National Indian
Health Board

HOUSE VETERANS AFFAIRS COMMITTEE
HEARING ON VETERAN SUICIDE PREVENTION:
INNOVATIVE RESEARCH AND EXPANDED PUBLIC HEALTH EFFORTS

TESTIMONY OF NATIONAL INDIAN HEALTH BOARD
WILLIAM SMITH, CHAIRMAN OF THE BOARD
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Chairman Takano, Ranking Member Bost, and Members of the Committee, thank you for holding this important hearing on Veteran Suicide Prevention: Innovative Research and Expanded Public Health Efforts, particularly as it relates to health care access for Native Veterans. On behalf of the National Indian Health Board (NIHB) and the 574 federally-recognized sovereign Tribal Nations we serve, I submit this testimony for the record.

Native Veterans and the United States Trust Responsibility

Over the course of a century, sovereign Tribal Nations and the United States signed over 300 Treaties requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those Treaties promised, in perpetuity, quality and comprehensive health resources and services to Tribal nations in exchange for millions of acres of land.

These Treaties, which are still the supreme law of the land, have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even Presidential Executive Orders. Together, they form the basis for the federal trust responsibility for Indian Tribes.

The United States, not just one federal agency, holds the trust responsibility to Tribal nations. Consequently, the federal government's trust responsibility to provide quality and comprehensive health services for all American Indian and Alaska Native (AI/AN) Peoples extends to every federal agency and department, including the Department of Veterans Affairs (VA).

Moreover, the United States has a dual responsibility to Native Veterans – one obligation specific to their political status as members of federally-recognized Tribes and one obligation specific to their service in the Armed Services of the United States. The Department of Defense, as well, continues to acknowledge the indispensable role of AI/AN Servicemembers throughout American history.

Status of Native Veterans

The AI/ANs enlist to serve this nation at nearly five times the national average and at higher rates per capita than any other ethnicity. By current estimates, there are over 140,000 Native Veterans. In a 2018 Veterans Health Administration (VHA) Survey of Veteran Enrollees' Health and Use of Health Care (2018 Survey), the VHA reported having 217,580 patients who self-identified as AI/AN – representing 2.5% of the agency's enrolled patient population.[1]

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[1] Veterans Health Administration. 2018 Survey of Veteran Enrollees' Health and Use of Health Care. https://www.va.gov/HEALTHPOLICYPLANNING/SOE2018/2018EnrolleeDataFindingsReport_9January2019Final508Compliant.pdf

Native Veterans are highly respected throughout Indian Country, in recognition of their warrior status and what they have sacrificed to protect Tribal communities and the United States. Yet despite the bravery, sacrifice, and steadfast commitment to protecting the sovereignty of Tribal Nations and the entire United States, Native Veterans continue to experience some of the worst health outcomes and face the greatest challenges to receiving quality health services, among all Americans. These enduring challenges have left Native Veterans at a significantly higher risk of COVID-19 due to these disparities.

Health Care for Native Veterans

After a long and disjointed history of poorly administered and funded health services to Tribal communities, in 1955, Congress established the Indian Health Service (IHS) to coordinate health resources and provide for "comprehensive" Indian health services. The IHS is charged with a mission similar to that of the VHA relative to administering quality health services, with the following differences:

- the federal government has Treaty and trust obligations to provide health care for all American Indians and Alaska Natives;
- the IHS is severely and chronically underfunded in comparison to the VHA, with per capita medical expenditures within the IHS at $3,779 in Fiscal Year (FY) 2018 compared to $9,574 in VHA per capita medical spending that same year[2]; and
- unlike the IHS, the VHA has been protected from government shutdowns and continuing resolutions (CRs) because Congress enacted advance appropriations for the VHA a decade ago.[3]

Moreover, while the VHA service population is only three times the size of the Indian health system, its discretionary appropriations are approximately thirteen times higher than those for IHS.

Our Tribal communities have endured many pandemics and tragedies in our history. Our People still experience significant historical and intergenerational trauma because of genocide, forced relocation from our homelands, forced assimilation into western culture, and persecution of our Native cultures, customs, and languages. As a result, our People experience some of the highest rates of suicide, drug overdose, Post-Traumatic Stress Disorder (PTSD), and mental illness among all U.S. populations.

