

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74501
Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: www.Tribalselfgov.org

**Testimony of
Chief Mutáwi Mutáhash (Many Hearts), Marilyn “Lynn” Malerba,
On Behalf of the Indian Health Service (IHS)
Tribal Self-Governance Advisory Committee (TSGAC)**

**Submitted to the
U.S. House of Representatives, Committee on
Veterans’ Affairs, Subcommittee on Health Hearing
“Native Veterans’ Access to Healthcare”
October 30, 2019**

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee,

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), it is an honor to submit the following formal written testimony on the unique barriers that Native veterans face when seeking access to quality, culturally competent care. Established in 1996, the TSGAC provides information, education advocacy, and policy guidance for the implementation of Self-Governance within the IHS.

Native Veterans have a uniquely special status with the United States. Our American Indian and Alaska Natives have fought alongside the colonial government beginning with the Battle of Bunker Hill, and they have subsequently fought for the United States armed forces in every war and conflict, at higher rates per capita than any other group in the United States.

Treaties between our native governments and the United States included health care for our people. Our Native veterans, as warriors on behalf of this nation are deserving of the best health care we can provide. All veterans, Native and non-Native, alike have sacrificed much for this country and are owed the best health care that we can provide.

The United States Commission on Civil Rights notes in the report titled “Broken Promises: Continuing Federal Funding Shortfall for Native Americans” “the United States expects all nations to live up to their treaty obligations and it should live up to its own.” It specifically recommends that the Federal government should provide steady, equitable and **non-discretionary** funding directly to Tribal nations to support the public safety, health care, education, housing, and economic development of Native Tribes and people.

One way to enhance the funding for the health of our Native veterans was implemented with the Memorandum of Understanding (MOU) between the U.S. Department of Veterans Affairs (VA) and the U.S. Department of Health and Human Services’ (HHS)

Indian Health Service (IHS). In fact, given the inequity of funding for our Native people within the Federal system, the ability to access VA funding for services provided to our Native veterans provides better care for our veterans and provides some relief for a very economically challenged Indian health care system. In 2017, the funding per person per year for an American Indian was \$3,332 while the Veterans Health Administration funding per person was \$8,759.

The TSGAC would specifically like to comment on the effectiveness of this MOU and provide solutions to overcome the systematic health inequities experienced by Native veterans as a means to improve Native veterans’ health status and wellbeing.

As reported by the U.S. Government Accountability Office (GAO) in 2019, Federal Indian policy has promoted Tribal self-government—the practical exercise of Indian tribes and nations’ inherent sovereign authority—for more than four decades. The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, authorizes Federally recognized tribes to assume the administration of a variety of Federal programs—or portions thereof—that were previously managed by the Indian Health Service. In effect, the Tribes are fulfilling the trust and treaty obligations of the United States through contractual arrangements with the Federal government.

Since enactment of ISDEAA, Tribal nations have demonstrated and proven that a government-to-government relationship based on respect of sovereignty and the inherent right of Tribes to self-govern is an effective and successful approach for both the delivery of services to Tribal communities and to uphold the United States’ trust responsibility to Tribal Nations and their citizens.

The VA reports there are 145,000 Native Veterans living in the United States. The VA also reported that Native Veterans have an average life expectancy four years shorter than that of the general U.S. population and are more likely than Veterans of other ethnicities to experience social and economic difficulties that may impact their health or wellness, such as lower income, lower education levels and higher unemployment. Native veterans are eligible to receive health care services from the VA, IHS, and Tribal nations and Tribal organizations that operate under a Self-Governance agreement (referred to as Tribal Health Providers or THPs).

Tribal Nations that elect to administer health programs and services under a Self-Governance agreement to their citizens and communities are effective, in part, because Tribal Nations know the needs of their communities and are in the best position to provide culturally appropriate solutions tailored to address those local needs. Many THPs have significant experience serving veterans in their communities and have

entered into reimbursement agreements with the VA, pursuant to Section 405(c) of the Indian Health Care Improvement Act (IHCIA).¹

As Native veterans return home and seek to access the benefits they are entitled to, healthcare services often fall short to meet their needs. Factors, such as, residing in remote rural communities, poverty, mental health conditions, historical mistrust and a limited number of culturally competent healthcare providers create barriers to care and lead to Native veterans experiencing greater health disparities compared to other veterans. Other social determinants of health impact the overall health of our Native veterans including lack of running water, lack of indoor plumbing, overcrowded housing and in some cases lack of fully functioning kitchen facilities for nutrition.

