STATEMENT OF
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BEFORE THE
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Good morning, Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee. I appreciate the opportunity to discuss how care at the Department of Veterans Affairs (VA) and our partnership with Indian Health Service (IHS) positively impact our Native American Veterans. I am accompanied today by my colleagues Ms. Stephanie Birdwell, Director for the Department of Veterans Affairs' Office of Tribal Government Relations and Dr. Thomas Klobucar, Executive Director for Veterans Health Administration's (VHA) Office of Rural Health (ORH.

Introduction

As Secretary Wilkie has shared during his meetings with Native American Veterans and tribal leaders across the country, our goal at VA is to shorten the distance between people in need of Veterans services. VA is working to increase our reach into tribal communities through telehealth, visits from VA representatives, and closer cooperation between VA and IHS. VA is committed to ensuring our Native American Veterans, more specifically our American Indian and Alaska Native (AI/AN) Veterans, receive and find access to quality, culturally competent care from VA and tribal health systems.

Five Goals of the Memorandum of Understanding between VA and IHS

A Memorandum of Understanding (MOU), originally signed in 2003 and updated again in 2010, established that IHS and VA can coordinate, collaborate, and share resources between the Departments. Five mutual goals were agreed upon when the MOU was signed:

- Increase access to and improve quality of health care and services to the mutual benefit of both agencies by effectively leveraging the strengths of VA and IHS at the national and local levels to afford the delivery of optimal clinical care;
- Promote patient-centered collaboration and facilitate communication among VA, IHS, AI/AN Veterans, Tribal facilities, and Urban Indian Clinics;
- Establish effective partnerships and sharing agreements among VA headquarters and facilities, IHS headquarters, and IHS, Tribal, and Urban Indian health programs in support of AI/AN Veterans;
- Ensure that appropriate resources are identified and available to support programs for AI/AN Veterans; and
- Improve health-promotion and disease-prevention services to AI/AN to address community-based wellness.

To achieve these goals, VHA has piloted and subsequently adopted several programs. To address access to care, achieve effective partnerships, and ensure the availability of resources, in 2012 VA began to establish a national reimbursement template with IHS which led to over 112 Tribal Health Programs (THP) agreements.

In addition to these reimbursement agreements, local VA medical centers have established, where appropriate, several agreements with THPs and IHS facilities to deliver telemental health care to AI/AN Veterans. The program serves tribal communities in Alaska, Montana, Wyoming, and Oklahoma. ORH's Veterans Rural Health Resource Center, Salt Lake City (VRHRC SLC) has an active portfolio of innovations in AI/AN Veteran health care, including the creation of a Rural Veteran Tribal Navigator program that will connect AI/AN Veterans with the benefits and care they have earned.

In addition, VA Video Connect (VVC) is a pilot program currently being deployed nationwide. VVC will allow rural AI/AN Veterans to access VA health care in their homes or local communities via cellular and wireless capabilities. VRHRC SLC is currently working to tailor this program to AI/AN Veteran-communities, creating a model

that will weave together the evidence-based Western medicine, traditional Native Healing, and rural Native communities' strengths through four main components: mental health care, technology (access), care coordination, and a tailored implementation facilitation strategy. In addition to these programs, VRHRC SLC is piloting programs to establish Tribal-VHA Partnerships in Suicide Prevention and developing Native Veteran Content for the VA Community Provider Toolkit.

One of the great successes in achieving the 2010 MOU goals was the establishment of the VA/IHS Consolidated Mail Order Pharmacy Program (CMOP) that sends prescription medications to AI/AN Veterans' homes. In 2018 alone, CMOP processed 840,000 prescriptions for AI/AN Veterans, up 17 percent from the previous year. Since its inception, CMOP has processed more than 3.6 million prescriptions for AI/AN Veterans served by IHS and THP programs.

The March 2019 Government Accountability Office (GAO) report **"VA and Indian Health Services: *Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans*"** cites challenges in obtaining the MOU goals, specifically around establishing targets for outcome metrics to assess progress. Specifically, the inadequacies found in performance metrics could limit the agencies' ability to measure progress towards MOU goals and ultimately impact decisions about programs or activities.

In early fiscal year 2019, VHA and IHS MOU leadership agreed that the 2010 MOU was no longer meeting the agencies' needs and required modification to create the flexibility needed to move the interagency relationship forward to a new level. The leadership team drafted a new MOU and conducted a first listening session with tribal leaders on May 15, 2019. Tribal input from that session was incorporated into the draft VHA-IHS MOU and VA and IHS conducted a subsequent consultation session at the National Indian Health Board annual meeting on September 16, 2019. This additional input is now being considered for inclusion in the draft MOU. After the IHS and VA MOU leadership team reaches agreement on the draft MOU, it will enter formal

clearance channels for approval by IHS and VA. The approved draft MOU document will be posted in the Federal Register and further tribal consultation for a period of no less than 60 days. Tribal input will be incorporated into the draft document and it will move forward for final approval and signature.

The challenges found in the 2010 MOU performance metrics may have limited the ability of VA and IHS managers to gauge progress and make decisions about whether to expand or modify programs or activities because the agencies did not have information on the effectiveness of the programs in supporting MOU goals. VA and IHS also acknowledge that the performance metrics contained weaknesses and that refining them is a top priority.

To address the shortcomings associated with the 2010 MOU metrics noted by GAO, VA and IHS have brought in metrics experts from each agency to the MOU development process. Once the draft is finalized, the process of creating new targets and metrics to meet the requirements outlined by GAO will take place as new programs and pilots are developed under the new instrument.

Reimbursement Agreements

Since the Summer of 2012, VA has signed individual reimbursement agreements with THPs to provide direct care services to eligible AI/AN Veterans closer to their homes in a culturally sensitive environment. In December 2012, VA signed a national reimbursement agreement with IHS. Today, the national reimbursement agreement with IHS covers 75 IHS sites. There are also 114 individual reimbursement agreements with THPs of which 26 are in Alaska and cover AI/AN Veterans and Non-Native Veterans.

From August 2012 through August 2019, VA has reimbursed IHS and THPs over $103 million covering approximately 10,645 AI/AN Unique Veterans. Of the $103 million, VA has reimbursed approximately $32.2 million to Alaska THPs for covering an

estimated 1,513 AI/AN Unique Veterans. Additionally, VA has reimbursed Alaska THPs approximately $27.7 million for approximately 4,787 Unique Non-Native Veterans.

IHS and several THPs have requested that the agreements be expanded to cover reimbursements for purchased referred care (PRC) under which IHS and THPs can refer AI/AN Veterans to their contracted community care. They feel this will enhance care coordination. VA is also looking to enhance care coordination with IHS and THP facilities. However, VA has the primary responsibility for care provided to Veterans and related care coordination. If VA approves PRC for AI/AN Veterans under the reimbursement agreements, VA may lose track of that care provided to Veterans. As a result, VA is developing a standardized care coordination process that will enhance care coordination for AI/AN Veterans. Initial steps include establishing an Advisory Board for care coordination and inviting Tribal Officials to be members on the Board. The Board's main scope will be to implement the standardized care coordination process and to improve care coordination between VA and IHS/THP sites for the benefit of Veterans.

Conclusion

The health and well-being of all our nations' Veterans is of the utmost importance. We strive to consistently provide high quality care to all Veterans and continue to make significant strides in enhancing the practice and culture of the Department to be more accessible to our Native American Veterans. Working with many diverse, sovereign tribes is essential to successfully achieve the goals of the MOU. VA is committed to ensuring that our goals align with IHS and that the needs of our Native American Veterans are met. I want to thank the Committee for hosting this hearing. This concludes my written testimony.