Indeed, the AI/AN communities experienced some of the starkest disparities in mental and behavioral health outcomes before the COVID-19 pandemic began. According to the Centers for Disease Control and Prevention (CDC), from 1999 to 2017, suicide rates increased by 53% among women of all ages, and 26% among men of all ages. But among AI/ANs specifically, suicide rates increased by 139% among our

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[2] The full FY 2022 IHS Tribal Budget Formulation Workgroup Recommendations are available at https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf

[3] The full FY 2022 IHS Tribal Budget Formulation Workgroup Recommendations are available at https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf

women, and by 71% among our men.[4] Rates of PTSD among our People are twice as high as the general population,[5] while a staggering 84% of our women experience violence in their lifetime.[6]

These are just some of the challenges our Tribal communities continue to face during the COVID-19 emergency. While our People remain resilient and committed to advancing innovative health care, the COVID-19 pandemic added more tragedy upon the historical trauma passed down for generations from our ancestors who experienced historical plagues, such as smallpox and tuberculosis, without appropriate health care. Many of our Tribes are reporting increased rates of intimate partner violence, substance use, and overdose due to the increased isolation and inaccessibility of care during this emergency.

Native Veterans Results in the 2018 Survey

Across the board, AI/AN Veterans report higher rates of issues around quality of care and accessibility that have undermined trust in the VHA system and left AI/AN Veterans significantly more vulnerable to adverse health outcomes, including for COVID-19. For instance, the 2018 Survey found that only 66.9% of AI/AN Veterans reported that it was easy to schedule medical appointments in a reasonable time, compared to 78.7% of White Veterans.

The 2018 Survey further found that only 67.2% of AI/AN Veterans reported easy access to the local VA or VA-approved facility (compared to 82.7% of White Veterans) and only 65.7% of AI/AN Veterans reported short wait times after arriving for an appointment (compared to 80.6% of White Veterans). Even more alarmingly, only 79% of AI/AN Veterans reported receiving respect from VHA employees, and only 78.2% reported that VHA employees accepted them for who they are – percentages lower than any other ethnicity.

The AI/AN Veterans also reported the least satisfaction with three out of four indicators related to their healthcare decision-making process – reporting the least satisfaction with:

- how healthcare problems were explained to them (72.4% compared to 84% among White Veterans);
- their personal level of participation in decisions about their healthcare (65.7% compared to 81.8% among White Veterans); and
- explanations of their options for care (65.2 percent compared to 80.5% among White Veterans).

A whopping 45.2% of AI/AN Veterans reported prior dissatisfaction with the level of VA care received – nearly double the rate for White Veterans.

It is unlikely that these experiences of substandard care at VHA facilities have been resolved during the current COVID-19 crisis. These types of negative experiences reported by AI/AN Veterans are more likely

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[4] Curtin SC, Hedegaard H. Suicide rates for females and males by race and ethnicity: United States, 1999 and 2017. NCHS Health E-Stat. 2019

[5] Substance Abuse and Mental Health Services Administration. Mental Health Disparities: American Indians and Alaska Natives. Received from https://www.integration.samhsa.gov/workforce/mental_health_disparities_american_indian_and_alaskan_natives.pdf

[6] National Institute of Justice. Violence Against American Indian and Alaska Native Women and Men. Retrieved from https://nij.ojp.gov/topics/articles/violence-against-american-indian-and-alaska-native-women-and-men

to contribute to even greater challenges in receiving sufficient, patient-centered care from VHA facilities during the COVID-19 pandemic.

Behavioral Health Outcomes of Native Veterans

Destructive federal Indian policies and unresponsive human service systems have left these Veterans and their communities with unresolved historical and intergenerational trauma. From 2001 to 2015, suicide rates among Native Veterans increased by 62% (50 in 2001 to 128 in 2015).[7]

In FY 2014, the Office of Health Equity within the VHA reported significantly higher rates of mental health disorders among Native Veterans compared to non-Hispanic White Veterans, including in rates of PTSD (20.5% vs. 11.6%), depression symptoms (18.7% vs. 15.2%), and major depressive disorder (7.9% vs. 5.8%).[8]

Native Veterans are 1.9 times more likely to be uninsured than non-Hispanic White Veterans and are significantly more likely to delay accessing care due to the lack of timely appointments and transportation issues.[9] Among all Veterans, Native Veterans are more likely to have a disability, service-connected or otherwise.[10]

Native Veterans are exponentially more likely to be homeless, with some studies showing that 26% of low-income Native Veterans experienced homelessness at some point compared to 13% of all low-income Veterans.[11] There exists a paucity of Native Veteran specific health, housing, and economic resources and programs that are accessible and culturally appropriate. It is essential that the VHA work with Indian Tribes, the IHS, and other federal agencies to create more resources specifically for Native Veterans.