Further, regulatory barriers exacerbate Native veterans’ ability to access care. Restrictions on specialty care, assessment of co-pays, duplicative processes, overly-burdensome administrative requirements and lack of coordination of care delay access to care and have caused irreparable harm to veterans.

Native Veterans reside in rural areas in greater proportions when compared to Veterans of other races—with nearly 40 percent of Native veterans residing in rural areas, often on geographically dispersed reservations or Tribal lands which are often remote, isolated and considered highly rural. THPs are often one of few, if any, health providers in rural areas. As such, THPs are a critical partner for increasing access to quality healthcare to all veterans, both Native and non-Native. IHCIA Section 405(c) provides the authority for Tribes to receive reimbursement for services provided to non-Native veterans but THPs are limited from playing a greater role in providing increased access to healthcare because VA limits the services that IHS can provide to non-Native veterans.

In recent years, the VA and IHS made some progress overcoming these challenges to ensure eligible veterans can access efficient adequate health services in their own communities through THP’s. However, the VA limits the types of care that can be provided at IHS and does not cover non-Native veterans who would otherwise routinely receive services through IHS, such as non-Native women pregnant with Native children; even in cases where the IHS or THP is the only facility in close proximity to the veteran. Limiting the services that IHS can provide in turn limits the services that Tribally-administered healthcare programs can provide to their communities.

¹Section 405 (c) of the IHCIA provides that...the Service, Indian tribe, or Tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a Tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

Coordination Between VA and IHS

In 2010, VA and IHS expanded upon a 2003 memorandum of understanding (MOU) to improve the health status of American Indian and Alaska Native veterans through coordination and resource sharing among VA, IHS, and Tribal Nations. This 2010 MOU outlined mutual goals for VA and IHS collaboration and coordination of resources and health care services provided to AI/AN veterans. For example, it included provisions for joint contracts and purchasing agreements, sharing staff, ensuring providers in VA and IHS could access the electronic health records of shared patients, and the development of reimbursement policies and mechanisms to support care delivered to AI/AN veterans eligible for care in both systems.

In December 2012, VA and IHS signed a reimbursement agreement that facilitates reimbursement from VA to IHS facilities for the direct care services they provide to eligible Native veterans. VA has established similar reimbursement agreements with individual Tribally administered healthcare programs. The VA and IHS are now in the process of updating the MOU. This process provides a tremendous opportunity for the VA, IHS, and Tribal governments to work collaboratively to identify activities that will help ensure Native Veterans are receiving the quality healthcare services they are owed.

The current MOU between VA and IHS includes the following five primary goals:

1. Increase access to care and services for American Indian and Alaska Native Veterans
2. Promote patient-centered collaboration and communication
3. Improve health-promotion and disease prevention
4. Consult with Tribes at the regional and local levels
5. Ensure appropriate resources are identified and available.

In accordance with these five goals, the MOU contains specific areas in which VA and IHS agreed to collaborate and coordinate on, including:

- Reimbursement: development of payment and reimbursement policies and mechanisms to support care delivered to dually eligible Native veterans.
- Sharing staff: sharing of specialty services, joint credentialing and privileging of health care staff, and arranging for temporary assignment of IHS Public Health Service commissioned officers to VA.
- Staff training: providing systematic training for VA, IHS, THP, and Urban Indian Health Program staff on VA and IHS eligibility requirements to assist them with appropriate referrals for services.
- Information Technology Interoperability: interoperability of systems to facilitate sharing of information on common patients, and establishment of standard mechanisms for VA, IHS, and THP providers to access records for patients receiving care in multiple systems.

We offer the ***following comments and recommendations*** that are related to several of the goals and/or areas of agreed collaboration and coordination:

Patient Referrals

As VA, IHS, and Tribal Nations work to build greater partnerships, we must 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 Tribal facility for service and needs a referral, the same patient must then be seen within the VA system before a referral can be secured. This is not an efficient use of Federal funding as it is duplicative, fails to acknowledge similarly credentialed providers and makes care navigation difficult for Native veterans.

