

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education

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The Honorable Robert Wilkie, Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Room 1000
Washington, DC 20420

RE: *Inclusion of Purchased and Referred Care (PRC) in Veterans Affairs and Indian Health Service Reimbursement Agreements*

Dear Secretary Wilkie:

I write on behalf of the Indian Health Service (IHS) Tribal Self-Governance Committee (TSGAC), which is representative of 360 Federally-recognized Tribal governments participating in Self-Governance. The TSGAC advises the Director of IHS on health policy and other matters affecting Tribes. Many of these Tribes have reimbursement agreements with Veterans Affairs (VA) pursuant to Section 405(c) of the Indian Health Care Improvement Act (IHCA).

American Indians/Alaska Natives (AI/ANs) continue to serve in our country's armed forces in greater numbers per capita than any other group. The U.S. Census Bureau's 2015 American Community Survey (ACS) identified 133, 899 veterans as AI/AN.¹ AI/AN veterans are more likely to lack health insurance than veterans of other races. Upon return from their dedicated service however, many AI/AN veterans encounter various challenges to receiving VA benefits and access to quality healthcare services.

Factors, such as, residing in remote rural communities, poverty, mental health conditions, historical mistrust and a limited number of culturally competent healthcare providers create barriers to care and lead to AI/AN veterans experiencing greater health disparities compared to other veterans. In addition, regulatory barriers further exacerbate AI/ANs ability to access care. Restrictions on specialty care, assessment of co-pays, duplicative processes, overly-burdensome administrative requirements and lack of coordination of care delay access to care and have caused irreparable harm to veterans.

It is incumbent upon the Federal Government and its subsidiary agencies, VA and IHS, to uphold their trust obligations and ensure that Native veterans receive timely and quality culturally appropriate healthcare.

Coordination of Care Between VA and IHS and Current Reimbursement Agreements

The VA-IHS Memorandum of Agreement (MOU) does not currently provide for reimbursement of PRC at IHS or Tribal healthcare facilities. Consequently, veterans are forced to maneuver through a complex healthcare system and an elaborate administrative process

¹ American Indian and Alaska Native Veterans: 2015 American Community Survey, August 2017.

usually requiring multiple referrals in order to address their healthcare needs. This overly-burdensome duplicative referral process is counterproductive and impedes timely and efficient access to care for Native veterans.

Although the MOUs have demonstrated success in facilitating patient care for veterans, neither the current national agreement nor the Tribal agreements include reimbursement for PRC. The legal authority that authorizes this provision of care already exists. Section 405(c) of the IHCA, as amended and enacted by the Affordable Care Act (ACA), requires the VA to reimburse the IHS or Tribal healthcare facilities for services provided to beneficiaries.

Veterans often require additional services that are not available at IHS or Tribal healthcare facilities. In many instances eligible veterans are also eligible for PRC services. The PRC program authorizes Indian Healthcare facilities to purchase services from a network of private providers. IHS and Tribal health programs are the payors of last resort², which require that all other sources of obtaining health services must 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. Many Tribes utilize provider networks to ensure veteran's healthcare needs are being met.

The VA, however, will not reimburse Tribes for their referrals but instead insist that the veteran in need of specialty care return to the VA health system for a VA referral for care. 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 illogical and inconsistent type management of care is inefficient, a waste of resources (both time and money) and fails to prioritize the healthcare needs of Native veterans. Further, this policy does not align with the VA's mission and creates additional barriers for AI/AN veterans in need of care. Rather than creating additional obstacles, we need to ensure and improve access to all types of care for Native veterans. Including purchased and referred care in the National and Tribal MOU and allowing for reimbursement for these referrals is essential to ensure that veterans receive quality healthcare. Attached to this correspondence is a brief paper describing further how reimbursing IHS and Tribes for PRC benefits Native veterans' access to care and improves care coordination.

Establish A Workgroup or VA Tribal Advisory Committee

The TSGAC urges the VA to establish a formally sanctioned workgroup or Tribal Advisory Committee comprised of Federal and Tribal officials to provide education, advocacy, policy guidance and recommendations regarding implementation of the VA-IHS MOU, related individual Tribal MOUs, and to ensure cooperation and coordination of healthcare programs and services for veterans. Currently, the VA has a Minority Veterans Committee, however it is not sufficient for meaningful tribal consultation and deliberation on issues that pertain to the complex and varying infrastructure of tribal healthcare facilities. Members of the

² 25 U.S.C. § 1623. Special rules relating to Indians; and 42 CFR § 136.61 Payor of last resort.

workgroup/committee will serve as liaisons for Tribes and Veterans within their communities and regions, as well as, Advisors to agency.

Further, the establishment of a formal workgroup/committee will provide a forum for Tribes and the agencies to work together as government-to-government partners to address policy, legislative, budget, program and service issues from a principled standpoint and formulate recommended actions with the goal of advancing healthcare access and quality of care for veterans. While the IHS serves an important role in providing funding and technical support to Tribal healthcare facilities, they do not supplant Tribal governments as key decision-makers. Tribes must be afforded a seat at the table and there must be a comprehensive and properly structured process that allows Tribes to participate fully.

We firmly believe that adhering to mutually agreed upon solution-oriented processes will create policies that promote and support veterans care and respect Tribal sovereignty and self-determination. This Tribal-Federal partnership remains a work in progress to ensure that the treaty and trust obligations of the Federal government are upheld and serve as a backdrop against which all VA policy decisions directly affecting and/or impacting Tribes should be measured. If you have any questions or would like to discuss these comments, please contact me at lmalerba@moheganmail.com. Thank you.

Sincerely,



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

cc: Stephanie Birdwell, Director, Office of Tribal Government Relations, VA
RADM Michael D. Weahkee, Assistant Surgeon General, USPHS and Acting
Director, Indian Health Service
Jennifer Cooper, Director, Office of Tribal Self-Governance
TSGAC and Technical Workgroup Members

Attachment: Reimbursement for Purchased and Referred Care (PRC)