National Indian Health Board

TESTIMONY OF NATIONAL INDIAN HEALTH BOARD – ANDREW JOSEPH J.R.
HEARING ON NATIVE VETERANS' ACCESS TO HEALTH CARE
HOUSE VETERANS SUBCOMMITTEE ON HEALTH
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Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee, thank you for holding this important hearing on health care access for Native Veterans. On behalf of the National Indian Health Board (NIHB) and the 573 federally-recognized sovereign Tribal Nations we serve, I submit this testimony for the record. 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).

By current estimates from the VA, there are roughly 146,000 AI/AN Veterans, with Native Servicemembers enlisting at higher rates than any other ethnicity nationwide. Indeed, the Department of Defense continues to acknowledge the indispensable role of AI/AN Servicemembers throughout American history. Native Veterans are highly respected throughout Indian Country, in recognition of 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 among the worst health outcomes, and among the greatest challenges in receiving quality health services.

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 – including for provisions of quality and comprehensive health resources and services – have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even presidential executive orders. These federal promises have no expiration date, and collectively form the basis for what we now refer to as the federal trust responsibility. 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.

In 1955, Congress established the Indian Health Service (IHS) in partial fulfillment of its constitutional obligations for health services to all AI/ANs. The IHS is charged with a similar mission as the VHA as it relates to administering quality health services, with the exception of the following differences: (1) the federal government has Treaty and Trust obligations to provide health care for all American Indians and Alaska Natives; (2) IHS is severely and chronically underfunded in comparison to the VHA, with per capita medical expenditures within IHS at $4,078 in Fiscal Year (FY) 2017 compared to $10,692 in VHA per capita medical spending that same

year[1]; and (3) unlike IHS, the VHA has been protected from government shutdowns and continuing resolutions (CRs) because Congress enacted advance appropriations for the VHA a decade ago.[2]

Health Outcomes among Native Veterans and AI/ANs Overall

Destructive federal Indian policies and unresponsive human service systems have left Native 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).[3] In FY 2014, the Office of Health Equity within 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%).[4]

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 lack of timely appointments and transportation issues.[5] Among all Veterans, Native Veterans are more likely to have a disability, service-connected or otherwise.[6] 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.[7] 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 IHS and Tribes to create more resources specifically for Native Veterans.

According to IHS, AI/ANs born today have a life expectancy that is on average 5.5 years less than the national average.[8] In states like South Dakota, however, life expectancy for AI/ANs is as much as two decades lower than for Whites. Health outcomes among AI/ANs have either remained stagnant or become as AI/AN communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. According to the Centers for Disease Control and Prevention, in 2016, AI/ANs had the second highest age-adjusted mortality rate of any demographic nationwide at 800.3 deaths per 100,000 people.

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[1] The full IHS Tribal Budget Formulation Workgroup Recommendations are available at https://www.nihb.org/docs/04242019/307871_NIHB%20IHS%20Budget%20Book_WEB.PDF

[2] *See* 38 U.S.C. 117; P.L. 111-81

[3] VA, Veteran Suicide by Race/Ethnicity: Assessments Among All Veterans and Veterans Receiving VHA Health Services, 2001-2014 (Aug. 2017) (citing CDC statistics).

[4] 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

[5] 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

[6] 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

[7] 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

[8] Indian Health Service. 2018. Indian Health Disparities. Retrieved from https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf

In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). AI/ANs also have the highest Hepatitis C mortality rates nationwide (10.8 per 100,000); and higher rates of chronic liver disease and cirrhosis deaths (2.3 times that of Whites). Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for AI/ANs. For instance, from 1999 to 2015 AI/ANs encountered a 519 percent increase in drug overdose deaths – the highest rate increase of any demographic nationwide.[9] All of these health determinants of health and poor health status could be dramatically improved with adequate investment into the health, public health and health delivery systems operating in Indian Country.

The VA's Veteran Outreach Toolkit lists AI/ANs as an "at-risk" population, citing this troubling suicide rate. Additionally, AI/ANs grapple with complex behavioral health issues at higher rates than any other population—for children of AI/AN veterans, this is compounded by the return of a parent who may suffer from post-traumatic stress disorder (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.

Funding Levels for IHS versus VHA: The Need for Advance Appropriations

1. **Tribes and NIHB strongly urge Congress to pass bipartisan legislation that would enact advance appropriations for Indian programs**

By the most recent estimates, federally-operated IHS facilities, Tribally-operated health facilities and programs, and urban Indian health programs collectively serve roughly 2.6 million AI/ANs nationwide. In comparison, the VHA serves roughly 6.9 million Veterans through 18 regional networks. In FY 2019 discretionary appropriations for IHS equaled roughly $5.8 billion; in comparison, spending within the VHA totaled over $76 billion. In effect, this means that while the VHA service population is roughly only three times the size of the Indian health system, its discretionary appropriations are *approximately thirteen times higher* than for IHS.

