

# National Indian Health Board



Submitted via email: [tribalgovernmentconsultation@va.gov](mailto:tribalgovernmentconsultation@va.gov)

November 7, 2016

Mr. David J. Shulkin, MD  
Under Secretary for Health  
U.S. Department of Veterans Affairs  
Office of Intergovernmental Affairs (075F)  
810 Vermont Avenue, NW, Suite 915G  
Washington, DC 20420

**RE: Tribal Health Programs – Community Care Consolidation Tribal Consultation**

Dear Under Secretary for Health,

On behalf of the National Indian Health Board (NIHB), I write to submit comments in response to the Notice of Tribal Consultation published on Thursday, September 29, 2016 in the Federal Register requesting input from Tribes on the Veterans Health Administration's (VHA) Proposal to Consolidate Community Care Programs into one standard program with standard rates. NIHB appreciates the opportunity to provide input on improving continuity of care and health care access through community care for American Indian and Alaska Native (AI/AN) Veterans in Tribal communities across Indian Country.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

American Indian and Alaska Natives (AI/ANs) serve in the armed forces at a high rate and have a higher concentration of female service members. AI/AN Veterans are also more likely to lack health insurance and have a disability, service-connected or otherwise, than Veterans of other races.<sup>1</sup> Unfortunately, many AI/AN Veterans do not have faith and trust in the VA after past experiences and delays in enrollment, denial of care, or lack of access to VA services. As a result,

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<sup>1</sup> United States Department of Veterans Affairs, American Indian and Alaska Native Service Members and Veterans 2 (September 2012).

Tribal memoranda of agreements (MOAs) and engagement with the Tribal health system, including the Indian Health Service (IHS), Tribes and Tribal organizations, as well as urban Indian organizations provides a method for the federal government and agencies to preserve and build on the existing relationships that the VA has with IHS and Tribal Health Programs.

NIHB appreciates the opportunity to provide Tribal input regarding the Tribal health programs participation in the core provider network, and the model under which Tribal health programs deliver quality health care to all eligible, VA enrolled Veterans. AI/ANs serve in the U.S. military at higher rates than any other race, yet they are underrepresented among Veterans who access the services and benefits they have earned. It is critical that AI/ANs Veterans not fall through the cracks and that they have access to the best care possible, whether that is through the I/T/U system or through the VA.

### ***Background***

The Indian Health Service (IHS) is a federal health care program with a similar status to the U.S. Department of Veterans Affairs (VA) with the exception of the following differences: (1) American Indians and Alaska Natives (AI/ANs) have treaty rights for the provision of health care; (2) IHS is severely underfunded in comparison to other federal health care programs, for example the VA medical spending per patient is \$8,760 compared to \$3,136 IHS medical spending per patient; and (3) Unlike other federal mandatory health programs, IHS is subject to sequestration and funded through discretionary funds, which are not increased with population growth, inflation, nor new technology.

Section 813 of the Indian Health Care Improvement Act (IHCIA) authorizes Tribes and Tribal organizations to provide health care services to non-beneficiaries.<sup>2</sup> As a result, many Tribes and Tribal organizations already serve non-IHS-eligible beneficiaries, many of whom may be Veterans. In addition, 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.<sup>3</sup> Since the passage of IHCIA, the Veterans Access, Choice and Accountability Act of 2014 (Choice Act) established an additional opportunity for Tribal health programs to serve Veterans. However, the Choice Act provides lower reimbursement rates and is more burdensome for Tribal health systems to implement.

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. **We highly recommend that the VA maintain and strengthen the current agreements between VA, IHS, and Tribal Health Programs (THPs). In addition, strategic partnerships with IHS, THPs, and Federally Qualified Health Centers (FQHCs) must be enhanced to partner in providing higher quality care to Veterans and to better manage costs.** In support of our recommendations, we set our

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<sup>2</sup> 25 U.S.C. § 1680c. IHS may also serve non-AI/ANs with the consent of the tribes being served by the IHS directly operated health care program.

<sup>3</sup> 25 U.S.C. § 1645(c)

responses to the questions posed by the VA regarding Tribal health program community care consolidation below:

*(1) What would be the impact of transitioning from the existing reimbursement agreement structure, which requires each Tribe to enter into an individual reimbursement with VA, to a standard arrangement for reimbursement for direct care services provided to eligible Veterans managed by a third part administrators for VA?*

The Veterans Access, Choice and Accountability Act of 2014 (Choice Act) was enacted because many Veterans lack access to health care benefits to which they are entitled by law, often because the nearest VA facility is too far away or because the wait times are far too long for the Veteran to obtain care. For Veterans in rural areas, the closest health care facility is often an Indian health care program operated directly by an IHS service unit or Tribal health program, which, when paired with the disproportionately high number of AI/AN Veterans makes these programs familiar with the unique nature of Veteran health care and well suited to provide Veterans with health services in partnership with the VA. The inclusion of I/T/U facilities in Section 101 of the Choice Act underscores the understanding of the vital role of I/T/Us to increase access to quality health care within the VA health care system. The current VA-IHS/THP agreements have proven beneficial for AI/AN Veterans in the Indian health care system. Veterans have been able to receive quality health care services at local IHS and Tribal health care facilities, which are often much more accessible and conveniently located than the nearest VA facilities. However, the MOU agreements are not flawless and can certainly be strengthened.

**NIHB requests that the VA establish a Federal/IHS/Tribal workgroup to engage in discussions and provide recommendations on issues related to the MOU agreements.** To the extent that new model language or agreements are considered to streamline I/T/U contracting with VA to provide services to AI/ANs, NIHB considers it imperative that Tribal and urban health program representatives are at the table with IHS in the negotiations or discussions with the VA. Such a process would assure that the differences among the IHS, Tribal and urban Indian health programs are recognized and addressed from the start. There is vast experience among Indian health providers in working through representatives to negotiate model agreements that do not displace government-to-government negotiations and individual program autonomy, but speed up the process of reaching workable solutions that can be rapidly implemented.

The VA-IHS/THP agreements honor the government-to-government relationship and the unique status of Tribes providing health care to Veterans on behalf of the federal government. **NIHB supports a template Agreement for THPs to utilize with the ability to provide provisions specific to their Tribal facility capacity and the needs of their patients. NIHB recommends an auto-renewal option for the Agreements if both parties agree.** According to the June 2013 Government Accountability Office (GAO) Report there are significant delays in finalizing agreements to expand services.<sup>4</sup> It has been reported that it can take years to finalize service expansion agreements between VA and IHS or THP facilities, which could limit incentives to

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<sup>4</sup> GAO Report: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans (June 2013).

pursue such agreements. For example, in one area it took three years to process an agreement to allow a VA medical center to use a small area in an IHS facility for two days per week, in part due to lengthy legal and contracting reviews by the VA and layers of approval to establish an agreement between the local VA medical center and the THP provider to expand optometry services to AI/AN Veterans. **NIHB recommends that the time period to approve the VA-IHS/THP agreements be shortened to increase health care incentives.**

**NIHB strongly opposes the consolidation of the VA-IHS/THP agreements with outside private vendors as a procurement source.** IHS and THPs are federally funded programs carrying out federal responsibilities alongside the Veterans Health Administration (VHA). IHS and, therefore, THPs are not contractors, procurement sources, or outside, private vendors. As such, we continue to recommend that IHS and THPs be allowed to directly bill and receive reimbursement from the VA without going through an intermediary service, which would add another costly layer of bureaucracy. IHS is a federal health care program that implements the treaty obligation for the provision of health care to eligible AI/ANs across the United States. The MOU agreements promote access to culturally competent exceptional health care for Veterans near home, including services provided in rural and medically underserved communities. A breach in the current agreements will be a failure of the federal government to provide treaty secured care to AI/AN Veterans across the Nation.

*(2) Would Tribal health programs be interested in expanding direct care services under this new structure to include reimbursements for care provided to all Veterans enrolled in VA health care, regardless of whether they are eligible for IHS-funded health care or not?*

The current VA-IHS/THP agreements have proven to be a successful method to date that has increased access to care for AI/AN Veterans. The current agreements must be renewed to secure the continuity of care. The current agreements meet all statutory stipulations and are within current authority to enact. **NIHB supports 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. The existing MOU is the least burdensome manner to accomplish timely access to care. Today, some THPs are providing limited services under Choice Act or Community Care Agreements. However, these services are just filling gaps, not actually extending greater access or quality to all Veterans. **It has been and continues to be our position that the VA should honor and fully implement Section 405 (c) of the Indian Health Care Improvement Act (IHCIA) to include services to non-Native veterans.** We believe that VA has the authority under IHCIA and that such an extension could continue to provide equal access for all Veterans.

The conditions of the authority to serve non-AI/AN Veterans in the Agreements should be easily exportable to other VA agreements with Indian health programs through referrals for non-Native

Veterans to the Indian Health Program or that the non-AI/AN Veteran lives more than 40 miles from a Veterans Health Administration (VHA) program that can provide the service the Veteran needs. The referrals that occur for Veterans who live near a VHA facility occur when VHA determines that its facilities lack adequate capacity, usually because of difficulties recruiting adequate numbers or types of providers or lack adequate facilities and equipment, such as the inability to perform mammograms or other specialized preventive or treatment services.

In instances where an AI/AN Veteran is eligible for a particular health care service from both VA and IHS, VA is the primary payer. Under Section 2901(b) of the ACA, I/T/Us are payers of last resort regardless of whether or not a specific agreement for reimbursement is in place. The MOU provides for a broad range of collaboration between VA and IHS. One goal of the MOU is to bring together strengths and expertise from each agency to improve both the care and services provided by each organization. Neither the AI/AN Veteran, nor any IHS/Tribal health care facility should be responsible for co-payments for services provided at or referred through Tribal health care facilities.

