IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74502
Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: www.tribalselfgov.org

Delivered electronically to: tribalgovernmentconsultation@va.gov

November 2, 2016

David J. Shulkin
Under Secretary for Health
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington DC 20420

RE: TSGAC Comments on Veteran Affairs' Proposal to Consolidate Community Care Programs

Dear Under Secretary Shulkin:

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), I am writing to provide comments on the Veteran Affairs' (VA) Proposal to Consolidate Community Care Programs. Thank you for the ability to consult with the Veteran's Administration on the very important issue of improving continuity of care and health care access for Veterans. We expect that the VA, as part of the Federal government, will partner with us to provide the best possible health care for people who, not only have treaty rights to health care, but have also fought in every war, beginning with the American Revolution, at higher rates than any other race in this country.

As a Federal health care program, IHS is similar in status to the VA with the exception of three very important points:

1. Only American Indians and Alaska Natives (AI/ANs) have treaty rights for the provision of health care.
2. IHS is severely and chronically underfunded in contrast to every other Federal health care program. While the Veteran's Health Administration is funded at twice the level per person than IHS, in fact, the budget for 200,000 homeless veterans is equivalent to the total funding for the more than five million eligible individuals for IHS.
3. Unlike other Federal health care programs, IHS is a discretionary line item in the budget, not a mandatory line item. Parity with other programs is lacking, which results in IHS actually providing fewer services each year, because unlike mandatory health programs, IHS funding does not increase with population growth, inflation, or new technology, and is subject to sequestration.

Considering these differences, TSGAC provides the following comments in response to your consultation request, dated September 12, 2016:

Extend the current VA-IHS/Tribal Health Program (THP) Memorandum of Understanding (MOU) until December 2018, at minimum.
TSGAC has expressed its concern in previous communication and oral testimony that failure to extend the currently operating MOUs will disrupt care for AI/AN veterans. There are a number of issues that remain for both parties to explore prior to any substantive changes taking place. Therefore, we recommend that VA establish and utilize a short-term Federal-Tribal workgroup to develop recommendations on issues related to the agreements which include, but are not limited to:

- Serving non-native veterans living in our service areas;
- Tribal access to the VA centralized mail order pharmacy;

- Coordination of care with the current Indian health referral system;
- Inclusion of Purchased/Referred Care Program; and,
- Elimination of co-pays for AI/AN veterans.

VA has not provided any compelling evidence to Congress, IHS, nor Tribes to discontinue the current agreements. A breach in the current agreements will be a failure by the Federal government to provide treaty secured care to AI/AN veterans across the Nation.

Do not consolidate the current MOU into the larger Community Care Program or standardize IHS/Tribal Agreements with other contracted care.
In a previous Dear Tribal Leader Letter, dated October 7, 2015 the Veterans Administration requested Tribal consultation on whether IHS and THPs agreements should be included in the core provider network under the Choice Act. VA affirmed our request that IHS and Tribal programs not be considered part of the core provider network or as a non-department provider in the report to Congress, *Plan to Consolidate Community Care Programs*. 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. We are a Federal health care program that implements the treaty obligation for provision of health care to eligible AI/ANs across the United States

Do not change the agreed upon reimbursement rates.
To date, the reimbursements received and the number of veterans cared for are low in comparison to other care providers. Indeed, from 2012 to 2015 the VA reported that is has provided just $33 million in reimbursements to IHS and THPs – approximately 0.06% of the entire Veterans' Health budget and 1% of the IHS budget. While there are approximately 140,000 eligible AI/AN veterans, only 6,000 use the VA system for health care. Additionally, 360 Tribes participate in Self-Governance, yet only 89 agreements have been executed with the VA, suggesting there is much more capacity to improve our access to care for veterans especially in remote and rural locations. 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. The Choice Act provisions are less desirable for IHS and THP 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.

Additionally, 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. TSGAC does not support any reduction in the rate, given the dire circumstances Indian Country faces with regard to physical health and the social determinants of health. Any reduction in reimbursement will only further exacerbate the conditions the Indian Health System faces. We understand that this MOU specifically deals with reimbursement for care and that the other major issues we face are well beyond the scope of the VA. However, we find it necessary to remind the VA that Tribal Nations are struggling to meet basic needs. For example, some of the major issues and lack of basic needs currently facing AI/ANs include:

- Joblessness rates at or above 47%
- 40% of AI/AN living on reservations live in poverty

- 8-24% lack complete plumbing (reservation/Alaska)
- 7.5-33.3% lack a complete kitchen (reservation/Alaska)
- 18.9-17.3% lack a telephone (reservation/Alaska)
- 14.4%-27.2% live in overcrowded conditions (reservation/Alaska)

To suggest that reimbursement rates should be diminished, only further harms our citizens and adds to the struggle of meeting those basic needs by diminishing the amount of health care available in Tribal communities.

Allow current Agreements to extend to 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. We support offering care to non-Native veterans as well, using the current MOU, due to the fact that many of our health care facilities are located in remote, rural areas and would provide more timely access to the veterans living in those areas, where often no other healthcare providers exist. However, the Choice Act is administratively burdensome for Tribal Health Programs to administer, which creates a barrier to care for 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 to fill gaps, not to extend 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.

Fully implement Section 405 (c) of IHCIA.
To date, the VA-IHS/THPs MOUs have proven to be successful in facilitating patient care and provided the least administratively burdensome for all parties. However, 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 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. THPs, in particular, work hard to provide a seamless health care experience lack of coordination for specialty care paid by PRC will only exacerbate a veteran's experience with both systems. In general, failure to include PRC in the initial agreement further rations the amount of health care IHS and THPs can provide to Native veterans and other eligible AI/ANs in the system.

An additional concern which VA should work to find a solution to under this section is reimbursement of 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.

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 all THPs to access CMOP. Tribes who are first entering Self-Governance need flexibility from VA to have access to this Program. 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.

Discontinue the practice of collecting co-payments from AI/AN Veterans.
Currently, AI/AN's who present at a VA facility are assessed co-pays. TSGAC has previously expressed our concern that this practice is wrong and does not in 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 the Indian Health System should be responsible for any co-pays.

Specific recommendations the Tribal Self-Governance Advisory Committee have previously provided are contained in the letters noted below for your review and response. If you would like copies, please let me know:

- **August 23, 2016:** Opportunities for Partnership between Tribal Health Programs and the Veterans Administration
- **April 18, 2016:** Reimbursement Agreement between the IHS and VA
- **October 27, 2015:** Comments on the Veterans Access, Choice and Accountability Act of 2014
- **January 14, 2015:** Comments Submitted in Notice of Tribal Consultation: Section 102 (c) of the Veterans Access, Choice and Accountability Act of 2014

In closing, working in partnership with the VA, IHS, and THPs offer more timely and more convenient access to our Nation's veterans. We support the effort to ensure that all of our veterans receive the best care possible, in recognition of all their sacrifices on our behalf and for this Country.

If you have any questions or wish to discuss these comments further, please contact me at (860) 862-6192 or via email at lmalerba@moheganmail.com. We look forward to your response to this letter and the letters noted above which have yet to be responded to.

Sincerely,

Lynn Malerba

Chief Lynn Malerba, Mohegan Tribe of Connecticut
Chairwoman, IHS TSGAC

cc: TSGAC Members and Technical Workgroup
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS
Stephanie Birdwell, Director Office of Tribal Government Relations, VA