

National Indian Health Board



Delivered Electronically to consultation@ihs.gov

Yvette Roubideaux, M.D.
Director, Indian Health Service
The Reyes Building
801 Thompson Avenue, Suite 400
Rockville, MD 20852

Dear Dr. Roubideaux:

The National Indian Health Board (“NIHB”) appreciates the opportunity to file comments in response to the Dear Tribal Leader Letter (“DTLL”) describing the contents of the October 1, 2010 “Memorandum of Understanding Between the Department of Veterans Affairs (VA) and the Indian Health Service (IHS),” (hereafter “2010 MOU”) asking for thoughts regarding priorities for implementation and timing of implementation strategies, and suggestions for activities under any of the strategies. Per capita, American Indians and Alaska Natives (“AI/ANs”) have the highest rate of military service of any ethnic group, and it is vital that their sacrifice is rewarded with fully coordinated and accessible services.

Established nearly forty years ago, NIHB is an inter-tribal organization that advocates on behalf of Tribal governments, American Indians and Alaska Natives (AI/AN) for the provision of quality health care to all AI/AN. NIHB is governed by a Board of Directors consisting of representatives from each of the twelve IHS Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative. Area representatives communicate policy information and the concerns of the Tribes in their area to NIHB. Whether Tribes operate their own health care programs through contracts or compacts, or receive health care directly from the IHS, NIHB is their advocate. NIHB also enters into partnerships with national organizations, foundations, corporations and other groups that share NIHB’s goal of advancing the health care status of AI/AN.

These comments are built on two fundamental principles. The first is that the United States has special trust responsibilities and legal obligations to AI/ANs to ensure their highest possible health status and all resources necessary to effect that policy.¹ The second is that AI/ANs who have chosen to give even more to our country by serving in the armed forces should be entitled to receive services consistent with the mission of the Department of Veterans Affairs

¹ Section 3 of the IHCA, as amended by Sec. 103 of S. 1790.

To provide veterans the world-class benefits and services they have earned – and to do so by adhering to the highest standards of compassion, commitment, excellence, professionalism, integrity, accountability, and stewardship.²

In our view this mission cannot be fulfilled without facilitating the enrollment of all AI/AN veterans in VA benefit programs for which they are eligible, ensuring them access to health programs that are both culturally competent and knowledgeable about their special health issues as veterans, ensuring that resources are made available to support access to care. These goals must be achieved; ensuring that they can be provides the underpinning of our analysis of the 2010 Memorandum and the comments in this letter.

RELEVANT PROVISIONS OF THE IHCIA

The 2010 MOU identifies the Indian Health Care Improvement Act (“IHCIA”), 25 U.S.C. 1645 and 1647 and 38 U.S.C. 523(a), 6301-6307, and 8153, as authority. 2010 MOU, Section II. The IHCIA authority for IHS and VA to share facilities and services has been in place since 1988.³ Although the ACA did not amend the previous authority, it addressed similar issues in the new Section 405 of the IHCIA.⁴ The principal differences between the new provisions in Sections 405 and 816 are that the newer Section 405—

- expanded the participants to the authorized sharing arrangements from just VA and IHS to also include Indian Tribes and Tribal organizations⁵ and the Department of Defense (“DoD”);
- required consultation by the Secretary with any Indian tribes that will be significantly affected by the arrangement prior to finalizing such arrangement;
- provided for reimbursement to the IHS, Tribe or Tribal organization (hereafter “Indian health program”) by VA and DoD “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”;⁶ and
- did not include provisions affecting certain specific Service Units and requiring certain reports to Congress.

Congress also added a new Section 407 to the IHCIA⁷ regarding eligible Indian veteran services. This new section is intended to encourage collaborations between VA and IHS regarding treatment of Indian veterans at facilities of the Service and increased enrollment for services of the VA by Indian veterans. Section 407 seeks to reaffirm the goals in the February 25, 2003,

² http://www.va.gov/about_va/mission.asp.

³ The authority was enacted as Section 716 and added to the IHCIA on November 23, 1988. It was redesignated as Section 816 on October 29, 1992, and codified at 25 U.S.C. 1680f. Section 816 was not amended by the reauthorization and amendment of Pub. L. 94-437, as amended most recently pursuant to Sec. 10221 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (“ACA”) (incorporating by reference S. 1790 as reported by the Committee on Indian Affairs of the Senate in December 2009.)

⁴ See, Sec. 154 of S. 1790. Section 405 is codified at 25 U.S.C. 1645.

⁵ Section 405(a)(1).

⁶ Section 405(c).

⁷ See, Sec. 155 of S. 1790.

Memorandum of Understanding between the VA/Veterans Health Administration and HHS/Indian Health Service” (hereafter “2003 MOU”). The principal vehicle it relies upon is negotiation of Local MOUs, which is defined to mean

a memorandum of understanding between the Secretary (or a designee, including the director of any area office of the Service) and the Secretary of Veterans Affairs (or a designee) to implement the document entitled ‘Memorandum of Understanding between the VA/Veterans Health Administration and HHS/Indian Health Service’

Section 407(b)(2). The HHS Secretary is required to consult with Tribes that would be affected by the Local MOU. Section 407(d). Subsection (c)(1) appears to impose a duty on the Secretary of HHS to provide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b)(1)(B), which defines “eligible Indian veteran” as an Indian or Alaska Native veteran who receives any medical service that is:

- (A) Authorized under the laws administered by the Secretary of Veterans Affairs; and
- (B) Administered at a facility of the Service (including a facility operated by an Indian tribe or tribal organization through a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq)) [“ISDEAA”] pursuant to a local memorandum of understanding.

