

**INDIAN HEALTH SERVICE (IHS)/VETERANS ADMINISTRATION (VA) ISSUE**  
**Reimbursement for Purchased and Referred Care (PRC)**  
**August 2018**

**Background:**

In addition to providing primary healthcare services, IHS and Tribal Health Programs (THPs) utilize provider networks to provide specialty services (or other services not directly provided by IHS/THPs) to American Indian/Alaska Native (AI/AN) veterans. The networks are critical in providing care to veterans living in rural and remote areas. The VA currently reimburses IHS and THPs for care they directly provide under the IHS/VA Memorandum of Understanding (MOU). Despite the payor of last resort requirements that are included in federal policy<sup>1</sup>, the VA has not provided reimbursement for PRC specialty and referral care provided through IHS/THPs.

Practically, if a veteran receives care directly from IHS and THPs, the VA reimburses. However, if a referral is needed for specialty care (or other services not directly provided by IHS/THPs), the VA only pays for the specialty service if the veteran goes back to the VA health system and gets another referral by a VA provider. The PRC program authorizes Indian health care facilities to purchase services from a network of private providers. The payor of last resort statute and regulations require that all other sources of obtaining health services be exhausted prior to receiving care through the PRC program. These services may include primary or specialty care that is not available at an IHS and/or Tribal healthcare facility.

Because the assessment and referral conducted by the IHS/THP provider is not accepted by VA, resulting in having another initial consultation by a VA provider (more time, money for redundant assessments at additional cost to the taxpayer). There are often additional challenges with coordination of care between the VA or VA providers and the initial IHS/THP provider that made the referral. This is a not a good use of federal funding, nor is it navigable for veterans. In certain instances, this level of care may be directly available and provided under the current reimbursement agreements and reimbursed by the VA. However, because the mix of direct versus purchased care varies across the Indian health system, some IHS or Tribal health programs may purchase more care from outside providers, which is currently going unreimbursed by VA. This is illogical and results in inconsistent coordination and quality of care to the Native veteran. It is also expensive, inefficient, and waste of valuable tax payer dollars.

As a result, THPs are choosing to, with consent of the veteran, refer out for specialty treatment or other medically necessary health services without VA involvement and eating that cost so veterans can be treated in a complete and timely manner. The impact to veterans that do go back to the VA is delayed treatment and results in a different level/standard of care for AI/AN veterans. The bottom line is that, in the best interest of the veteran, THPs that run their own health programs are often forced to absorb the costs when they refer veterans out for third party care rather than sending them back to the VA for the referral. Since health care systems (IHS, THP, VA) all utilize Medicare Like Rates, and all other resources such as Medicare, Medicaid and private insurance are required to be collected by the contracted provider prior to

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<sup>1</sup> 25 U.S.C. § 1623. Special rules relating to Indians; and 42 CFR § 136.61 Payor of last resort.

IHS/THP payment, the cost would remain approximately the same to VA to reimburse IHS/THPs for PRC services.

Another barrier that is created by forcing Native veterans to return to VA is the assessment of co-payments for certain veterans. Health care provided to Native Americans and Alaska Natives is based upon solemn treaties, other federal law and the government-to-government relationship that has established a federal trust obligation for such services. The IHS is barred from collecting co-payments for health services for AI/AN, as this would be contrary to the federal trust responsibility to provide health care. When veterans are returned for specialty care to VA, co-payments are applied to these AI/AN veterans, which is inappropriate for the aforementioned reasons. However, the VA has determined it is required to collect co-pays from all veterans as applicable under federal statute, including AI/AN veterans. If the IHS/THPs can simply be reimbursed for any purchased care provided through their programs, the problem of the assessment of co-pays to these veterans is significantly lessened.

**Full implementation of Section 405 (c) of Indian Health Care Improvement Act:**

To date, the VA-IHS/THPs MOUs have proven to be successful in facilitating patient care and has been the least administratively burdensome approach for all parties, most of all AI/AN veterans. However, the Indian Health Care Improvement Act (IHCA 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).

25 U.S. Code § 1645 - Sharing arrangements with Federal agencies (c)  
Reimbursement - The Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

PRC consists of purchased health care that is provided through IHS/THPs. 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 and other medically necessary care paid by PRC will only create more barriers for our veterans. We recommend that the VA include PRC in the IHS/THP reimbursement agreements so that there is no further rationing of health care provided by IHS and THPs to Native veterans and other eligible AI/ANs in the system. The aim of this initiative is to ensure the IHCA is fully implemented and ensure the VA fully reimburses for services provided by IHS/THPs as required in Section 405(c) of the IHCA.