

National Indian Health Board



Submitted via e-mail: Tribalgovernmentconsultation@va.gov

June 10, 2019

U.S. Department of Veterans Affairs
VACO/OTGR
Attn: Clay Ward
810 Vermont Ave. NW, Ste. 915a
Washington, DC 20420

Re: Improving the Quality of Care for our Nation's American Indian and Alaska Native Veterans

Dear Ms. Habel,

The National Indian Health Board (NIHB)¹ appreciates the opportunity to comment on the Dear Tribal Leader letter dated April 16, 2019, regarding stakeholder consultation under the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018. The MISSION Act requires the United States (U.S.) Department of Veterans Affairs (VA) to develop a strategic plan to meet health care demands for veterans, in consultation with Tribal government leaders and other stakeholders. AI/ANs serve in the U.S. military at higher rates than any other race, yet AI/ANs are consistently underrepresented among veterans who access the services and benefits they have earned.² It is critical that, moving forward, AI/AN veterans are not overlooked and that they have access to the best care possible—whether they choose to seek care within the Indian health care system or the Veterans Health Administration (VHA).

¹ 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.

² There are approximately 146,000, AI/AN veterans in the U.S. National Center for Veterans Analysis and Statistics: Veteran Population (last updated May 24, 2019), https://www.va.gov/vetdata/veteran_population.asp.



We appreciate that the VA is undertaking this Tribal consultation but we remind the VA that Tribes are not just another “stakeholder,” and that the United States has a unique legal and political relationship with American Indian and Alaska Native Tribal governments. This relationship was established through treaties and affirmed by the United States Constitution, Supreme Court decisions, federal laws and regulations, and presidential executive orders. Central to this relationship is the federal government’s trust responsibility to protect the interests of Indian Tribes and communities, including through the provision of health care and public health services to AI/ANs. The federal government’s trust responsibility to provide health care to all American Indians and Alaska Natives extends across each of its departments and agencies and includes the VA.

A 2011 report showed that approximately one-quarter of Indian Health Service (IHS)-enrolled veterans use the VHA for health care, commonly receiving treatment for diabetes mellitus, hypertension or cardiovascular disease in both organizations.³ Some of the reasons cited for dual use include preference for IHS services in general, and longstanding relationships with IHS staff, or preference for VHA for specific types of care based on quality, cost, and customer service.⁴ On the Indian health side, more than 2,800 AI/AN veterans are served at IHS facilities.⁵

Use of multiple healthcare systems is permitted among VHA and IHS enrollees. In instances where an AI/AN veteran is eligible for a particular health care service from both the VA and IHS, the VA is the primary payer. Under section 2901(b) of the Patient Protection and Affordable Care Act (ACA), health programs operated by the IHS, Tribes and Tribal organizations, and Urban Indian organizations (collectively referred to as the “I/T/U”) are payers of last resort regardless of whether or not a specific agreement for reimbursement is in place. Creating reimbursement agreements that work for Tribal health care systems is complicated by the fact that VA has 172 medical centers, all of which potentially have a relationship with a Tribal Health Program (THP).⁶ To date, VA has reimbursed approximately \$94 million to IHS programs.⁷ Recent developments in VA and Tribal relationships have been positive, with senior VA officials reporting the establishment of over 114 signed agreements with THPs and 77 implementation agreements. The understanding of Tribes is that the commitment made by the VA in each agree will be reinforced by the Mission Act consultation, and increase the opportunities for collaboration in the future.

Tribal Implications and Priorities

NIHB and Tribes are committed to improving the health care outcomes of American Indian/Alaska Native veterans and their families. As such, we appreciate the VA’s request for Tribal Consultation on the MISSION Act and Tribal priorities, and have provided our responses below.

³ Kramer, BJ, Wang M, Jouldjian S, Lee ML, Finke B, Saliba D. Healthcare for American Indian and Alaska native veterans: The roles of the veterans health administration and the Indian Health Service. *Medical Care*.

⁴ See Dual Use of Veterans Health Administration and Indian Health Service: Healthcare Provider and Patient Perspectives, B. Josea Kramer, Rebecca L. Vivrette, Delight E. Satter, Stella Jouldjian, Leander Russell McDonald *J Gen Intern Med*. 2009 Jun; 24(6): 758–764. Published online 2009 Apr 18.

⁵ VA/IHS listening session held on May 15, 2019.

⁶ Veterans Health Administration: About VA (last updated Dec. 27, 2018), <https://www.va.gov/health/aboutvha.asp>.

