National Indian Health Board

**Department of Veterans Affairs Tribal Roundtable Discussion**

**Tribal Talking Points**

**Heard Museum - Phoenix, Arizona**

**July 12, 2017**

## I. BACKGROUND

On September 28, 2016, the Department of Veterans Affairs (VA) facilitated consultation and requested comments on the VA's community care consolidation effort. In response to Tribal comments, the VA renewed existing reimbursement agreements through June 30, 2019.

The VA has posed the following questions to receive feedback from Tribal leaders and Tribal representatives.

- Do THPs have any suggestions on how VA can move from the all-inclusive rate payment methodology to more recent industry standard payment methodology (e.g., value based rate structure)?
- Do THPs have quality related standards in place that can be shared with VA and utilized as the basis for developing a value based rate structure?
- Do THPs have any suggestions related to care coordination between VA and THPs?
- Do THPs have any established care coordination procedures that may be utilized as basis for enhancing care coordination between VA and THPs?

## II. DISCUSSION - TRIBAL TALKING POINTS

### *Proposal to continue the current VA Reimbursement Agreements with IHS and THPs*

We propose that the VA does not consolidate the current memorandum of understanding (MOU) into a larger Community Care Program or standardize IHS/THP agreements.

- IHS and Tribal health programs (THPs) are not considered as part of the core provider network or non-department provider. This was reaffirmed by the VA in the department's *Plan to Consolidate Community Care Programs* report to Congress. THPS are not contractors, procurement sources, or outside private vendors.

- VA community care network partnerships with IHS, Tribes and Tribal organizations, as well as urban Indian organizations are crucial to deliver health care services, reduce redundancies in federal health services and increase access to quality health care.

- Section 405(c) of IHCIA, as amended and enacted by the Affordable Care Act (ACA), requires the VA to reimburse IHS, an Indian Tribe, or a Tribal organization for services provided to beneficiaries eligible for services from either the VA or IHS.

- RECOMMENDATION: We do not support or recommend that Tribal agreements be standardized to incorporate Choice Act provisions because the current agreements are successful in providing additional care to AI/ANs and respect the government-to-government relationship. IHS and THPs are federal health care programs that implement the federal treaty obligation to provide health care to American Indians and Alaska Natives (AI/ANs). Therefore we recommend that IHS and THPs continue to be able to directly bill and receive reimbursement from the VA without going through an intermediary service.

- VALUE-BASED RATE STRUCTURE PARTICIPATION CONCERNS:
    - Tribal health care programs may lack the financial resources to make the initial operability resources and it could take years to recoup the investments.
    - The Native veteran population is a distinct patient population in diverse geographic locations, which can affect the ability of the practices to manage their care, especially when the majority of the American Indian population is placed in rural and underserved health care delivery areas.
    - Small and rural providers in Indian Country with small patient populations may be susceptible to skewed quality and efficiency measures due to serving Native veteran patients that may require more care or more expensive care.
    - Tribal health care programs with fewer staff may have difficulty in balancing for direct patient care, care management activities, and additional administrative activities for comprehensive participation.

- RECOMMENDATION: We propose the need for a more consistent coordination of care between IHS/VA/THPs to ensure the future and stability of the program. Additionally, there is a need to strengthen the infrastructure, communications, and operations of reimbursement agreements between VA/IHS/THPs.

***Recommendation to not alter the agreed upon reimbursement rates***

From 2012 to 2015, IHS and Tribal health programs have been reimbursed $33 million from the last 5 years from the VA. There is $9 billion for VA to purchase care in the community. The $33 million in reimbursements to IHS and THPS is approximately 0.06% of the entire Veterans' Health budget and 1% of the IHS budget. Therefore, $33 million reimbursed to IHS and THPs is a drop in the bucket compared to the $9 billion designated for community care. To date, the reimbursements received and the number of Native veterans cared for are low in comparison to other community care providers. While there are approximately 140,000 eligible AI/AN veterans, only 6,000 use the VA system for health care.

- The Choice Act does not pay at the agreed upon Office of Management & Budget (OMB) rate, which is cost-based and was included in the initial MOU. Each Federal program that reimburses IHS and Tribes for health care (Medicare and Medicaid) does so at these

rates. IHS appropriations are currently at approximately $3,200 per patient, far below VA health resources per patient and national average health spending.

