaborate on such efforts, within VA and elsewhere[1]. Native Veteran healthcare is particularly vulnerable because the IHS does not receive advance appropriations, is subject to discretionary appropriations, and has been grossly underfunded since its inception and is now at a high point in appropriations with funding 56% of the current level of need. Further, Indian Country is deeply impacted when changes are implemented which fail to recognize the unique challenges of the Indian health system. For example, when VA announced its 2017 decision to replace its open source electronic health record (EHR), the Veterans Health Information Systems and Technology Architecture (VistA) with a commercial off the shelf system, the problems and difficulties in achieving interoperability between VA, the Department of Defense (DoD), and IHS were exacerbated for the Indian health system. As health information technology (IT) at VA advanced, the Indian health system was left behind, despite the fact that IHS relies on VA to provide patchwork updates to its EHR—the Resource Patient Management System (RPMS). The close partnership between the VA and IHS, which greatly contributed to the once ground-breaking and historic development of VA's legacy system, was overlooked. When VA transitioned towards its new Cerner-based EHR, the development of RPMS improvements was halted and the future of the IHS' EHR became largely unknown. The current state of Indian health IT has become near dire because VA received appropriations to support their transition towards a new EHR system without any comparative funding for the Indian health system to subsidize this loss. Congress must ensure that the Indian health system is fully integrated across the development and implementation of the VA's transition to its new EHR. Difficulties in achieving IT interoperability among VA, the DoD, and Indian health facilities pose significant problems for Native Veterans' care coordination.

- *Support meaningful Tribal Consultation and Urban Confer across the VA:* During the hearing, witnesses were asked if they felt assured that IHS and VA would include them in renegotiations of the memorandum of understanding (MOU). The best way to ensure that Native people are at the table is through a meaningful and robust consultation and confer process between Tribal Nations, UIOs, and federal agencies. This cannot be adequately achieved without a strong consultation policy in place at the department and agency levels. We recommend that VA work with Tribal Nations and UIOs to update theirs regularly. Ideally, the proposed VATAC could support updates to VA's Tribal Consultation and Urban Confer policy and process for Tribal Nations and UIOs. Such an opportunity to provide input on a Tribal consultation policy further reinforces the sacred government-to-government relationship between Tribes and the federal government. Also, a year ago, GAO Report 19-291 noted shared inadequacies by VA and IHS in measuring progress of their MOU as well as ineffective Tribal Consultation and

[1] Because the IHS system is chronically underfunded, it heavily relies on third party reimbursements from third party payers like VA.

Urban Confer regarding the MOU—we believe that the two are inextricably linked and have provided further information regarding the MOU in the next section.

- *Ensure that Tribes and Tribal health programs are exempt from the establishment and consolidation of VA community care networks (CCNs):* The VA MISSION Act seeks to consolidate VA's current outside provider programs to eliminate confusion for both the Veterans Health Administration (VHA) and Veterans. The VA MISSION Act indicates which providers will be part of the new CCN, and it does not list Tribal Nation programs, or IHS as a consolidated part of this new network.[2] We recommend that VA exempt the Tribal Nations and IHS from consolidation to be managed under the third party administrator, like other outside providers. As noted before, Tribal Nations and Tribal organizations have a unique government-to-government relationship with federal departments and agencies. Because of this unique relationship, third-party administrators and administrative services organizations (ASO) often do not correctly complete necessary reimbursements or enrollments accurately. We have seen this time and again in state Medicaid programs across the country which use ASOs and Managed care organizations (MCO). Even when ASO and MCO contracts include provisions requiring them to work with Tribal Nations and IHS and to honor existing agreements, the ASOs and MCOs fail to meet these requirements. Therefore, Tribal agreements and management of these agreements should be maintained by the VA. This approach has the best chance to ensure continued success in future coordination and collaboration.

<u>Improving Coordinated Care</u>

Native Veterans are highly respected throughout Indian Country and deserving of healthcare systems which honor their status as both AI/AN and Veteran. And yet, they are among the least connected and underrepresented among other Veterans who access the services and benefits[3]. Most of them continue to give more than is required as they wait patiently for a well-coordinated healthcare system that can adequately meet their unique healthcare needs. To date, progress to eliminate barriers for Native Veterans, streamline access to care, and to achieve a coordinated effort by VA and IHS has been slow. In 2010, VA and IHS expanded upon a 2003 MOU to improve the health status of Native Veterans through coordination and resource sharing among VA, IHS, and Tribal Nations. It is our hope that the current iteration of the MOU will eliminate barriers and streamline access to healthcare and services.

