

**Vice-President Sonya Tetnowski for the National Council of Urban Indian Health
Testimony for the House Committee on Veterans' Affairs, Subcommittee on Health,
Oversight Hearing entitled "Native Veterans Access to Healthcare"
October 30, 2019**

My name is Sonya Tetnowski, I am a member of the Makah tribe, a U.S. Army Paratrooper Veteran, and the Chief Executive Officer of the Indian Health Center of Santa Clara Valley in California. I'm also the Vice President of the National Council of Urban Indian Health (NCUIH), which represents 41 Title V Urban Indian Health Organizations (UIOs) across the nation, as well as the President of the California Consortium for Urban Indian Health (CCUIH). UIOs provide high-quality, culturally competent care to urban Indian populations, which constitute more than 78% of all American Indians and Alaska Natives (AIANs). I would like to thank Chairwoman Brownley, Ranking Member Dunn, and other distinguished members of the subcommittee for holding this important hearing. It is my pleasure to testify today regarding H.R. 4153, the Health Care Access for Urban Native Veterans Act.

H.R. 4153 is a necessary and critical piece of legislation, one that will make a real meaningful difference in the funding for health care services provided by UIOs across the United States. Just last month, I came to Washington D.C. to advocate and give in person testimony on this very issue before the House Indigenous Peoples of the United States Subcommittee Legislative Hearing on held on September 25, 2019 and to voice my support of H.R. 4153.

I cannot express more urgently, that the single most important thing the Department of Veterans Affairs (VA) can do to improve healthcare to AI/AN Veterans, is to fully implement the VA and Indian Health Services' Memorandum of Understanding (VA-IHS MOU) and Reimbursement Agreement for Direct Health Care Services. This would allow UIOs to be reimbursed for providing culturally competent care to AI/AN Veterans residing in urban areas. Despite an embattled history between tribal people and the United States government, and as an inherited

responsibility to safeguard the lands of their ancestors, AI/ANs serve this country at a higher rate than any other group in the nation. A significant number of these Veterans live in urban areas and seek out the high-quality, culturally competent care at their local UIO.

UIOs were formally recognized by Congress following the end of the Termination Era in 1976 under the Indian Health Care Improvement Act to fulfill the federal government's health care-related trust responsibility to Indians who live off the reservations. Each UIO is led by a Board of Directors that must be majority Indian. They are collectively represented by the National Council of Urban Indian Health (NCUIH), which is a 501(c)(3), member-based organization devoted to the development of quality, accessible, and culturally sensitive healthcare programs for AI/ANs living in urban communities. UIOs are a critical part of the Indian Health Service (IHS), which uses a three-prong approach to provide health care: Indian Health Services, Tribal Programs, and Urban Indian Organizations commonly referred to as the I/T/U.

VA-IHS MOU Historical Background

In February 2003, the VA and IHS signed a Memorandum of Understanding (MOU) and updated this MOU in October 2010. The very first paragraph of the MOU states:

“ the intent of this MOU (is) to facilitate collaboration between IHS and VA, and **not limit initiatives, projects, or interactions between the agencies in any way**. The MOU recognizes the importance of a coordinated and cohesive effort on a national scope, while also acknowledging that the implementation of such efforts requires local adaptation to meet the needs of individual tribes, villages, islands, and communities, as well as local VA, IHS, Tribal, and **Urban Indian health programs.**”

In December 2012, the two agencies signed a reimbursement agreement allowing the VA to financially compensate IHS for health care provided to AI/ANs that are part of the VA's system