Recommendation: The VA should accept referrals made by IHS and THPs in order to provide the best services to our veterans.

Reimbursement of Purchased and Referred Care

Although the MOUs and agreements with VA have demonstrated success in facilitating patient care for veterans, neither the current national agreement nor the Tribal agreements include reimbursement for Purchased and Referred Care (PRC) at IHS or Tribal healthcare facilities. Consequently, veterans are forced to maneuver through a complex healthcare system and an elaborate administrative process.

Veterans often require additional services that are not available at IHS or THPs. In many instances eligible veterans are also eligible for PRC services. The PRC program authorizes Indian Healthcare facilities to purchase services from a network of private providers. IHS and THPs are the payors of last resort, which require that all other sources of obtaining health services must be exhausted prior to receiving care through the PRC program. These services may include primary or specialty care that is not available at an IHS and/or Tribal healthcare facility. Many THPs have existing provider networks to ensure veteran’s complex healthcare needs are met.

The VA, however, will not reimburse THPs for their referrals but instead insist that the veteran in need of specialty care return to the VA health system for a VA referral for care. In certain instances, this level of care may be directly available and provided under the current reimbursement agreements and reimbursed by the VA. However, because the mix of direct versus purchased care varies across the Indian health system, some IHS or Tribal health programs may purchase more care from outside providers, which currently is unreimbursed by VA.

This illogical and inconsistent management of care is inefficient, a waste of resources (both time and money) and fails to prioritize the healthcare needs of Native veterans. THPs work hard to provide a seamless health care experience. Lack of coordination of care for specialty care and other medically necessary care paid by PRC creates more

barriers for our veterans. This creates misalignment with the VA’s mission for care which strives for improved access to all types of care.

Recommendation: VA should include PRC in the IHS/THP reimbursement agreements to eliminate further rationing of health care provided by IHS and THPs to Native veterans and other eligible veterans and to ensure timely quality healthcare.

Native Veterans Co-Pays

Native veterans who seek health care services at a VA facility are assessed co-payments which is in direct opposition to the Federal trust obligation to provide health care for all American Indians and Alaska Natives. IHS and THPs are the payor of last resort (section 2901(b) of the ACA) whether or not there is a specific agreement in place for reimbursement. Therefore, neither the Native Veteran nor the IHS should be responsible for any co-payments.

Recommendation: The TSGAC recommends the discontinuation of the practice of collecting co-payments from Native Veterans.

Tribal Provider Credentialing

Although stated in the MOU, the VA does not accept provider credentialing from THPs. Tribes that administer their health programs through Self-Governance agreements have the right to choose and operate their own credentialing system or to leverage the credentialing system administered by IHS.

VA acceptance of IHS/THP-credentialed providers facilitates care coordination by allowing IHS/THP primary care providers to refer directly into the VA system for either continued care to be provided in a VA facility, or for care to be purchased through outside providers. This would eliminate the duplicative primary care visit and referral and ensures that the Veteran continues with their primary care provider of choice who coordinates their care and receives all reports and results from other providers. VA has attempted in some local areas to re-credential IHS/THP providers under the VA system, but the length of time required for a provider to proceed through the entire VA credentialing process is not practical or timely.

Recommendation: To ensure care coordination is effective and efficient, VA should accept provider credentialing from IHS/THPs, upon the provider releasing the credentialing package to VA.

Graduate Medical Education (Tribal Medical Residency Programs)

IHS and THPs have significant workforce challenges due, in part, to most facilities being located in rural and/or remote locations. The HHS Health Resources and Services Administration (HRSA) automatically designates IHS, Tribally-operated and Urban Indian Health programs as Health Professionals Shortage Areas (HPSAs) and Medically

Underserved Area and Medically Underserved Population (MUA/MUP) for these reasons. Several THPs currently have Tribal medical residency programs.

TSGAC was very encouraged to review the provisions of the recent VA Mission Act, specifically Section 403 which included a “Pilot Program on Graduate Medical Education and Residency.” This new pilot includes facilities operated by Tribes, Tribal Organizations and IHS as “covered facilities” for purposes of the program and requires such facilities have a priority in placement of residents.

Recommendation: VA should include IHS and Tribes in the planning of the pilot program to ensure that any regulations or policies that may be developed in the future for the pilot work optimally in Indian Country.

Access to Consolidated Mail Order Pharmacy (CMOP)

Currently only those IHS and Tribal Health Programs that use the RPMS system have access to CMOP. This is an important means of improving compliance with prescriptions when those medicines are delivered directly to the Veteran’s homes. This reduces barriers to effective disease management

Recommendation: Information Technology Systems experts from both VA and IHS need to ensure that all systems used by Tribal Health programs are compliant and compatible with the CMOP system.

Quality Measures

The TSGAC is supportive of quality measures that provide for tracking of meaningful outcomes. However, the TSGAC would be very disturbed at the prospect of developing either data reporting requirements that affect reimbursements to IHS/THPs, or that require new collection of data and reporting systems in addition to those already imposed on IHS/THPs. All IHS/THPs receiving reimbursement from VA are required to be accredited by a nationally recognized health accreditation agency, which assures quality standards are being maintained. The VA also conducts quality monitoring, and visits IHS/THP programs regularly for review, even though this is not a requirement of the statute. Finally, all IHS/THPs participating in Medicare and Medicaid must comply with all of their quality and performance programs and reporting, as applicable. The VA itself is not required to comply with this level of accountability to external agencies.

Recommendation:

The IHS and VA should work together and consult with the Tribes to develop evaluation measures for assessing the progress toward MOU goals. Additionally, the VA should not impose any additional quality programs upon IHS/THPs, because it is very burdensome, costly, and unnecessary because there are sufficient quality requirements already in place.

Health Information Exchange

VA belongs to the eHealth Exchange—a national health information exchange—and it reported to GAO in March 2019 that IHS or THPs could join the exchange to access information about common veteran patients. However, IHS reported to GAO that although the agency explored connecting to the eHealth Exchange several years ago, testing and onboarding costs to participate were prohibitive. THPs that GAO spoke with reported being a part of other, more locally-based health information exchanges, but noted that VA was not part of these exchanges.

Recommendation: Local VA health care facilities should work with their local THPs to ensure health information can be exchanged at the local levels through local health information exchanges rather than one national health information exchange.

Tribal Advisory Board

Tribal advisory committees provide an effective forum for Tribes and Federal agencies to work together as government-to-government partners to address policy, legislative, budget, program and service issues and formulate recommended actions. In response to GAO’s March 2019 report, VA stated that it will establish a Tribal advisory group that will make recommendations related to care coordination guidance and policies. The VA set a target completion date for establishing this group is spring 2020.

Recommendation: The VA should work in coordination with Tribes to establish a Tribal Advisory Board. Tribal leaders have significant experience serving on Tribal advisory committees/boards at Federal agencies and can provide crucial input on key components and characteristics that make an effective advisory board.

GAO’s Review of Coordination Between VA and IHS

The TSGAC fully supports the development of specific, measurable metrics by which to evaluate the progress being made under the MOU. Although there are a number of measures identified in annual reports issued by the IHS and VA, they are largely process measures which report on the number of veterans served, amount of reimbursements, number of trainings or events, etc.

In March 2019, GAO reported that the MOU signed by the VA and IHS lacks sufficient measures for assessing progress towards its goals. Specifically, GAO reported that the agencies established 15 performance measures, but they did not establish targets against which performance could be measured. For example, while the number of shared VA-IHS trainings and webinars is a performance measure, GAO noted that there is no target for the number of shared trainings VA and IHS plan to complete each year. Two of the three recommendations GAO made to the VA and IHS focus on the lack of performance measures and one focuses on the lack of written policy and guidance.

Recommendation: Federal agencies should focus their limited resources on actions that will directly improve the health and wellbeing of Native veterans and should ensure

that measures they develop are focused on outcomes rather than counting administrative activities that should already occur as part of routine operations. Additionally, these outcome measures should be developed and agreed upon jointly.

In closing, VA and IHS have made progress and have demonstrated a willingness to improve quality access to care for Native Veterans. But, as you see in my statements here, there are still significant opportunities for improvement. The TSGAC truly appreciates the opportunity to provide the Subcommittee with these written recommendations. Thank you.