National Indian Health Board

NATIONAL INDIAN HEALTH BOARD
VINTON HAWLEY, CHAIRMAN
TESTIMONY FOR THE RECORD: LEGISLATIVE HEARING ON OCTOBER 24, 2017

DRAFT LEGISLATION RELATED TO THE VETERANS CHOICE PROGRAM THE DEPARTMENT OF VETERANS AFFAIRS' (VA'S) LEGISLATIVE PROPOSAL, THE VETERAN COORDINATED ACCESS AND REWARDING EXPERIENCES (CARE) ACT

On behalf of the National Indian Health Board[1] (NIHB) and the 567 federally recognized Tribes we serve, I offer this testimony for the record for the legislative hearing held on October 24, 2017. NIHB appreciates the opportunity to provide input on VA priorities for American Indian and Alaska Native (AI/AN) Veterans in Tribal communities across Indian Country, as well as the many non-Indian veterans in our communities for whom Tribally operated health care may be the only realistic choice. Today we will offer comments on draft legislation related to the Veterans' CHOICE program and the Department of Veterans Affairs' (VA) legislative proposal – the Veteran Coordinated Access and Rewarding Experiences (CARE) Act.

The federal government's trust responsibility to provide health care to all AI/ANs extends across all departments and agencies of the United States and includes VA. And yet, although AI/ANs serve in the U.S. military at higher rates than any other race, they are underrepresented among Veterans who access the services and benefits they have earned. AI/AN Veterans are also more likely to lack health insurance and to have a disability, service-connected or otherwise, than Veterans of other races.[2] Unfortunately, many AI/AN Veterans do not have faith and trust in the VA after past experiences and delays in enrollment, denial of care, or lack of access to VA services.

The Indian Health Service (IHS) is a federal health care program designed to provide health care to over 2.2 million AI/ANs. It is an agency with a similar mission and purpose to the U.S. Department of Veterans Affairs (VA) and other federal health programs with the exception of the following differences: (1) American Indians and Alaska Natives have treaty rights for the provision of health care; (2) IHS is severely underfunded in comparison to other federal health care programs (for example, in 2015 the VA medical spending per patient was $8,760 compared to $3,136 IHS

[1] Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

[2] United States Department of Veterans Affairs, American Indian and Alaska Native Service Members and Veterans

medical spending per patient); and (3) unlike other federal mandatory health programs, IHS is subject to sequestration and funded through discretionary funds, which are not increased with population growth, inflation, or new technology.

Indian health system and memoranda of agreements with the VA

Section 813 of the Indian Health Care Improvement Act (IHCIA) authorizes Tribes and Tribal organizations to provide health care services to non-beneficiaries.[3] As a result, many Tribes and Tribal organizations already serve non-IHS-eligible beneficiaries, many of whom are Veterans. In addition, section 405(c) of the IHCIA, as added by the 2010 Affordable Care Act (ACA), requires the VA to reimburse IHS, an Indian Tribe, or a Tribal organization for services provided to beneficiaries eligible for services from either the VA or from IHS.[4] In 2014, the Veterans Access, Choice and Accountability Act (Choice Act) established an additional mechanism for the VA to work with Tribal health programs to serve Veterans. However, the Choice Act provides lower reimbursement rates and is more burdensome for Tribal health systems to implement. There is also a general preexisting authority in 38 U.S.C. 8153 for the VA to enter into "sharing agreements" to purchase care, and at times the VA and Tribes have used this authority to enter into agreements.

The Tribal memoranda of understanding (MOUs) between the VA and the Indian Health Service, Tribes and urban Indian health care providers authorized under the Indian Health Care Improvement Act are ideal mechanisms for the federal government to preserve and build on the existing excellent relationships that the VA has with IHS and Tribal Health Programs. To date, the VA has over 100 agreements with the IHS, Tribes, and Tribal Organization entered into under the authority of section 405 of the IHCIA.

The first of these MOUs was completed in 2012 well before the Choice Act was enacted. Between 2012 and 2017 the VA reimbursed $50 million to IHS and Tribal facilities, serving over 5,000 eligible veterans nationwide. This is just a fraction of one percent of the VA's annual budget. NIHB and Tribes have continuously gone on record supporting the continuation of the current MOU system. The MOU agreements promote access to culturally competent exceptional health care for Veterans near home, including services provided in rural and medically underserved communities. IHS and THPs are federally funded programs carrying out federal responsibilities alongside the Veterans Health Administration. IHS and, therefore, THPs are not contractors, procurement sources, or outside, private vendors. The MOUs are crucial to the delivery of quality health care not only to Native American Veterans, but to thousands of non-Native Veterans as well.