In 2012, VA and IHS signed a reimbursement agreement which enabled VA to begin financially compensating IHS (a system that is chronically underfunded) for direct healthcare provided to Native Veterans that are part of VA system. In furtherance of this collaboration, we offer the additional considerations and recommendations that will build upon the federal government's efforts to coordinate care for the dual users of the VA and IHS systems.

Patient Referrals and Purchase/Referred Care (PRC) Reimbursements

[2] P.L. 115-182, Section 101(a).

[3] Additionally, as a group, they are also more likely to lack health insurance and receive disability benefits. Source: AI/AN Veterans: 2015 ACS Survey, https://www.va.gov/vetdata/docs/SpecialReports/AIANReport.pdf.

Native Veterans often require additional services that are not available within the Indian health system. Often, Native Veterans are referred by VA facilities to Tribal and IHS facilities that are eligible to receive reimbursements for providing specialty care. However, VA does not reimburse a referral for services provided by external providers at Tribal health or IHS facilities, through PRC Purchase/Referred Care program. This is overly burdensome, results in duplicative processes that limit access to care for Native Veterans, and wastes federal resources. Additionally, VA should reimburse for services provided by external providers which are paid for by Tribal or IHS facilities through PRC – an IHS program which authorizes Indian healthcare facilities to purchase services from a network of private providers. VA should accept referrals made by the Tribal Nations and IHS, in order to provide the best services to our Native Veterans. Accordingly, we recommend that Congress clarify statutory language under section 405(c) of the Indian Health Care Improvement Act and make explicit the VHA's requirement to reimburse Tribal Nations and IHS for services under Purchased/Referred Care (PRC).

Memorandum of Understanding

As VA and IHS continue modifying their interagency MOU, we urge Congress to ensure that Tribal Nations and UIOs are immediately placed on the MOU leadership team. We believe that renegotiation of the MOU is rooted in the federal treaty obligations and trust responsibility to Tribal Nations, and therefore, this renegotiation should be reflective of government to government relations. It is often communicated to Tribal Nations and UIOs that interagency activities such as renegotiating MOUs are inherent governmental functions. Active participation by representatives of the Tribal Nations and UIOs in the revision of the MOU's 15 performance measures and other related issues will enable the MOU to truly meets the needs of Native Veterans and safeguard their access to care. Therefore, we urge you to keep the agencies accountable by including Tribal Nations and UIOs on the MOU leadership team. We are also concerned about the process and timeline of measures which track the progress of GAO Report 19-291 recommendations and findings. We ask the Subcommittee to consider the following:

- The VA and IHS should include Tribal Nations and UIOs in MOU renegotiations prior to Tribal Consultation and Urban Confer, to develop the measures for assessing progress toward MOU goals;
- The IHS and VA should identify and present their expected interoperability challenges in supporting the MOU, and consult with Tribal Nations to determine what services will be covered by VA, IHS and DoD;
- Congress should ensure that measures the agencies develop are focused on outcomes rather than counting administrative activities that should already occur as part of routine operations;
- The VA should not impose any additional quality programs upon Tribal Nations or IHS. Sufficient quality requirements already exist and duplicative requirements are burdensome, costly, and unnecessary.
- VA should recognize that the language and intent of the original MOU between the VA and IHS includes UIOs as a part of the MOU; all of the Indian health system, including UIOs, should be able to enter into reimbursement agreements with VA.

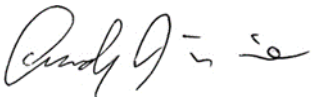
Conclusion

We commend the Subcommittee on its noble pursuit, in fulfillment of the federal treaty obligations and trust responsibility to Tribes, to meet the health care needs of Native Veterans. We greatly appreciate your work to address the many challenges and barriers faced by Native Veterans. We look forward to working with this Subcommittee on a bipartisan basis, and the Administration, to advance federal policies that support those who have served our country and protected our Nations.

Thank you.

Sincerely,

Victoria Kitcheyan, Chair
National Indian Health Board



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