According to the 2019 Government Accountability Office (GAO) Report No. GAO-19-291 (2019 GAO Report), "facilities reported conflicting information about the processes for referring Native Veterans from IHS or Tribal facilities to VHA and the VA Headquarters officials confirmed that there is no national policy or guide on this topic."[12]

The 2019 GAO Report notes: "Total reimbursements by VA for care provided to AI/AN veterans increased by about 75 percent from fiscal year 2014 to fiscal year 2018. This increase mainly reflects the growth in reimbursement from VA to tribal health program facilities— facilities that receive funding from IHS, but are operated by tribes or tribal organizations. Similarly, the number of VA's reimbursement

[7] VA, Veteran Suicide by Race/Ethnicity: Assessments Among All Veterans and Veterans Receiving VHA Health Services, 2001-2014 (Aug. 2017) (citing CDC statistics).
[8] Lauren Korshak, MS, RCEP, Office of Health Equity and Donna L. Washington, MD, MPH, Health Equity-QUERI National Partnered Evaluation Center, and Stephanie Birdwell, M.S.W., Office of Tribal Government Relations
[9] Johnson, P. J., Carlson, K. F., & Hearst, M. O. (2010). Healthcare disparities for American Indian veterans in the United States: a population-based study. Medical care, 48(6), 563–569. doi:10.1097/MLR.0b013e3181d5f9e1
[10] U.S. Department of Veterans Affairs. (2015a). American Indian and Alaska Native Veterans: 2013 American Community Survey. Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/AIANReport2015.pdf
[11] US Department of Housing and Urban Development, US Department of Veterans Affairs, National Center on Homelessness Among Veterans. Veteran Homelessness: A Supplemental Report to the 2010 Annual Homeless Assessment Report to Congress. Washington, D.C.2011:56
[12] U.S. Gov't Accountability Off., GAO-19-291, VA and Indian Health Service: Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans. (2019).

agreements with tribal health programs and the number of AI/AN veterans served under the reimbursement agreements also increased during this period."[13]

One of the leading collaboration practices identified by the GAO is to have written guidance and agreements to document how agencies will collaborate. Without written policy or guidance documents on how referrals should be managed, neither agency can ensure that VHA, IHS, and Tribal facilities have a consistent understanding of the options available for referral of Native Veterans for specialty care.

The NIHB has been informed that some Native Veterans prefer to simply *hand carry* their electronic health records (EHRs) from their IHS provider to their VHA provider to avoid this confusion among providers. In short, the lack of written policy perpetuates this burdensome, pointless, and complicated process that only serves to frustrate and potentially harm patients, worsen administrative red tape, and increase expenditures.

The GAO identified that the IHS and VA lack sufficient measures for quantifiable assessments of progress towards MOU goals and objectives. Although the VHA and IHS have created fifteen performance measures, no specific targets or indicators have been established that allow Tribes to measure progress towards achieving the goals and objectives of the MOU.[14]

The VA's Veteran Outreach Toolkit lists AI/ANs as an "at-risk" population, citing the troubling suicide rate. For the children of AI/AN veterans, high rates of complex behavioral health issues are compounded by the return of a Veteran parent who may suffer from PTSD. Outreach events for AI/AN communities should be a VA priority to increase wellness, decrease stigma, and prevent suicide. It is essential that the VHA continue to engage with Tribal leaders, through consultation, to assist in carrying out these activities.

Culturally-Competent Health Care for Native Veterans

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Health and Human Services (HHS) has developed general requirements that, while they apply to Certified Community Behavioral Health Clinics (CCBHCs) for culturally competency, recognize particular health care delivery methods specific to AI/ANs including "traditional approaches or medicines."[15] Culturally competent care was noted as "the first brick of building compassion."[16] It improves the potential of building trust between patient and provider and increasing the likelihood that the Native Veterans will seek continuity of care. That need for patient-provider trust takes on a whole new level of significance in light of the 2018 Survey results.

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[13] *Id.,* at 2.
[14] *See Id.*
[15] Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics. Department of Health and Human Services. https://www.samhsa.gov/section-223/cultural-competency#requirements (last updated 4-22-20) (4.b.2. "Person-centered and family-centered care includes care which recognizes the particular cultural and other needs of the individual. This includes, but is not limited to, services for consumers who are American Indian or Alaska Native (AI/AN), for whom access to traditional approaches or medicines may be part of CCBHC services. For consumers who are AI/AN, these services may be provided either directly or by formal arrangement with tribal providers.").
[16] Cultural Competence In Caring For American Indians and Alaska Natives. Ahmed Nahian, Natasha Jouk. Last Update: May 7, 2021. Found at *https://www.ncbi.nlm.nih.gov/books/NBK570619/*

Culturally competent care includes, in part, the traditional approaches, medicines, and methods that have been practiced in Native communities for generations. Traditional healing may encompass different techniques including physical, psychological, or nutritional therapies that can vary among Indian Tribes. However, culturally competent care also encompasses the need for understanding of and acknowledgement of a patient's background.[17]

The background is of particular importance to understand because the health providers must recognize the historical trauma, PTSD, and how these problems acutely affect Native Veterans. This background should inform treatment plans, at a minimum, but should also inform far greater platforms for health care reform and improvement. Without recognizing the importance of cultural competency in health care delivery systems, then an opportunity for significant improvements is overlooked.

For example, the potential for incorporating traditional healing into health care systems is not realized when those services cannot be reimbursed either by the VHA or by Medicaid or when they cannot be covered by *Federal Tort Claim Act* coverage. The National Indian Health Board would recommend that Congress and the Administration work together with Indian Tribes to ensure that the benefits and the potential of culturally competent care continue to be examined and advanced through legislation including H.R. 912, the *American Indian and Alaska Native Veterans Mental Health Act*, passed by this Committee or through the full implementation of VA-IHS/Tribal MOUs.

Additional Policy Recommendations

1. **Clarify statutory language under section 405(c) of the Indian Health Care Improvement Act and make explicit the VHA's requirement to reimburse IHS and Tribes for services under Purchased/Referred Care (PRC).**

By law, an AI/AN Veteran is eligible for services under both the VHA and IHS. A 2011 report showed that approximately one-quarter of IHS-enrolled Veterans use the VHA for health care, commonly receiving treatment for diabetes mellitus, hypertension, or cardiovascular disease from both federal entities.[18]

According to the VA, more than 2,800 AI/AN Veterans are served at IHS facilities.[19] 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 payor. 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 payors of last resort regardless of whether a specific agreement for reimbursement is in place.

Section 407(a)(2) of the *Indian Health Care Improvement Act* (IHCIA) reaffirms the goals of the 2003 MOU between the VHA and IHS established to improve care coordination for Native Veterans. In

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[17] *See generally* https://www.ruralhealth.va.gov/docs/webinars/richardson-cultural-sensitivity-062712.pdf#:~:text=Cultural%20aspects%20of%20work%20with%20Native%20Veterans%20What,into%20individual%20patient%E2%80%9Fs%20healthcare%20assessment%2C%20diagnosis%2C%20and%20treatment.

[18] Kramer, BJ, Wang M, Jouldjian S, Lee ML, Finke B, Saliba D. Healthcare for American Indian and Alaska Native Veterans: The Roles of the Veterans Health Administration and the Indian Health Service. Medical Care.
[19] VA/IHS listening session held on May 15, 2019.

addition, section 405(c) of the IHCIA was amended to require the VHA to reimburse IHS and Tribes for health services provided under the IHS Purchased/Referred Care (PRC) program.

In 2010, the VHA and IHS modernized their 2003 MOU to further improve care coordination for Native Veterans by achieving the following:

- bolstering health facility and provider resource sharing;
- strengthening interoperability of EHRs;
- engaging in joint credentialing and staff training to help Native Veterans better navigate IHS and VHA eligibility requirements;
- simplifying referral processes; and
- increasing coordination of specialty services such as for mental and behavioral health.

According to the 2019 GAO Report, since implementation of the 2010 MOU, the VHA has reported entering into 114 signed agreements with Tribal Health Programs (THPs), along with 77 implementation agreements to strengthen care coordination.[20] While a single national reimbursement agreement exists between federally-operated IHS facilities and the VHA, THPs continue to exercise their sovereignty by entering into individual agreements with the VHA. From 2014 to 2018, those reimbursement agreements with THPs alone increased by 113%.[21]

The VA reimbursements to IHS and THPs overall during that same time period increased by 75%, reaching $84.3 million in total. Yet these increased reimbursements still represent just a fraction of one percent of the VA's annual budget. While recent increases in the quantity of agreements and reimbursements demonstrates a positive trend, there continue to be significant challenges in care coordination between the VHA and IHS.

The 2019 GAO Report highlighted three overarching challenges related to care coordination:

- ongoing issues in patient referrals between I/T/U facilities and the VHA;
- significant problems in EHR interoperability; and
- high staff turnover within both the VHA and IHS.[22]

These complications continue to stifle Native Veterans' access to health care, erodes patient trust in both the IHS and VHA health systems, and obstructs efforts to improve health outcomes.

These issues are exacerbated by VHA claims that no statutory obligation exists for reimbursement when IHS refers a Native Veteran to VHA or when THPs provide specialty or referral services. To clarify, the VHA currently reimburses IHS and THPs only for care that the IHS or THPs provide directly as prescribed by their respective MOUs.

Despite repeated requests from Tribes, the VA has not provided reimbursement for PRC specialty care or referral services provided through IHS/THPs. This is highly problematic, as AI/AN Veterans should have

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[20] GAO analysis of Department of Veterans Affairs (VA) data. GAO-19-291. https://www.gao.gov/assets/gao-19-291.pdf
[21] *Id.,* at 22
[22] *See Id.*

the freedom to obtain care from either the VA or an Indian health program. If a Native 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 reimbursement does not happen, greater care coordination issues and burdensome requirements for Native Veterans continue to impede health care delivery for these Veterans. For example, if a Native veteran goes to an IHS or THP for service and obtains a referral, the same patient must be seen within the VHA system before the referral can be fulfilled. This means the VHA 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 receive a VHA referral. In other words, the VHA appears not to recognize the IHS or THP initial services or referral and this confusion or distrust leads to a duplication in at least some services.

This type of health care management is neither a good use of federal funding, nor is it navigable for Native Veterans. 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 the Veterans 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.

2. **VHA should consult with Tribes and work through their MOU with IHS to create and publish an active list of available Veterans Liaisons/Tribal Veterans Representatives across all IHS and VHA regions.**

The VHA must do more outreach and education with Native Veterans to improve care coordination. Tribes and NIHB have consistently stressed the need for VHA to create toolkits and guides to assist Native Veterans in navigating care access. The paucity of currently available newsletters, outreach workers and liaisons such as Tribal Veteran Service Officers (TVSOs), and online resources specifically for Native Veterans also sends the message that care for Native Veterans is not a priority. But despite repeated Tribal demands, the agency has yet to implement this request.

3. **Include Pharmacists, Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors, and other providers as eligible provider types under Medicare for Reimbursement to Indian Health Care Providers**

There is a severe, longstanding, and well-documented shortage of healthcare professionals in Indian Country. Because of this shortage, Indian healthcare programs rely extensively and increasingly on the services of other types of licensed and certified non-physician practitioners, including Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), Certified Community Health Aides and Practitioners (CHAPs), Behavioral Health Aides and Practitioners (BHAPs), and Pharmacists. The LMFTs, LPCs, and higher-level BHAPs are qualified to furnish many of the same services that psychiatrists, CSWs, and psychologists do.

Among other services, pharmacists in Indian programs deliver clinic-based, protocol-driven care on behalf of physicians, including tobacco cessation, and medication-assisted treatment (MAT) for substance use disorders. All these providers furnish essential, effective, and high-quality care that is covered by many Medicaid programs, yet Medicare does not cover them, nor do the many non-governmental healthcare

plans and health insurers that follow Medicare’s lead. This deprives Indian health programs of critically needed federal reimbursement for vital healthcare services to American Indians and Alaska Natives, particularly Native Veterans.

Conclusion

The federal government has a dual responsibility to Native Veterans that continues to be ignored. As the only national Tribal organization dedicated exclusively to advocating for the fulfillment of the federal trust responsibility for health, NIHB is committed to ensuring the highest health status and outcomes for Native Veterans. We applaud the House of Representatives Committee on Veterans’ Affairs for holding this important hearing and stand ready to work with Congress in a bipartisan manner to enact legislation that strengthens the government-government relationship, improves access to care for Native Veterans, and raises behavioral and mental health outcomes.