According to the IHS Tribal Budget Formulation Workgroup, IHS appropriations must reach nearly $38 billion – phased in over twelve years – in order to fully meet current health needs. In other words, even if today IHS were fully funded at the level of need identified by sovereign Tribal Nations, it would only equal half the total FY 2019 discretionary appropriation for the VHA. Indeed, the federal government's continued abrogation of its trust responsibility for health services for AI/ANs is clearly exemplified by the gravity of the divide in health funding for the VHA versus IHS.

Although the IHS budget has nominally increased by 2-3% each year, these increases are barely sufficient to keep up with rising medical and non-medical inflation, population growth, facility maintenance costs, and other expenses. According to a 2018 report by the Government

[9] Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. MMWR Surveill Summ 2017;66(No. SS-19):1–12. DOI: http://dx.doi.org/10.15585/mmwr.ss6619a1

Accountability Office (GAO-19-74R), from 2013 to 2017, IHS annual spending increased by roughly 18% and per capita spending increased by roughly 12%; in comparison, annual spending under the VHA increased by 32% and per capita spending increased by 25% during the same time period.[10] The widening gap in funding levels between IHS and the VHA only serves to perpetuate the disproportionately higher levels of health disparities experienced by Native Veterans and AI/ANs overall.

Unequivocally, the U.S. federal government has a moral and ethical obligation to ensure all U.S. Veterans can access quality health services – and it must continue to honor this responsibility. But the U.S. also has a Trust obligation to ensure all AI/ANs, including Native Veterans, can receive quality health services, that it continuously fails to honor. It is long past due for the federal government to make good on its constitutional obligation to Native Veterans an all AI/AN Peoples.

The discrepancies do not end with chronic underfunding of IHS. Of the four major federal healthcare entities, IHS is the only one subject to the devastating impacts of government shutdowns and continuing resolutions (CRs). This is because Medicare and Medicaid receive mandatory appropriations, and the VHA was authorized by Congress to receive advance appropriations nearly a decade ago. As a result, the VHA has been insulated from every government shutdown, CR, and discretionary sequestration over the past decade. While it is true that no sector of government is fully spared by the repercussions of endless shutdowns and CRs, those repercussions are neither equal nor generalizable across all entities. In fact, the worst consequences are levied on Indian Country.

For instance, during the 2013 federal budget sequester, the IHS budget was slashed by 5.1% - or $221 million – levied on top of the damage elicited by that year's government shutdown. In fact, IHS was the only federally funded healthcare entity that was subject to full sequestration because Congress had already exempted the VHA when it authorized it to receive advance appropriations. Once again, during the most recent 35-day government shutdown – the nation's longest and most economically disastrous – IHS was the only federal healthcare entity to be shut down. While direct care services remained non-exempt, providers were not receiving pay. Administrative and technical support staff – responsible for scheduling patient visits, conducting referrals, and processing health records – were furloughed. Contracts with private entities for sanitation services and facilities upgrades went weeks without payments, prompting many Tribes to exhaust alternative resources to stay current on bills.

Several Tribes shared that they lost physicians to hospitals and clinics not impacted by the shutdown. Some Tribal leaders even shared how administrative staff volunteered to go unpaid so that the Tribe had resources to keep physicians on the payroll. These are just a few examples of the everyday sacrifices and ongoing struggles that widen the chasm between the health services afforded to AI/ANs and those afforded to the nation at large. While it is impossible to measure the full scope of adversity brought on by the 35-day government shutdown, one reality remains clear – Indian Country was both unequivocally and disproportionately impacted.

[10] Government Accountability Office. 2018. Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs. Retrieved from https://www.gao.gov/assets/700/695871.pdf

In 2018, GAO released a report examining the benefits of authorizing advance appropriations for the IHS and thus establishing parity between IHS and the VHA (GAO-18-652). The report outlined how Congress has been forced to use short-term or full-year CRs in all but four of the last 40 years. In fact, only once in the past two decades – in FY 2006 – has Congress successfully passed the Interior, Environment, and Related Agencies appropriations package (which funds IHS) before the end of the fiscal year. As a result, year after year, the Indian health system is curtailed from making meaningful improvements towards the availability and quality of health services and programs, further restraining efforts to advance quality of life and health outcomes for AI/ANs.

While a CR is always preferable to a government shutdown, they are not devoid of obstacles that directly impact patient care. Because of budget authority constraints under a CR, IHS is prohibited from initiating any new activities or projects that were not expressly authorized or appropriated in the previous fiscal year. In addition, under a CR, IHS must exercise significant precaution over expenditures, and is generally limited to simply maintain operations as opposed to improve them. When you compound the impact of chronic underfunding and endless use of CRs, the inevitable result are the chronic and pervasive health disparities seen across Indian Country. As such, **Tribal Nations and NIHB strongly urge Congress to pass bipartisan legislation that would authorize advance appropriations for Indian programs**.

Lack of IHS and VHA Care Coordination and Reimbursement Agreements

1. **NIHB recommends 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 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.[11] According to the VA, more than 2,800 AI/AN Veterans are served at IHS facilities.[12] 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.

Section 407(a)(2) of the Indian Health Care Improvement Act (IHCIA) reaffirms the goals of the 2003 Memorandum of Understanding (MOU) between the VHA and IHS established to improve care coordination for Native Veterans. In addition, during permanent reauthorization of IHCIA, section 405(c) was amended to require the VHA to reimburse IHS and Tribes for health services provided under the Purchased/Referred Care (PRC) program. In 2010, the VHA and IHS modernized their 2003 MOU to further improve care coordination for Native Veterans by

[11] 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.
[12] VA/IHS listening session held on May 15, 2019

bolstering health facility and provider resource sharing; strengthening interoperability of electronic health records (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 a 2019 GAO report (GAO-19-291), 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. 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%.

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 VHA and IHS. These complications continue to stifle Native Veterans' access to health care, erodes patient trust in both 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 of specialty and referral services provided *through* IHS or THPs. To clarify, the VHA currently reimburses IHS and THPs for care that they provide *directly* under the MOU. Despite repeated requests from Tribes, the VA has not 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 *before* a referral can be secured. 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 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.

As a step toward mitigating the confusion surrounding reimbursement for care provided by the VHA, NIHB recommends the VHA include PRC in future IHS/THP reimbursement agreements, so that there is no further rationing of health care provided by IHS and THPs to Native Veterans and other eligible AI/ANs. Ultimately, however, NIHB recommends that Congress clarify the statutory language under section 405(c) of IHCIA and make explicit VHA's requirement to reimburse under PRC.

2. **NIHB also strongly supports the GAO recommendation that the VHA work with IHS to create written policy or guidelines to clarify how referrals from IHS and THP facilities to VHA facilities for specialty care should be managed, and to establish specific targets for measuring action on MOU performance measures**.

The GAO report cited how, for example, facilities reported conflicting information about the processes for referring Native Veterans from IHS or Tribal facilities to VHA, and VA headquarters officials confirmed that there is no national policy or guide on this topic. One of the leading collaboration practices identified by 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 consistent understanding of the options available for referral of Native Veterans for specialty care.

As is currently the case, the result is duplicative care for Native Veteran and duplicative costs for the federal government. NIHB has heard that some Native Veterans prefer to *simply hand carry their EHR records from their IHS provider to their VHA provider to avoid having to receive the same care twice*. In short, lack of written policy perpetuates this burdensome, pointless, and complicated process that only serves to frustrate patients, worsen administrative red tape, and increase expenditures.

For numerous Tribes, and especially for the Veterans themselves, it is an undue barrier to constantly have to refer patients back and forth to the VA that ultimately wastes time and delays access to care. The GAO identified that 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.

3. **Tribes and NIHB have strongly recommended that the VHA consult with Tribes and work through their MOU with IHS to create and publish a living 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.

A closely related issue is the fact that Native Veterans are still charged copays and deductibles when receiving services under the VHA. The federal government's trust responsibility for health services extends to all Native Veterans. In recognition of this, AI/ANs do not have copays or deductibles for services received at an I/T/U facility. Additionally, the ACA further affirmed the trust responsibility when it included 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.

4. **Congress should pass legislation exempting Native Veterans from copays and deductibles**

Section 222 of IHCIA prohibits cost sharing of AI/ANs in cases where an AI/AN receives a referral from the from an IHS or THP under the PRC program. Like IHS and the Marketplace, the VHA is another means by which the federal government must uphold its trust responsibility to AI/ANs. As such, it is imperative that Congress enact legislation that requires the VHA to similarly exempt AI/AN Veterans from copays and deductibles in the VA system in recognition of the federal trust responsibility. Importantly, copay costs should not be shifted to IHS or Tribes. The VHA must absorb these costs on behalf of AI/AN Veterans in recognition of their Trust and Treaty obligations to AI/AN Peoples.

