National Indian
Health Board

Responses to Questions for the Record
Legislative Hearing on H.R. 6237
United States House of Representatives
Natural Resources Committee
Subcommittee for Indigenous Peoples of the United States
August 5, 2020

Can you please explain why it is necessary for the VA to reimburse the medical transportation costs described in H.R. 6237? Can you provide an example of a scenario in which this would be necessary?

It is necessary for the VA to reimburse the medical transportation costs described in H.R. 6237 because it would clarify in federal statute the requirement that VHA reimburse IHS and Tribes for the full scope of services authorized under Purchased/Referred Care (PRC). The IHS is the payer of last resort in recognition that it is chronically and woefully underfunded. The PRC system is designed for IHS and Tribes to purchase care from external providers to help make up for the paucity of primary and specialty care providers within the Indian health system. However, it is limited to only circumstances where the patient has first exhausted all other available forms of health coverage include private insurance, Medicare and Medicaid. Without medical transportation reimbursement, in this rationed care environment, Native Veterans access to care is curtailed.

The Journal of Community Health reported that, "Transportation barriers are often cited as barriers to healthcare access. Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use."[1] Many Tribes are located in rural or frontier locations with sparse populations and limited access to healthcare facilities and providers. In some parts of Indian Country, the closest healthcare facility can be several hours away round trip, with very little access to first responders and ambulatory transport. The State of Alaska, for example, spans 665,384 square miles and has a population density of just 1.2 people per square mile. Furthermore, approximately 80% of Alaska's communities are not connected to the road system. Transportation is a considerable component to accessing care, particularly if a higher level of care is needed, or a physician or specialist is needed.

In Alaska, if a village-based Native Veteran, who lives in a community not connected to the road system needs to be seen by a cardiologist, that Native Veteran needs to be transported from the village to where he or she can get care, be it in a Tribal hospital or one outside of the Alaska Tribal Health System. In such cases those programs depend on PRC. PRC supports travel when any type of service is not available locally or in the case of emergency travel, such as requiring a medivac.

How long has NIHB sought an administrative change to the VA's PRC reimbursement policy? What, historically, has been the VA's reasoning behind interpreting the reimbursement statute the way it does?

[1] Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling towards disease: transportation barriers to health care access. Journal of community health, 38(5), 976–993. https://doi.org/10.1007/s10900-013-9681-1

NIHB has been advocating for a permanent fix to the VA PRC reimbursement issue for at least a decade, working with both the VA and Congress. In instances where an AI/AN Veteran is eligible for a particular health care service from both the VA and IHS, the VA is the primary payer. Under section 2901(b) of the Patient Protection and Affordable Care Act (ACA), health programs operated by the IHS, Tribes and Tribal organizations, and urban Indian organizations (collectively referred to as the "I/T/U" system) are payers of last resort regardless of whether or not a specific agreement for reimbursement is in place.

For years the VA should have been paying for PRC services provided to eligible AI/AN veterans under the IHS's payer of last resort rule. Following reauthorization of the IHCIA, the VA should have been doing so under the language in Section 405(c), which requires the VA to reimburse the Indian Health Service, Tribes and Tribal organizations where "services are provided through the Service, an Indian tribe, or tribal organization." But again and again, VA has simply claimed that under their interpretation of current law, they are not obligated to reimburse for specialty care services.

The VA claims that no statutory obligation exists for reimbursement of specialty and referral services provided *through* IHS or Tribal health programs (THPs). To clarify, the VA currently reimburses IHS and THPs for care that they provide *directly* under the MOU. Despite repeated requests from Tribes, the VA has <u>not</u> provided reimbursement for PRC specialty and referral care provided *through* IHS/THPs. This is highly problematic, as AI/AN Veterans should have the freedom to obtain care from either the VA or an Indian health program. If a Veteran chooses an Indian health program, that program should be reimbursed even if the service could have been provided by a VA facility or program in the same community.

But because that doesn't happen, it creates greater care coordination issues and burdensome requirements for Native Veterans. For example, if a Native veteran goes to an IHS or THP for service and needs a referral, the same patient must be seen within the VA system <u>*before*</u> a referral can be secured. This means the VA is paying for the same services twice, first for those primary care services provided to the Veteran in the IHS or THP facility, and then again when the patient goes back to the VHA for the same primary care service to then receive a VHA referral.

This is neither a good use of federal funding, nor is it navigable for veterans. In order to provide the care that Native Veterans need, many THPs are treating Veterans or referring them out for specialty care and paying for it themselves so that they can be treated in a timely and competent manner. For those Veterans that do go back to the VHA for referrals, there is often delayed treatment and a significantly different standard of care provided.