- RECOMMENDATION: We do not support any reduction in the reimbursement rate, given the serious health disparities and social determinants of health for Native Veterans. The health disparities for Native veterans may not be conducive to the value-based methodology without an adequately financed health system to address the issue. We understand that the MOU specifically deals with reimbursement for care and that the other major health disparity issues that Tribal communities constantly face are well beyond the scope of the VA. Diminishment of the current reimbursement rates would only further harm Tribal citizens and contribute to the struggle of meeting basic health care needs by limiting quality health care available for Native veterans in Tribal communities.

- The Indian health system has varying degrees of structural differences in cost depending on area. IHS does not provide health care along with factors included in the Inpatient Prospective Payment System (IPPS) cost report, such as infrastructure, level of need and costs that are generated into the cost of providing care. Therefore, the Indian health system cannot be compared to the private sector utilizing the IPPS cost report for the value-based payment methodology.

- Another significant issue is the fact that many Native veteran patients are not assigned to a single provider. So you will have a Native veteran who is seeing multiple providers. The health care services can be crossed for the patient, but it will become a burden if the value-based method would only apply to the Tribal health program.

- RECOMMENDATION: We do not support or recommend that Tribal agreements be standardized to incorporate Choice Act because the Choice Act provisions are less desirable for IHS and THPs for a number of reasons, including, the Act's requirement for preapprovals and lower reimbursement rate. Pre-approvals delay care, interrupt continuity of care for Veterans and increase costs, due to the need to travel and the requirement to see additional VA providers for pre-approval.

- QUESTIONS:
    - Please describe the types of agreements have you negotiated with private hospitals?
    - How would you measure the outcome value for value-based health care?
    - What have the outcomes been for your current value-based agreements
    - What are the incentive payments?
    - Are there rural and/or small private sector hospitals that participate in the value-based payment agreement with the VA and have successful outcomes equal to those of other private sector hospitals?
    - Can you share the private sector value-based payment methodology agreement template with Tribes?

***Tribal support for current Agreements to extend to health care services provided to non-Native Veterans***

We believe we can and should do better for our veterans in offering care at the most convenient and culturally sensitive locations. The existing MOU is the least burdensome manner to accomplish timely access to care. Some THPs are providing limited health care services under the Choice Act or Community Care Agreements. However, these services are to fill gaps, not to extend greater access or quality to all veterans. Section 405 (c) of the Indian Health Care Improvement Act (IHCIA) provides the authority to include services to non-Native veterans. Therefore, the VA has the authority under the IHCIA to extend the current agreements for services provided to non-Native veterans.

- RECOMMENDATION: We support offering care to non-Native veterans using the current MOU, due to the fact that many I/T/U health care facilities are located in remote, rural areas and would provide more timely access to the veterans living in those areas, often where no other health care providers exist. However, the Choice Act is administratively burdensome for THPs to administer, which creates a barrier to care for veterans. Therefore, IHS and each THP must approve the provision to provide care to non-Native veterans.

***Full implementation of Section 405 (c) of IHCIA***

To date, the VA-IHS/THPs MOUs have proven to be successful in facilitating patient care and has proved to be the least administratively burdensome for all parties. However, the Indian Health Care Improvement Act (IHCIA Section 405(c) has not been fully implemented. The current national agreement and, by default, nearly all THP agreements do not include reimbursement for Purchased/Referred Care (PRC).

- Reimbursement for specialty care provided through PRC is essential to ensure that Native veterans receive the best care possible. Nationally, only one in thirteen visits is an inpatient visit, but veterans often need additional services which cannot be provided directly by an IHS Service Unit or THP.

- RECOMMENDATION: THPs, in particular, work hard to provide a seamless health care experience. Lack of coordination of care for specialty care paid by PRC will only exacerbate a veteran's experience with both systems. We recommend that the VA include PRC in the initial agreement so that there are no further rations for the amount of health care provided by IHS and THPs to Native veterans and other eligible AI/ANs in the system.

- RECOMMENDATION: VA should work to find a solution to reimburse for care provided by traditional healers. Traditional healers are an essential component of care within many Indian communities and veteran's choices should not be limited to a certain type of provider.

**Discontinue the collection of co-payments from AI/AN Veterans**

Currently, American Indians and Alaska Natives (AI/ANs) who seek health care services at a VA facility are assessed co-payments.

- RECOMMENDATION: We recommend the discontinuation of the practice of collecting co-payments from AI/AN Veterans. Currently, AI/ANs who enter a VA facility are assessed and pay co-payments. We believe that this practice does not align with the trust responsibility to provide health care to all AI/ANs. IHS and THPs are the payer of last resort (section 2901(b) of the Affordable Care Act) whether or not there is a specific agreement in place for reimbursement. Therefore, neither the Native Veteran nor the Indian health system should be responsible for any co-payments.