⁷ VA/IHS listening session held on May 15, 2019.

I. What are the most important health care needs of Veterans in your area now and in the future?

1. VA reimbursement to IHS and Tribal providers for services provided under the purchased/referred care (PRC) program. PRC consists of purchased health care that is provided through IHS and THPs. Reimbursement for specialty care provided through PRC is essential to ensure that AI/AN veterans receive the best care possible. Nationally, only 1 in 13 visits is an inpatient visit, but veterans often need additional services which cannot be provided directly by an IHS Service Unit or THP. The VA currently reimburses the IHS and THPs for care that they provide directly under the IHS/VA Memorandum of Understanding (MOU). Despite repeated requests from Tribes, the VA has not provided reimbursement for PRC specialty and referral care provided through IHS/THPs. AI/AN veterans should have the option to obtain care from either the VA or an Indian health program. If the Veteran chooses an Indian health program, that program should be reimbursed even if the service could have been provided by a VA facility or a program in the same community. As a step toward mitigating the confusion surrounding reimbursement for care provided by the VA, NIHB recommends the VA include PRC in future IHS/THP reimbursement agreements, so that there is no further rationing of health care provided by IHS and THPs to American Indian and Alaska Native veterans and other eligible AI/ANs. This would ensure the Indian Health Care Improvement Act (IHCIA)⁸ is fully implemented and ensure the VA fully reimburses for services provided by IHS/THPs as required in section 405(c) of the IHCIA.

At the community level, the Office of Rural Affairs should collaborate with hospitals to create culturally appropriate systems, or provide culturally sensitive training to employees to explain the process of receiving care and the requirements for referrals to medical institutions outside of the IHS.

2. Improved quality and care coordination between the IHS and the VA.⁹ Lack of coordination between the IHS and VA is a major barrier to obtaining quality health care. The GAO, in its recent report on oversight and coordination of care for AI/AN veterans identified 3 key challenges:¹⁰ referring patients to VA facilities, information technology interoperability and

⁸ In 2010, the Indian Health Care Improvement Act (IHCIA) was permanently re-authorized and included an amendment that allows the IHS to collect reimbursement payments from the VA for services provided to eligible Native Veterans by the IHS and Tribal facilities. In October of 2010, an MOU between VA and IHS was renewed to establish coordination, collaboration, and resource-sharing between VA and IHS. Because the IHS system is chronically underfunded, it is heavily reliant on third party reimbursements from 3rd party payers like the VA. In fiscal year 2018, the VA reported its total disbursed dollar amount through reimbursement agreements at \$7.69 million to IHS and \$ 12.07 million to Tribally operated systems.

⁹ Care coordination has been an issue for AI/AN veterans for over a decade. *See* Military Medicine, Exploring Veteran Identity and Health Services Use among Native American veterans, <https://academic.oup.com/milmed/article/170/9/782/4577653> (“Some of the suggestions by our focus group participants for improving coordination included setting up systems for more comprehensive care (e.g., telemedicine), transferring funds from the VA system to the IHS to provide ongoing care for Native American veterans, and holding a VA clinic on the reservations once per month for older veterans who cannot travel to a VA facility”).

¹⁰ VA and Indian Health Service, Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans (Mar. 2019), <https://www.gao.gov/assets/700/697736.pdf>.

access, and high staff turnover.¹¹ Lack of care coordination and case management results in longer patient visits in primary care settings, can lead to instances of duplicated care, can cause delays in treatment, and can lead an AI/AN veteran to feel like he or she being passed off from one system to the other. To ensure that AI/ANs experience as little disruption in health care treatment as possible, the VA should provide written materials and training that can be used by AI/AN veterans and Indian health providers to determine the range of services that VA facilities and programs provide to VA beneficiaries, as well as services that are reimbursable by VA even if performed by a third party provider. This will help to improve coordination of care and referral from IHS/THPs to VA programs when an AI/AN veteran chooses the VA system for care, or the Indian health system cannot provide the services needed by the AI/AN veteran.

3. Interoperability of EHR between IHS and VA. Difficulties in achieving IT interoperability among VA, IHS, and THP facilities pose significant problem in coordination of care for American Indian and Alaska Native veterans.¹² The VA and IHS have not identified a systemic solution to increasing interoperability between Tribes and VA hospitals. This results in a scenario where a THP provider—having treated a veteran and referred the veteran to the VA for specialty care—would not receive the veteran’s follow-up records as quickly as if they had access to each other’s systems. Although the VA is taking steps to overhaul its system for electronic health record exchange by transitioning to the Cerner system, this has forced the IHS, which is largely dependent on VA IT, to re-evaluate its own health IT needs. Although the results of the IHS survey—the Health IT Modernization Project—will not be available until fall of 2019, AI/AN veterans are suffering within the IHS and VA systems now. VA must do what it can to provide technical assistance to Tribes at the local and regional levels to ensure some coordination of electronic health records can occur in the interim and into the future.

4. Suicide prevention and treatment of Post-traumatic stress disorder (PTSD) and mental health. Destructive federal Indian policies and unresponsive human service systems have left AI/AN veterans and their communities with unresolved historical and generational trauma. From 2001 to 2015, AI/AN veteran suicide rates increased by 62% (50 in 2001 to 128 in 2015).¹³ The VA’s Veteran Outreach Toolkit lists AI/ANs as an “at-risk” population, citing this troubling suicide rate.¹⁴ Additionally, AI/ANs grapple with complex behavioral health issues at higher rates than any other population—for children of AI/AN veterans, this is compounded by the return of a parent who may suffer from PTSD. Outreach events for AI/AN communities should be a VA priority to increase wellness, decrease stigma, and prevent suicide. Continuing to engage with Tribal leaders to assist in carrying out these activities is essential.

The 2010 Memorandum of Understanding (MOU) between the VA and IHS outlines twelve areas of active collaboration between VA and IHS and is in line with the aforementioned priorities. As the VA works to strengthen the MOU ahead of its 10th anniversary, we urge the VA to pay particular attention to working with Tribes to resolve these issues.

¹¹ VA and Indian Health Service, Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans (Mar. 2019), <https://www.gao.gov/assets/700/697736.pdf>.

¹² VA and Indian Health Service, Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans (Mar. 2019), <https://www.gao.gov/assets/700/697736.pdf>.

¹³ VA, Veteran Suicide by Race/Ethnicity: Assessments Among All Veterans and Veterans Receiving VHA Health Services, 2001-2014 (Aug. 2017) (citing CDC statistics).

¹⁴ VA, <https://www.va.gov/ve/docs/outreachToolkitPreventingVeteranSuicideIsEveryonesBusiness.pdf>.

II. If you were to redesign the VA health care system, what are the five most important changes, if any, you would like to suggest?

1. Development of payment and reimbursement policies should be an extremely high priority and Tribes and Tribal health programs should actively participate in the effort. The VA should reimburse Tribal health care providers and the IHS for services provided by any licensed or certified provider, including certified community health aides, behavioral health practitioners, and dental health aides/therapists, in order to assure the availability of services to veterans living in the most remote communities and to address shortages in the number of providers. Reimbursement should be made for services delivered through telehealth and telemedicine applications in order to reduce unnecessary travel costs and provide for greater access to all levels of care in the most remote communities and specialty care in a much broader range of Indian health programs. Any prior authorization or other VA policies that limit reimbursement to non-VA providers should be expressly waived so long as the AI/AN veteran is obtaining medically necessary care through an Indian health program. Reimbursement for services provided by Tribal health programs should be made without requiring any prior agreement between the Tribal health program and the VA. Further, reimbursement should be made according to the Medicaid rates published annually in the *Federal Register* for Indian health programs.¹⁵

2. Improved AI/AN Veteran Enrollment and Screening for VA Benefits and Services. A critical issue facing AI/AN veterans is their persistent under-enrollment in the VA benefits programs to which they are entitled. To tackle this issue, VA should work with Area Indian Health Boards and Tribes to publish eligibility enrollment explanations that clearly identify who is eligible for VA benefits, how eligibility is determined, how an eligible AI/AN veteran can apply for VA benefits, and any applicable appeals process in the event that enrollment is denied. AI/ANs should be aware and can access all of the benefits and resources available with VA through their service.

3. Training and Sharing. The VA should provide specialized training to Indian health programs in health problems particularly prevalent among AI/AN veterans, such as screening, diagnosis and treatment of PTSD and brain trauma, and treatment and physical rehabilitation of veterans who have suffered physical injuries that create temporary or permanent limitations. These programs are especially important where there are behavioral health components of the AI/AN veteran's condition that affect not only the veteran, but others in the family or community. The VA should seek training for its behavioral health providers from specialists in serving AI/ANs with mental health or substance abuse issues, including how to work with the family and community in culturally appropriate ways to provide support for the veteran and his or her family.