***(3) Would Tribal health programs be interested in receiving standard reimbursement rates based on Medicare rates plus a feasible percentage of those rates to minimize improper payments and comply with industry standards?***

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 between the VA and IHS. Each Federal program that reimburses IHS and Tribes for health care (Medicare and Medicaid) does so at these rates. The current reimbursement structure is based on average costs calculated by an independent professional cost report preparer engaged by the IHS utilizing costs from audited financial statements and workload statistics maintained by the IHS in its National Database Warehouse. The calculated rates, which are calculated on a “per visit” or “per encounter” basis, are reviewed by the Centers for Medicare & Medicaid Services (CMS) and the OMB and, once approved, are published in the Federal Register for the purpose of reimbursing all IHS facilities for medical care, including Medicare, Medicaid, and others.

IHS appropriations are currently at approximately \$3,200 per patient, which is far below VA health resources per patient and national average health spending. IHS and THPs are only funded around 54% of need, therefore lower reimbursement rates for more services will further drain health care resources within the system.<sup>5</sup> In 2015, the VA provided only \$33 million, less than one tenth of a percent of the Veterans Health Administration (VHA) budget, in reimbursements to IHS and THPs. IHS and THPs utilize robust, established provider networks that round out the services provided directly to AI/AN Veterans. These networks are critical in providing care to Veterans living in rural and remote areas. **NIHB strongly opposes the standard rate and any reduction in the rate because of the circumstances that AI/ANs face with regards to physical health and**

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<sup>5</sup> NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP’S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2018 BUDGET, 10 (2016)

**social determinants of health.** Any reduction in reimbursement will further exacerbate the conditions that the Indian Health System faces.

With regard to “improper payments,” there is no basis to suggest that any of the care provided or payments received were improper. The appropriateness of the payment is addressed above. As to the health care delivered, VA has access to health records that establish that the care provided by Tribal health programs is clinically needed and necessary. If the VA has evidence of improper payments, VA should provide the data to IHS and THPs for this issue to be directly addressed.

*(4) Would Tribal health programs be interested in extending existing reimbursement agreements between VA and Tribal health programs through December 2018, and ensuring any new reimbursement agreements between VA and tribal health programs extend through December 2018, as VA works in collaboration with Tribes and other VA stakeholders on implementing a consolidated community care program?*

**NIHB requests that the VA-IHS/Tribal Health Program (THP) Memorandum of Understanding (MOU) be extended until December 2018, at a minimum.** Failure to extend the currently operating VA-IHS/THP MOUs will significantly disrupt access to health care for AI/AN Veterans. For planning and capacity purposes it is critical in the care of our AI/AN Veterans that stability and continuity is offered. In order to facilitate this the current VA-IHS/THP MOU must be extended until December 2018, at minimum, to facilitate planning and capacity support reflective of the initial Tribal Sharing Agreements.

The VA and IHS have taken a variety of actions to improve access to care for AI/AN Veterans under the 2010 MOU; however according to stakeholders, these agencies face substantial implementation challenges. Prioritization of the MOU implementation is lacking and leadership has not made implementation a priority, which threatens the ability of the agencies to move forward. Therefore, there needs to be reasonable assurance through quality metric evidence that the objectives of the MOU related to access to care are being addressed. The VA and IHS must establish written policy or guidance designating specific roles and responsibilities for agency staff to hold leadership accountable and improve implementation and oversight of the MOU.

#### *Additional Concerns*

**NIHB requests that the VA provide equal access to the Consolidated Mail Outpatient Pharmacy (CMOP) Program.** Another aspect of the partnership between VA, IHS, and THPs that should be addressed is the ability of THPs to access CMOP. It is essential in maintaining current services when IHS transfers pharmacy responsibilities to a Tribe. Access to CMOP would align IHS, Tribal and the VA systems mission by decreasing transportation costs for the fulfillment of prescriptions and wait times to fill a prescription. Extension of this CMOP access would also increase medical compliance.

**NIHB recommends 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. NIHB

believes that this practice is unacceptable and 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. Neither the AI/AN Veteran nor IHS should be responsible for any co-payments.

### *Conclusion*

Thank you for this opportunity to provide Tribal comments and recommendations for the VA-IHS/THP community care consolidation proposal, we look forward to further engagement with the VA. NIHB hopes that the VA, in the spirit of its commitment to fulfilling its Tribal consultation policy and shared interest in improving AI/AN Veteran access to quality health care, will work with Tribes to advance access to quality health care for our Veterans. NIHB is committed to promoting quality health care to AI/AN Veterans. Please contact NIHB's Director of Federal Relations at [ddelrow@nihb.org](mailto:ddelrow@nihb.org) or (202) 507-4072 if there are any additional questions or comments on the issues addressed in these comments.

Sincerely,



Lester Secatero  
Chairman, National Indian Health Board

cc: Mary Smith, Principal Deputy Director, Indian Health Service