IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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Submitted via email to: Tribalgovernmentconsultation@va.gov

January 14, 2015

Tracy Parker Warren
VA Office of Public and Intergovernmental Affairs
Office of Tribal Government Relations (075F)
Department of Veterans Affairs
810 Vermont Avenue, NW Room 1068
Washington, DC 20420

Re: Comments Submitted In Response to Notice of Tribal Consultation: Section 102(c) of the Veterans Access, Choice and Accountability Act of 2014

Dear Tracy Parker Warren:

On behalf of the Tribal Self-Governance Advisory Committee, I write to provide our comments on the Dear Tribal Leader letter dated December 30, 2014, regarding Tribal Consultation on Section 102(c) of the Veterans Access, Choice and Accountability Act of 2014. In that letter, the Veteran's Affairs (VA) requests comments on the feasibility and advisability of the Indian Health Service (IHS) and Tribal Health Programs entering into agreements with the VA for reimbursement of the costs of direct care services provided to eligible Veterans who are not American Indian or Alaska Native (AI/AN). Established in 1996, the TSGAC provides information, education advocacy and policy guidance for the implementation for Self-Governance within the Indian Health Service (IHS). We appreciate the opportunity to provide these comments.

We urge the VA and IHS to recommend in its report to Congress, and the VA to move forward with agreements for reimbursement of the costs of services provided to eligible Veterans who are not AI/AN. In addition to this overarching recommendation, we have a number of specific proposals that we hope will be addressed in the joint VA/IHS report required under section 102(c) or in implementation of expanding the relationship between VA and the Indian health system in their joint efforts to help VA meet its obligations to all Veterans.

In order to improve Veterans' access to care, the Veterans Access, Choice and Accountability Act of 2014 provides that health care services shall be offered to eligible Veterans at certain non-VA facilities through agreements with the VA. The IHS, Tribal and urban health care facilities and programs (I/T/U) are encompassed by the statutory list of entities which may provide such services under Section 101(a)(1). Section 102 is specifically designed to enhance collaboration between the VA and the IHS and directs the VA and the IHS to, among other things, submit a report on the feasibility and advisability of entering agreements to reimburse the IHS and Tribal health facilities for the costs of direct care services provided to Veterans who are not Indians.

Under Section 813 of the Indian Health Care Improvement Act (IHCIA), Tribes and Tribal organizations may elect, but are not required, to provide health care services to non-beneficiaries.[1] As a result, many Tribes and Tribal organizations already serve non- IHS-eligible beneficiaries, many of whom may be Veterans. Section 405(c) of the IHCIA, as amended and enacted by the Affordable Care Act (ACA), requires the VA to reimburse the IHS, an Indian Tribe, or a Tribal organization for services provided to beneficiaries eligible for services from either Department.[2] Further, under Section 2901(b) of the ACA, I/T/Us are payers of last resort regardless of whether or not a specific agreement for reimbursement is in place.[3]

Despite these provisions of law, which were enacted in 2010, to date the VA, outside of Alaska, has generally agreed to reimburse the IHS and Indian Tribes and Tribal organizations, pursuant to written agreements, for certain direct services provided to IHS-eligible AI/AN Veterans. The model agreement negotiated between IHS and the VA does not address reimbursement for services provided to non- IHS-eligible individuals, nor does it address services provided through Purchased/Referred Care (formerly IHS's contract health services (CHS) program), although among other services, both are within the scope of Section 405(c) of the IHCIA and Section 2901(b) of the ACA. Tribes have always urged full implementation and compliance with Section 405(c) of the IHCIA and Section 2901(b) of the ACA, and have taken the position that reimbursement is legally required and that any agreements should cover the full scope of services.

Notwithstanding their limitations, however, the agreements that have been implemented in the last two years between the IHS and Tribal health care facilities and the VA have proven beneficial. Veterans have been able to receive quality health care services at local IHS and Tribal health care facilities, which are often much more accessible and conveniently located than the nearest VA facilities. This has been especially true in Alaska where agreements routinely addressed services to non-AI/AN Veterans and have resulted in significantly greater access to timely health services near their homes for both AI/AN and non-AI/AN Veterans. Especially in light of the goals and policies reflected in the Veterans Access, Choice and Accountability Act of 2014, which seeks to improve access to care for *all* Veterans, we believe that expanding the scope of reimbursement agreements to include services provided to non-American Indian and Alaska Native Veterans is both feasible and desirable.

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[1] 25 U.S.C. § 1680c. IHS may also serve non-AI/ANs with the consent of the Tribes being served by the IHS directly operated health care program.

[2] Section 405(c) of the IHCIA reads: "The [Indian Health] 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.C. § 1645(c).