III. What are the top three to five recommendations you would make to help VA improve how it provides care to Native American Veterans who use VA health care?

1. NIHB recommends that the Department of Veterans Affairs create guidelines to improve coordination of care from IHS and THP facilities to VA facilities. The GAO recently reported on actions needed from the VA and IHS to strengthen oversight and coordination of health care for AI/ANs. In the report, the GAO recommended that the VA secretary, in consultation with IHS

¹⁵ Authorized under section 401(d) of the IHCA.

and the Tribes, establish and distribute a written policy or guidance on how referrals from IHS and THP facilities to VA facilities for specialty care can be managed. It found:

The VA, IHS, and Tribal facility officials GAO spoke with described several key challenges related to coordinating care for AI/AN veterans. For example, *facilities reported conflicting information about the process for referring AI/AN veterans from IHS or Tribal facilities to VA, and VA headquarters officials confirmed that there is no national policy or guide on this topic.* One of the leading collaboration practices identified by GAO is to have written guidance and agreements to document how agencies will collaborate. Without a written policy or guidance about how referrals from IHS and Tribal facilities to VA facilities should be managed, the agencies cannot ensure that VA, IHS, and Tribal facilities have a consistent understanding of the options available for referrals of AI/AN veterans to VA specialty care. This could result in an AI/AN veteran receiving, and the federal government paying for, duplicative tests if the veteran is reassessed by VA primary care before being referred to specialty care.

NIHB strongly supports the GAO's recommendation to create written guidance as a collaboration practice.

2. NIHB recommends that the Department of Veterans Affairs, through its MOU with the Indian Health Service, provide guidance and support to exempt all Native veterans from copays and deductibles at the VA in accordance with the federal trust responsibility. Currently, AI/ANs who seek health care services at a VA facility are assessed co-payments. This practice does not align with the Federal trust responsibility to provide health care to all AI/ANs. IHS and THPs are the payers of last resort under section 2901(b) of the ACA, whether or not there is a specific agreement in place for reimbursement. Therefore, 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. NIHB recommends the discontinuation of the practice of collecting co-payments from AI/AN veterans.

3. Ensure and improve access to culturally competent quality health care for Native veterans. AI/AN veterans are more likely to lack health insurance, and have a disability, service-connected or otherwise, than veterans of other races. Many AI/AN veterans experience various challenges in receiving VA health care benefits in remote environments. AI/AN veterans experience health disparities and barriers to access quality health care service due to factors such as distance, poverty, mental health symptoms, historical mistrust, and a limited number of culturally competent providers. To address these challenges, NIHB recommends that the VA: educate agency officials about the uniqueness of the Indian health care system; ensure that any policy changes do not adversely affect the Indian health care system; and maintain and strengthen the implementation of the MOU between the VA, IHS, and THPs. Also, the VA should continue to support the creation of a VA Tribal Advisory Committee to properly ensure that the VA fulfills its trust responsibility to AI/AN veterans in a culturally competent and informed manner.

IV. What changes, if any, would you recommend to how VA develops and modifies its surveys to Veterans who use VA health care?

NIHB recommends that the VA distribute surveys that are uniquely tailored to American Indians and Alaska Natives. Legislation is pending in Congress that would authorize the VA to establish a Tribal advisory committee (TAC) to provide advice and guidance to the Secretary on matters relating to Indian Tribes, Tribal organizations, and Native American veterans. Should the VA TAC come to fruition, this is an opportunity from the VA to solicit consistent, up-to-date feedback, and to provide regular updates as to how many AI/ANs utilize or are utilizing surveys at the time.

Conclusion

AI/ANs have honorably defended the U.S. and are some of the most revered members of their communities. NIHB and the Tribes remain dedicated to lifting the unified voice of the community on this important health care issue. We thank you for this opportunity to provide our comments and recommendations to the VA as part of its MISSION Act Tribal consultation. We look forward to going more in-depth on issues surrounding AI/AN veterans at the fall VA/IHS consultation.

Should you have any questions regarding NIHB's comments, or for more information, please contact NIHB's Director of Policy, Devin Delrow, at ddelrow@nihb.org.

Sincerely,



Victoria Kitcheyan, Chair
National Indian Health Board

Cc: Ms. Stephanie Birdwell, Director, Office of Tribal Government Relations, United States
Department of Veterans Affairs