What kinds of services is the PRC fund normally used to reimburse?

IHS and Tribal programs utilize PRC for a broad range of medical services based on a priority system. PRC eligibility is based on the patient's place of residency, within what are known as contract health service delivery areas (CHSDAs). In certain states, like Arizona, the CHSDA encompasses the entire state; in other IHS Areas, the CHSDA is limited to a portion of the state. The medical priority system used by IHS to determine eligibility for PRC is as follows:

MP Level I: Emergent or Acutely Urgent Care Services are defined as threats to life, limb and senses.
MP Level II: Preventive Care Services are defined as primary health care that is aimed at the prevention of disease or disability.
MP Level III: Specialty Services are considered ambulatory care which include inpatient and outpatient care services.
MP Level IV: Chronic Tertiary and Extended Care Services are defined as requiring rehabilitation services, skilled nursing facility care.
MP Level V: Excluded Services are services and procedures that are considered purely cosmetic in nature, i.e., plastic surgery.

The Indian Health Service defines the Purchased/Referred Care (PRC) Program as such:

"The Purchased/Referred Care (PRC) Program at IHS is for medical/dental care provided away from an IHS or tribal health care facility. PRC is not an entitlement program and an IHS medical referral does not imply the care will be paid. If IHS is requested to pay, then a patient must meet the American Indian/Alaska Native tribal affiliation, residency requirements, notification requirements, medical priority, and use of alternate resources (including IHS facility)."[2]

The general purpose of the PRC Program is for IHS or Tribal facilities to purchase services from private health care providers in situations where:

1) No IHS or Tribal direct care facility exists,
2) The direct care element is not capable of providing required emergency and/or specialty care,
3) The direct care element has an overflow of medical care workload, and
4) Full expenditure of alternate resources (e.g., Medicare, private insurance) has been met and supplemental funds are necessary to provide comprehensive care to eligible Indian people.

IHS recognizes that this is a Rationed Health Care System:

"Because IHS programs are not fully funded, the PRC program must rely on specific regulations relating to eligibility, notification, residency, and a medical priority rating system. The IHS is designated as the payer of last resort meaning that all other available alternate resources including IHS facilities must first be used before payment is expected. These mechanisms enhance the IHS to stretch the limited PRC dollars and designed to extend services to more Indians. This renders the PRC program to authorize care at restricted levels and results in a rationed health care system."[3]

The Indian health system faces significant provider shortages including for primary care physicians, specialists, nurses, pharmacists, and nurse practitioners. A 2018 report from the Government Accountability Office (GAO-18-580) found an average 25% provider vacancy rate across eight IHS Areas with substantial direct service responsibilities.[4] This forces a reliance on

[2] https://www.ihs.gov/forpatients/prc/
[3] https://www.ihs.gov/newsroom/factsheets/purchasedreferredcare/
[4] Government Accountability Office (GAO-18-580). https://www.gao.gov/products/GAO-18-580

outside providers to make up for gaps in access within the Indian health system, which are paid for using PRC funds. But because of chronic underfunding of IHS, there are very limited funds available for PRC, further leading to the rationing of care. In 2019 alone, federally-operated IHS facilities denied and deferred an estimated $615,982,865 under PRC – equal to 155,842 services that were denied to AI/ANs due to lack of funds.[5] That is a shameful reality that uniquely impacts the Indian health system.

Your testimony explains that, if a veteran requires services that are not available in an IHS, tribal, or tribal organization facility, the veteran must either be referred back to the VA (for reimbursement) or turn to the Purchased/Referred Care (PRC) program within the Indian Health Service. How long would this process normally take? What happens if the veteran requires immediate services?

As explained in an earlier response, if a Native veteran goes to an IHS or THP for service and needs a referral, the same patient must be seen within the VA system *before* a referral can be secured. This means the VA is paying for the same services twice, first for those primary care services provided to the Veteran in the IHS or THP facility, and then again when the patient goes back to the VHA for the same primary care service to then receive a VHA referral.

While there isn't national data on exactly how long this process can take, NIHB has heard anecdotally from Tribes that sometimes Veterans are forced to wait weeks for the referral process to finalize. For Veterans in critical care, this degree of procedural delay can cost them their lives. Many times the urgency of the medical issue necessitates the Tribes to cover the cost of care out of pocket. But this system remains neither navigable nor equitable for Veterans, nor is it reflective of the care they deserve for their sacrifices in the defense of the United States. It also places undue financial burdens on IHS and Tribal health programs, who are the payer of last resort in statute.

[5] IHS FY 2021 Congressional Justification.
https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf