IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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Submitted via email to: tribalgovernmentconsultation@va.gov

June 7, 2019

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

RE: Comments on MISSION Act Strategic Plan

Dear Mr. Ward:

On behalf of the Indian Health Service's (IHS) Tribal Self-Governance Advisory Committee (TSGAC), I write to provide a response to your April 16, 2019, Dear Tribal Leader Letter providing an opportunity to submit comments on the Veteran's Affairs (VA) Strategic Plan to meet the health care demands in consultation with a variety of stakeholders, as required by the MISSION Act. The TSGAC appreciates that the VA recognizes that Native American Veterans have an important role in shaping the future of VA health care.

We offer the following comments on our most important issues:

1. American Indian/Alaska Native (AI/AN) Veterans Co-Pays

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 Tribal Health Providers (THP) are the payor of last resort (section 2901(b) of the Affordable Care Act) whether or not there is a specific agreement in place for reimbursement. Therefore, neither the Native Veteran nor the Indian health system should be responsible for any co-payments. The TSGAC recommends the discontinuation of the practice of collecting co-payments from AI/AN Veterans.

2. VA Accept Tribal Provider Credentialing

To ensure care coordination is effective and efficient, the TSGAC recommends the VA accept provider credentialing from THPs.

3. Health Information Exchange

TSGAC has had several conversations with the VA and recommended the VA consider inclusion in local health information exchanges which THPs in that area utilize. Again, we recommend local VA health care facilities work with their local THPs to ensure health information can be exchanged at the local levels through health information exchanges.

4. Graduate Medical Education (Tribal Medical Residency Programs)

The Indian health care system, consisting of facilities and programs operated by IHS, Tribes, Tribal Organizations and Urban Indian Health Programs, serve a great number of AI/AN Veterans, and often extend services to non-Native Veterans through partnerships with VA.

These Indian health programs have significant workforce challenges due to most facilities being located in rural and/or remote locations. The HHS Health Resources and Services Administration (HRSA) automatically designates IHS, Tribally-operated and Urban Indian Health programs as Health Professionals Shortage Areas (HPSAs) and Medically Underserved Area and Medically Underserved Population (MUA/MUP) for these reasons.

TSGAC was very encouraged to review the provisions of the recent VA Mission Act, specifically Section 403 which included a "Pilot Program on Graduate Medical Education and Residency." This new pilot includes facilities operated by Tribes, Tribal Organizations and IHS as "covered facilities" for purposes of the program and requires such facilities have a priority in placement of residents.

There are several THPs that have Tribal medical residency programs and we have had several conversations with VA officials regarding this provision. The TSGAC recommends that these conversations continue about how the Office of Academic Affiliations (OAA) envisions implementing the pilot, and how IHS and Tribes can be involved early in the planning to ensure that any regulations or policy that may be developed in the future for the pilot work optimally in Indian Country.

5. Reimbursement to Tribal Health Facilities for Specialty Care Services Provided Outside the Tribal Health Facility (PRC Reimbursement)

In addition to providing primary health care services, IHS and THPs utilize provider networks to provide specialty services (or other services not directly provided by IHS/THPs to 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, 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 health care facility.

Because the assessment and referral conducted by the IHS/THP provider is not accepted by VA, this requires an additional consultation by a VA provider resulting in more time for the patient and additional federal funds for redundant assessments. 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. 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 uncompensated by VA. This can result in inconsistent coordination and quality of care to the Native Veteran.

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

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 importantly AI/AN veterans. However, the Indian Health Care Improvement Act (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).

> IHCIA Section 405 (c) states - Sharing arrangements with Federal agencies
>
> 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. *25 U.S. Code § 1645(c)*

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.

The TSGAC 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 Native veterans and other eligible AI/ANs in the system. This would ensure the IHCIA is fully implemented and ensure the VA fully reimburses for services provided by IHS/THPs as required in Section 405(c) of the IHCIA.

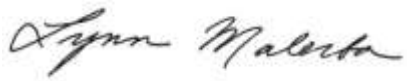
6. Establishment of VA/Tribal Care Coordination Workgroup

TSGAC has discussed with the VA several times about the formation of a VA/Tribal workgroup to address care coordination issues and the VA gave the Committee a commitment to develop the workgroup and have the first call in January 2019. To date, we have not heard anything

about the formation of this workgroup. We again recommend that the VA establish this very important workgroup as soon as possible.

In closing, we appreciate the opportunities to provide these comments. These issues are very important to the TSGAC. If you have any questions about our comments and recommendations, please feel free to contact me at lmalerba@mohegantribe.com. Thank you.

Sincerely,



Marilynn “Lynn” Malerba
Chief, Mohegan Tribe
Chairwoman TSGAC

cc: Jennifer Cooper, Director, Office of Tribal Self-Governance, IHS
TSGAC and Technical Workgroup Members