IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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Electronically sent to: Baligh.Yehia@va.gov

August 23, 2016

Dr. Baligh Yehia, MD
Assistant Deputy Undersecretary for Health for Community Care
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

RE: Opportunities for Partnerships between Tribal Health Programs and the Veterans Administration

Dear Dr. Yehia:

I write on behalf of the Indian Health Service Tribal Self-Governance Advisory Committee (IHS-TSGAC) to thank you for attending and presenting at the July TSGAC Quarterly Meeting in Washington, DC. Our attendees gained valuable information regarding the partnership options available to Self-Governance Tribes through the existing Indian Health Services/Tribal Health Programs-Veterans Administration (IHS/THP-VA) Memorandum of Understanding (MOU) and Choice Act Agreements.

TSGAC wishes to take the opportunity to provide follow up to our discussion and to share our written comments on the VA's proposals:

Exempt IHS and THPs from the initiative to consolidate "all non-Department provider programs." In a letter dated, October 27, 2015, TSGAC requested that the VA's report to Congress explicitly recommend that the Agreements entered into with IHS and THPs be exempt from the non-Department consolidation. Was this recommendation included in the report? If not, how does VA intend to enter into agreements with IHS and THPs in the future?

Fully implement the National VA-IHS MOU. To date, the VA-IHS MOU has proven to successfully facilitate patient care and provide the least administrative burden for VA, IHS, and THPs. However, Section 405(c) of the Indian Health Care Improvement Act (IHCIA) 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). IHCIA provided a broad directive to reimburse IHS and THPs for care provided to American Indian and Alaska Native (AI/AN) veterans and this includes specialty and referral care provided through IHS and THPs.

In 2015, the VA provided only $33 million, less than one tenth of a percent of the Veterans Health Administration 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. Given the minimal amount of funding supporting IHS and THPs reimbursement agreements, including PRC seems realistic as we work together to improve access to quality care for veterans across the country.

As VA, IHS, and THPs work to build greater partnerships, we must work to address issues with regard to coordination of care. Failing to adequately coordinate care is magnified by VA's unwillingness to reimburse referral services. For example, if a Native veteran goes to an IHS or THP for service and needs a referral, the same patient must been seen within the VA system before a referral can be secured. This is a not a good use of federal funding, nor is it navigable for veterans.

Utilize the National VA-IHS MOU to provide care to non-Native Veterans. TSGAC provided comments to the request for Tribal Consultation on implementation Section 102 of the Veterans Access, Choice and Accountability Act of 2014 (Choice Act) in a letter dated, January 14, 2015. Generally, Self-Governance Tribes assert that IHCIA Section 405(c) provides the authority for IHS and THPs to receive reimbursement for non-Native veterans. While the Choice Act is a means for VA to purchase services in addition to the IHS/THP-VA MOUs, Choice Act agreements cannot be viewed as a replacement for the existing MOUs. Together, we should strive to ensure that the Choice Act does not diminish existing agreements, but instead become a limited-use option for IHS and THPs to increase health care access for veterans.

Furthermore, the VA should not consider altering the IHS/THP-VA MOU to match that of Choice Act agreements. To do so would disrupt MOU payment provisions, as the Choice Act provisions are cost based, create unnecessary pre-approvals, interrupt continuity of care and extinguish IHS and Tribal authority under IHCIA.

Allow THPs to access the Consolidated Mail Outpatient Pharmacy (CMOP). VA routinely contracts with IHS to access the National Supply Service Center (NSSC) and save federal funding on high volume prescriptions. However, the Department has not extended the same opportunity to THPs. Tribes are assuming and operating the same health programs previously operated by IHS and, by statute, have the same access to the Prime Vendor Contract. As Tribes are assuming control of IHS facilities, their access to CMOP has been unilaterally cut off, and requests to VA to enter contracts with Tribes have been rejected thus far, which abruptly ceases mail order options for their patients. Use of CMOP would create significant cost savings for THPs who are fulfilling the same role as IHS and maintain the standard of care for patients, including decreasing patient travel cost and access to prescriptions. Small Tribes in particular who do not have the volume to effectively begin a mail order pharmacy program on their own are disproportionately affected. We urge that you begin contracting with Tribes to access CMOP at their request at the earliest opportunity.

Thank you for considering feedback and comments. We look forward to working with the VA to improve the health status of all veterans. If you have any questions or concerns regarding these requests, please contact me at (860) 367-1609 or via email at lmalerba@moheganmail.com.

Sincerely,

Lynn Malerba

Chief Lynn Malerba, Mohegan Tribe
Chairwoman, TSGAC

ENCLOSED: 1) TSGAC Comments in Response to Notice of Tribal Consultation: Section 102(c) of the Veterans Access, Choice and Accountability Act of 2014 [January 14, 2015]

2) TSGAC Comments on Veterans Access, Choice and Accountability Act of 2014 [October 27, 2015]
3) TSGAC Letter Regard Reimbursement Agreement between the Indian Health Service and Veterans Affairs [April 18, 2016]

CC: TSGAC Members and Technical Workgroup Members
Honorable Robert A. McDonald, Secretary, Department of Veterans Affairs
Stephanie E. Birdwell, Director, Office of Tribal Government Relations, Department of Veterans Affairs
Mary Smith, Principal Deputy Director, Indian Health Service
P. Benjamin Smith, Director, Office of Tribal Self-Governance, Indian Health Service