of patient enrollment. While this MOU has been implemented for IHS and Tribal providers, it has not been implemented for UIOs, despite the fact that UIOs are explicitly mentioned in the original language of the 2010 MOU, and provide healthcare within IHS's own I/T/U system. Leaving out UIOs is a violation of the MOU since the agencies agreed to "not limit initiatives, projects, or interactions between the agencies in any way." Not reimbursing UIOs for services provided to Native Veterans is limiting this vulnerable, underserved population from the healthcare they need and deserve. NCUIH and UIO leaders have been testifying before Congress for years that the MOU is not being recognized for UIOs. Members have said this is an "easy fix," and "an oversight," so we are happy to see that there is now a bill to address this issue once and for all. We maintain that as part of the I/T/U, the VA already has the authority to reimburse title V UIOs, but we are happy Congress is taking the next step to address this important issue. Between 2012 and 2015, the VA reimbursed over \$16.1 million for direct services provided by IHS and Tribal Health Programs covering 5,000 eligible Veterans under the IHS-VA MOU. In spite of the federal trust responsibility to AIANs, the VA had decided to deem UIOs ineligible to enter into the reimbursement agreement under the IHS-VA MOU. For context, UIOs are already extremely underfunded and receive less than \$400 per patient from IHS, versus national health expenditure rates of almost \$10,000 per patient. In 2018, UIOs received a total of \$51.3 million to support 41 programs, and that is before IHS's administrative costs are removed. UIOs only receive one line-item appropriation in the IHS budget- the urban Indian health line item. UIOs don't receive purchase and referred care dollars, Federal Tort Claims Act coverage, 100% FMAP, or facilities funding. In fact, a few UIOs temporarily closed during the shutdown due to the lack of parity within the IHS system. VA reimbursement, even half of the \$16.1 million, would drastically help our facilities. It is time to fix this issue for good.

The VA's position is that UIOs are not identified in 25 U.S.C. §1645(c) as one of the organizations it may reimburse. However, it is important to note that **two UIOs are covered under the IHS-VA MOU because VA officials report that those programs function as a service unit as defined in 25 U.S.C. §1603(20).**

There have been several Government Accountability Office (GAO) reports conducted on the VA-IHS MOU - two reports on VA and IHS implementation and oversight of the MOU were released in 2013 and 2014. In March 2019, the GAO released a study entitled "*VA AND INDIAN HEALTH SERVICE Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans*". The GAO was asked to provide updated information related to the agencies' MOU oversight. This report examines (1) VA and IHS oversight of MOU implementation since 2014, (2) the use of reimbursement agreements to pay for AI/AN veterans' care since 2014, and (3) key issues identified by selected VA, IHS, and tribal health program facilities related to coordinating AI/AN veterans' care. In this report the GAO report makes the recommendation to both the VA Secretary and IHS Director to ensure measurable targets to track and measure performance, and has jump started efforts by VA to conduct consultation and confer. The VA is currently working with IHS to revise the MOU, stating their goals for this revision: **increase access** and quality of care for AI/AN veterans, improve health promotion and disease prevention, encourage patient centered collaboration and communication, consult with Tribes at the regional and local levels, ensure appropriate resources for services for AI/AN Veterans. Furthermore, the VA in a 2018 report to Congress stated themselves that UIOs under IHCIA are "eligible, capable, and are entitled to receive reimbursement for healthcare services they provide to AI/AN veterans from any payer" as part of the IHS I/T/U system. They also acknowledge that they have no current legal authority to allow

for expanding existing reimbursement agreements to include UIOs. If the goal is to **increase access** to care for AI/AN veterans, then now is the time for the VA to finally recognize that UIOs are a critical part of the Indian Health Service (IHS), acknowledge the needs of the significant amounts of AI/AN veterans who live in urban areas and expand the reimbursement agreement to include UIOs.

Both the legislative and executive branches **strongly** support efforts to increase timely access of healthcare for Veterans. Recognition of the MOU for UIOs and urban Indian Veterans would be highly consistent with those efforts. NCUIH has worked closely with the National Congress of American Indians who recently passed a resolution in support of our efforts to ensure parity for UIOs. This resolution is being submitted as a part of my testimony today.

In Conclusion

We strongly recommend that the VA reimburses UIOs for services rendered to Native Veterans. These reimbursements must be accompanied by outreach and advocacy resources to ensure that Native Vets are aware of all the health care options available to them in their communities. The VA is known for its challenging wait times, yet we all agree access to care for Veterans is a priority. UIOs can provide excellent, culturally competent primary care, dental, and behavioral health services to Veterans, while reducing the burden on the VA and allowing it to focus on the specialty services it provides best.

Our national interest of serving Veterans will be best carried out when we extend the collaborative arrangements already agreed to by the VA and IHS to include the bulk of our nation's Native American Veterans—who either are or could be served by a UIO.

NCUIH strongly recommends, pursuant to **Section 405(c) of the Indian Health Care Improvement Act**, that the VA-IHS MOU be expanded to include reimbursement for care

provided by the UIOs. Thank you for holding this hearing today and for the Committee's support of urban Indian healthcare issues. We strongly support H.R. 4153 and look forward to working with Congress to serve as an expert resource regarding this legislation.