5. **Congress should pass the bipartisan H.R. 2791 – Department of Veterans Affair Tribal Advisory Committee Act of 2019**

Tribal Nations and NIHB have also strongly advocated for the seating of a Tribal Advisory Committee (TAC) within the Office of the Secretary at the VA. Establishing a Veteran TAC is essential for strengthening the government-to-government relationship, and improving VA accountability to Native Veteran health needs. Through the seating of a TAC, top VA officials would have the ability to hear directly from Tribal leaders about the unique health priorities and challenges that impact Native Veterans. In addition, it would help prevent the development of new rules or policies that would adversely affect care for Native Veterans. As such, Tribes and NIHB strongly support the bipartisan H.R. 2791, introduced by Representative Deb Haaland, and urges the House VA Committee to vote to pass this significant legislation.

EHR Interoperability and Health Information Technology (IT) Modernization

1. **Congress must ensure parity between the VA and IHS in appropriations and technical assistance for health IT modernization**

The Resource and Patient Management System (RPMS) – which is the primary health IT system used across the Indian health system – was developed in close partnership with the VHA and has become partially dependent on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture (VistA). The RPMS is an early adoption of VistA for outpatient use, and the legacy system was designed with the decision to keep the same underlying code infrastructure as VistA. IHS began developing different clinical applications for their outpatient services, and the VHA adopted code from RPMS to provide this functionality for VistA.

RPMS eventually began to use additional VistA code as the need for inpatient functionality increased. This type of enhancement and support for both the IHS and VHA was made possible because VistA's software components were designed as an Open Source solution. The RPMS suite is able to run on mid-range personal computer hardware platforms, while applications can operate individually or as an integrated suite with some availability to interface with commercial-off-the-shelf (COTS) software products.

Currently, the RPMS manages clinical, financial, and administrative information throughout the I/T/U, although, it is deployed at various levels across the service delivery types. However, in recent years, many Tribes and even several Urban Indian Health Programs (UIHPs) have elected to purchase their own COTS systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and are significantly more navigable and modern systems to use. As a result, there exists a growing patchwork of EHR platforms across the Indian health system.

When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), concentrated efforts to re-evaluate the Indian Health IT system accelerated, and arose significant concerns as to how VHA and I/T/U EHR interoperability would continue. In 2018, IHS launched a Health IT Modernization Project to evaluate the current I/T/U health IT framework, and to, through Tribal consultation, key informant interviews, and national surveys, develop a series of next steps and recommendations towards modernizing health IT in Indian Country.

Difficulties in achieving IT interoperability among VA, IHS, and THP facilities pose significant problems for Native Veterans' care coordination. Unfortunately, the VHA and IHS have yet to identify a systemic solution towards increasing EHR interoperability between I/T/U and VHA hospitals, clinics, and health stations. A resulting scenario includes situations where a THP provider – having treated a Veteran and referred them to the VHA for specialty care – would not receive the Veteran's follow-up records as quickly as if they had streamlined access to each other's systems.

Now that the VHA is transitioning to the Cerner system, it has worsened concerns around care coordination and sharing of EHRs between I/T/U and VHA systems. The fact is, Native Veterans are suffering today from the lack of health IT interoperability. **It is shameful that Native Veterans are put in a position where they have to find their own solutions to streamline EHR sharing, most shockingly exemplified by anecdotes of AI/AN Veterans hand carrying their health records between their IHS and VHA provider.**

Congress must ensure that the Indian health system is fully integrated across the development and implementation of the VHA's transition to Cerner; however, thus far it has failed to do so. By the most current estimates, the transition to Cerner will take up to 10 years to fully implement, with a current price tag of roughly $16 billion. None of the existing estimates include calculations of how much it will cost to include IHS in this transition; however, through its Health IT Modernization Project, IHS is attempting to arrive at an estimated dollar figure for this cost.

Tribes and NIHB were pleased to see that the FY 2020 President's Budget included a request for a new $20 million line item in the IHS budget to assist with health IT modernization, and that this

request was included in the House-passed FY 2020 Interior Appropriations package. But in comparison, the FY 2020 House Military Construction Appropriations bill budgeted $1.6 billion to assist VHA in its transition. Ensuring EHR interoperability between I/T/U and VHA health systems will be impossible if Congress fails to establish parity in appropriations for VHA and IHS health IT modernization.

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 VA Subcommittee for Health 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 health outcomes.