[3] Section 2901(b) provides: "Health programs operated by the Indian Health Service, Indian Tribes, Tribal organizations, and Urban Indian organizations … shall be the payer of last resort for services provided by such Service, Tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary." 25 U.S.C. § 1623(b).

The Veterans Access, Choice and Accountability Act of 2014 was enacted in part in recognition of the fact that many Veterans lack access to the health care benefits to which they are entitled by law, often because the nearest VA facility is too far away or because the wait times are far too long. For Veterans in rural areas, the closest health care facility is often an Indian health care program operated directly by IHS, or by a Tribal health program, or urban Indian health program, making I/T/U facilities particularly well suited to partner with the VA to carry out the agency's health service policies in conjunction with their own efforts to improve access to quality health care in the communities where they are located. With reimbursement agreements now in place covering services provided to IHS-eligible individuals, a foundation already exists for expanding the IHS/VA/Tribal partnership to leverage resources in pursuit of common goals and to implement the policies embodied in the Veterans Access, Choice and Accountability Act of 2014.

Most critically, it is imperative, to recognize that while IHS plays an important role in the funding and support of Tribal and urban Indian health programs, IHS cannot speak for those programs. Tribal health programs are able to exercise significant flexibility not available to IHS directly operated health programs. Thus, in all matters, we strongly urge that VA establish direct communication with Tribal and urban health programs regarding all aspects of its implementation of CHOICE and other VA initiatives. This should begin by providing Tribal and urban Indian health programs the opportunity to review and comment on the draft report that must be submitted to Congress and addressing the comments in the final report.

Secondly, to the extent new model language or agreements are considered to streamline I/T/U contracting with VA to provide services to AI/ANs, we consider it imperative that Tribal and urban health program representatives are at the same table with IHS in the negotiations or discussions with VA. We offer this recommendation with the greatest regard for the strengths of the IHS, but also with a keen awareness of the differences between its point of view and that of the Tribal and urban programs that are part of its larger system. Such a process would not negate the need for consultation with Tribes and conferring with urban Indian programs. However, it would both assure that the differences among the IHS, Tribal and urban health programs are recognized and addressed from the start. There is vast experience among Indian health providers in working through representatives to negotiate model agreements that do not supplant government-to-government negotiations and individual program autonomy, but do speed up the process of reaching workable solutions that can be rapidly implemented.

In addition to direct participation in, and Tribal consultation regarding, development and implementation of any such agreements or language (including those directly entered into with the IHS), we also believe that Tribal and urban Indian program representatives should be participants in satisfying the requirement of section 102(b) of identifying and developing the performance metrics for both VA and IHS under their Memorandum of Understanding regarding increasing access to health care, improving quality and coordination of health care, promoting effective patient-center collaboration and partnerships between the VA and IHS, and ensuring health-promotion and disease-prevention services are appropriately funded and available for beneficiaries under both health care systems.

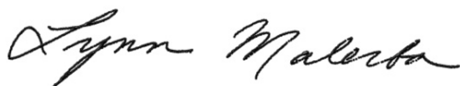
Both Tribal and urban health programs have unique awareness of the needs of the AI/AN and non-AI/AN Veterans who are part of their communities and service populations. Moreover, in all of Alaska and in vast swathes of the remainder of Indian country and urban Indian centers, they are the principal providers within the Indian health system, not the IHS. A relationship between the two federal agencies is invaluable, but it is not sufficient to substitute for direct interaction by the two agencies with Tribes and Tribal and urban Indian health programs at every stage of discussion, not just after decisions are made.

Finally, we also urge that the report not only recommend entering into agreements for reimbursement, but that it go further to recommend that current agreements be used and expanded where possible in order to speed up the implementation of all aspects of the efforts being made by VA to expand access to health care to eligible Veterans. As the agreements in Alaska between VA and every Tribal health program in the State demonstrate, it is possible to ensure ready access by bringing the Indian health system and VA together in partnership. To this end, we recommend that processes for development of model agreements not be a barrier to Tribal and urban Indian health programs that are ready to negotiate agreements immediately to expand the reimbursable services they offer to non-AI/AN Veterans.

We stand ready and willing to work closely with the VA to ensure full implementation of the Veterans Access, Choice and Accountability Act of 2014 in order to improve quality and access to health care for all our beneficiaries.

Please feel free to contact me if you are in need of additional information at (860) 862-6192; or via email: lmalerba@moheganmail.com. Thank you.

Sincerely,



Chief Lynn Malerba, Mohegan Tribe
Chairwoman, TSGAC

cc: Dr. Yvette Roubideaux, Director, IHS
P. Benjamin Smith, Director, Office of Tribal Self-Governance, IHS
Stephanie Birdwell, M.S.W., VA, OPIA, Director, Office of Tribal Government Relations
TSGAC Members and Technical Workgroup