Though the legislation considered at the legislative hearing includes the Choice Act, we think this is a critical opportunity for Congress to reaffirm its intent for the Indian health system to continue to use the MOU agreements as authorized by section 405 of the IHCIA. **NIHB therefore strongly**

[3] 25 U.S.C. § 1680c. IHS may also serve non-AI/ANs with the consent of the tribes being served by the IHS directly operated health care program.
[4] 25 U.S.C. § 1645(c)

recommends that the current bill be reframed in such a manner so as to reaffirm and maintain the current IHCIA Section 405 agreements between VA and IHS and Tribal Health Programs (THPs). The current national reimbursement agreements expire in 2019, but will hopefully be renewed.

With these thoughts in mind, NIHB recommends that the bill be modified to include Tribes and Tribal organizations, along with IHS, and that it also reaffirm Congress' intent to maintain existing MOUs with IHS and Tribal providers entered into under Section 405 of the IHCIA, and that it further make plain that nothing in the new enactment amends or limits in any manner the authorities set forth in Section 405. NIHB further recommends that provision be made to make clear that reimbursements under Section 405 agreements shall be at not less than the cost-based rates IHS annually publishes in the Federal Register. *See, e.g.* DHSS Indian Health Service -- Reimbursement Rates for Calendar Year 2017, 82 Fed. Reg. 5585 (Jan. 18, 2017).

Above all, it is critically important that **the new enactment not undermine or substitute for the continuation of MOUs that are already in place. Care under IHCIA Section 405 MOU's is both veteran centric and community centric because is permits our Veterans to receive care in their own communities. It also takes advantage of existing systems that the VA could not possibly match, in areas where the private sector cannot address the need.** [5]

Network Provider Clarification

The House bill includes IHS as a "network provider." **It is necessary that legislative language also include Tribes/ Tribal Organizations and Urban Indian Health Organizations, so they may participate if they so choose.** This will ensure that the whole Indian health system is clearly included as available providers. Additionally, legislative language should reflect that becoming a network provider in the Choice program is optional for Indian health providers.

Value Based Reimbursement Models

We also note that the draft bill would encourage the use of a "value-based" provider system. While we understand that this undefined term may make practical sense in other areas, the Indian health system should be exempted from such a system. Imposing value-based standards on Tribal health care systems is simply unworkable. Moreover, the existing system of annually-published IHS rates already reflects a value-based methodology because it is developed based on an analysis of actual costs. For Tribal facilities to have to engage about new "value-based" quality measures would mean taking away extremely scarce resources from patient care. Tribes already report to the federal government on Government Performance and Results Act (GPRA) for quality of care and adding additional quality standards may just impose additional burdens. In short, the Indian health system already utilizes quality measures through GPRA and other means, so to add another layer would be duplicative and burdensome, and would siphon off already sparse resources from patient

[5]We also note that the MOU has not been implemented for urban Indian health programs even though such programs are explicitly included in the 2010 agreement between VA and IHS. AI/AN Veterans may prefer to use an urban Indian health program instead of a VA facility. The participation of urban Indian health programs in the VA's community care network partnerships is important toward improving the quality of health care received by AI/AN Veterans.

care. **Therefore, we request that the Indian health system is specifically exempted from the requirement under the value-based reimbursement.**

Clarification on Contracted Rates

This proposed legislation and the Choice Act does not pay at the agreed upon Office of Management & Budget (OMB) rate, which is cost based and was included in the initial reimbursement agreement between the VA and IHS. Each Federal program that reimburses IHS and Tribes for health care (Medicare and Medicaid) does so at these rates. The current reimbursement structure is based on average costs calculated by an independent professional cost report preparer engaged by the IHS utilizing costs from audited financial statements and workload statistics maintained by the IHS in its National Database Warehouse. The calculated rates, which are calculated on a "per visit" or "per encounter" basis, are reviewed by the Centers for Medicare & Medicaid Services (CMS) and the OMB and, once approved, are published in the Federal Register for the purpose of reimbursing all IHS facilities for medical care, including Medicare, Medicaid, and others.

IHS and THPs utilize robust, established provider networks that round out the services provided directly to AI/AN Veterans. These networks are critical in providing care to Veterans living in rural and remote areas. NIHB strongly opposes the standard rate and any reduction in the rate because of the circumstances that AI/ANs face with regards to physical health and social determinants of health. Any reduction in reimbursement will further exacerbate the conditions that the Indian Health System faces.

Therefore, we recommend adding language to Section 101(d) of this draft legislation that would read:

> ***"(G) Nothing in this section shall impact reimbursement rates or other provisions of agreements entered into by the Veterans' Administration and the Indian health service, Tribal Health Programs, or Urban Indian Health programs as authorized by 25 U.S.C. § 1645."***

VA's Legislative Proposal

Section 303 - "Improving Graduate Medical Education and Resiliency"

NIHB appreciates the inclusion of IHS and Tribal health programs in Section 303 – "Improving Graduate Medical Education and Resiliency." In order to ensure the whole Indian health system is represented, we believe that it is appropriate to include Urban Indian Health Programs as part of the legislative language. Therefore, we recommend that the proposal be amended to read:

> *"(2) A facility operated by an Indian tribe or a tribal organization,* ***or an Urban Indian organization*** *as those terms are defined i****n Section 4 by the Indian Health Care Improvement Act (25 U.S.C. 1603)****.*

Section 221 of the VA's legislative proposal includes consolidating existing programs. Again, we would recommend adding legislative language that would ensure that MOUs between the VA and

Indian health system are not impacted. **Therefore, we recommend the following language be added to this section:**

> ***"Nothing in this section shall impact reimbursement rates or other provisions of agreements entered into by the Veterans' Administration and the Indian health service, Tribal Health Programs, or Urban Indian Health programs as authorized by 25 U.S.C. § 1645."***

Additional Recommended Legislative Changes

Reimbursement for Purchased/Referred Care Services: NIHB also believes that this is an opportune time to include other technical corrections for AI/AN Veterans. As discussed above, the VA-IHS MOU has proven to successfully facilitate patient care and provide the least administrative burden for VA, IHS, and THPs. Unfortunately, 25 U.S.C. § 1645 has not be fully implemented. The current national agreement and, by default, all THP agreements do not include reimbursement for Purchased/Referred Care (PRC) services. IHCIA provided a broad directive to reimburse IHS and THPs for care provided to AI/AN veterans and this includes specialty and referral care provided **through** IHS and THPs.

IHS and THPs utilize robust, established provider networks that round out the services provided directly to AI/AN veterans. These networks are critical in providing care to veterans living in rural and remote areas. Given the minimal amount of funding supporting IHS and THPs reimbursement agreements, including PRC services seems realistic as we work together to improve access to quality care for veterans across the country.

As VA, IHS, and THPs work to build greater partnerships, we must work to address issues with regard to coordination of care. Failing to adequately coordinate care is magnified by VA's unwillingness to reimburse referral services. For example, if a Native veteran goes to an IHS or THP for service and needs a referral, the same patient must been 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 facilities, and then again when the patient goes back to the VA for the same primary care services to receive a VA referral. This is a not a good use of federal funding, nor is it navigable for veterans. As stated previously, the Indian Health Care Improvement Act provides the authority for this reimbursement and the VA needs to adhere to the law. **Therefore, we recommend legislative language be included in this bill that would direct the Veterans Administration to include the reimbursement of Purchased/Referred Care to IHS and THPs for services provided to AI/AN veterans.**

Exemption for AI/AN Veterans from Co-pays and deductibles: As discussed above, the federal government has a unique trust responsibility AI/ANs Veterans, like all AI/ANs. In recognition of this, AI/ANs do not have copays or deductibles for services received at an Indian health facility. Additionally, this was recognized in the ACA, which includes language at Section 1402 to exempt all AI/ANs under 300% of the federal poverty level from co-pays and deductibles on plans purchased on the health insurance Marketplace and all AI/ANs are exempted from copays and deductibles if they have a referral from the from an IHS or THP. Like IHS and the marketplace,

the VA is another means by which the federal government upholds its trust responsibility to AI/ANs. **The Veterans' Administration should similarly exempt AI/AN Veterans from copays and deductibles in the VA system in recognition of the federal trust responsibility.** We believe that this legislation is an ideal opportunity for Congress to reaffirm this responsibility and include statutory language that would ensure that AI/ANs receiving services at the VA are similarly treated.

Conclusion

Thank you again for the opportunity to offer testimony on this important legislation. As noted above, the United States has a unique trust responsibility to provide health services for all AI/ANs, including AI/AN Veterans. While the Indian health system is the primary way AI/ANs receive health services, this federal trust responsibility also includes other federal providers including the VA. In recognition of this fact, the IHS-VA MOU outlines the need for collaboration between the two agencies in order to provide AI/AN Veterans and other Veterans with the best possible care. We believe that further modifications to both the House draft legislation and the VA's Legislative proposal are needed before the legislation can move forward in order to ensure that the current IHS-VA MOU is preserved and that the federal trust responsibility for health is fully honored by the VA.

We would welcome the opportunity to discuss these or other comments as this legislation moves through the legislative process.