Section 407(b)(1). With regard to the funding to cover expenses incurred under subsection (c)(1), subsection (e) provides that such expenses shall not be considered contract health service (“CHS”) expenses and that funds appropriated for the IHS (excluding funds for facilities, CHS, and contract support costs (“CSC”) shall be used.

We believe that Sections 405 and 407 are reconciled by recognizing that both VA and IHS have duties to fulfill to AI/AN veterans. Section 405 amends existing authority to share resources between IHS and VA with one very important difference –that VA is obligated to pay for services provided through Indian health programs to AI/ANs who are eligible for VA or DoD services. Section 407 restates the basic obligation of IHS to provide services to AI/ANs who are also veterans and encourages local MOUs to be developed between IHS and VA to assure appropriate services and define the IHS’s funding responsibilities (and, presumably, given the language of Section 405(c), the VA’s responsibility).

COMMENTS ON THE 2010 MOU.

Inclusion of Tribes and Tribal Health Programs as Partners. We appreciate the effort that IHS and VA made to develop the 2010 MOU. We are concerned, however, that Tribes and Tribal health programs were not represented in the team that undertook the work and that many provisions address the relationship between IHS and VA with no specific reference to Tribes and

Tribal and urban Indian health programs. IHS is a direct service provider for fewer than half the Tribes. Even those Tribes IHS serves directly carry out certain Indian health programs and have very decided and unique views about the needs of their veterans and how they can best be met.

Since the 2003 MOU, the participation of Tribes and Tribal and urban health programs in all aspects of the delivery of Indian health services has grown consistent with the intent of Congress expressed in both the ISDEAA and, more recently, in the IHCIA. ISDEAA Section 3(b) includes a commitment to establishment of meaningful Indian self-determination policy and “orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services.” More recently, in the Declaration of National Indian Health Policy found in Section 3 of the IHCIA⁸ Congress expressly imposed new policies in fulfillment of the Nation’s special trust responsibility and legal obligations:

(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;

...

(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; [and]

(7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

These policies cannot be achieved unless Tribes⁹ are at the table during negotiations, afforded all the benefits and opportunities contemplated under the MOU, and allowed to negotiate their own sharing arrangements on terms mutually acceptable to the Tribe or Tribal health program and VA.

We are concerned that while the purpose and actions set out in the 2010 MOU are apparently intended to lead to better results for all AI/AN veterans, critical players are left out. For instance in Section I Purpose there is no reference to Tribal health programs until the last sentence when there is an acknowledgement that implementation “requires local adaptation to meet the needs of individual tribes, villages, islands, and communities, as well as local VA, IHS, Tribal, and Urban Indian health programs.” Although in Section IV.A.3 there is a reference to “sharing agreements” with Tribal and Urban health programs, throughout most of the 2010 MOU where specific actions are described there are no references to those health programs.

⁸ As amended by Sec. 103 of S. 1790.

⁹ We assume that urban Indian health programs will be submitting their own comments and do not uniformly make reference to them. Failure to include a reference should not be interpreted as an effort to restrict a provision only to Tribes and Tribal health programs unless such restriction is expressly stated.

We believe that IHS should have found a way to include representatives of Tribes and Tribal health programs in its deliberations with VA. Had it done so, we believe that many of the comments we have now would have been addressed and not be left outstanding. The opportunity is not lost, however.

To relieve these concerns, we recommend that the 2010 MOU be amended to fully address the status and needs of Tribes and Tribal health programs as full partners. We recommend that representatives of Tribes and Tribal health programs be included in any IHS and VA teams that are formed for that purpose or to otherwise carry out the amended MOU. Finally on this topic, we recommend specific amendments to the MOU be considered. We are not wedded to the particular language here, but believe that the intent is more clearly expressed when shown in the context of the particular provisions of the MOU. As noted above, we believe Tribal representatives should be included in a team with IHS and VA representatives to negotiate amendments to this 2010 MOU to assure that it fully reflects the changed focus from sharing only between IHS and VA to sharing among IHS, VA, Tribes and Tribal organizations.¹⁰

IV.A.1 amend, as follows:

Increase access to and improve quality of health care and services to the mutual benefit of both agencies and Tribal and Urban Indian health programs. Effectively leverage the strengths of the VA, ~~and IHS, Tribes, and Tribal and Urban Indian health programs~~ at the national and local levels to afford the delivery of optimal clinical care.

If Indian health programs provided by Tribes and Tribal and urban Indian health programs are to be able to fully participate, there needs to be direct reference to them in the goals.

IV.B.3.c and d amend the reference to “VA and IHS” to read: “VA and IHS in direct collaboration with Tribes and Tribal and Urban Indian health programs,”. This change will assure that the agreements reached between VA and IHS are adequate to address unique issues faced by other Indian health providers with regard to health information technology.

IV.B.5.a amend the introductory language, as follows:

Sharing of contracts and purchasing agreements that may be advantageous to ~~both IHS, and VA,~~ and Tribes and Tribal and urban Indian health programs, supported by the development of

Without this amendment, the 2010 MOU may be interpreted to limit the benefits of sharing contracts and purchasing agreements only to VA and IHS directly-operated

¹⁰ The statute uses the term “tribal organization.” Following the convention of the MOU, we refer to Tribal health programs, which, of course, may be serving a single Tribe or may be serving multiple Tribes through a Tribal organization, as that term is defined in Section 4(26) of the IHCA (as amended by Sec. 104 of S. 1790).

programs. This would undermine the opportunities for improving access and efficiencies in those areas where Tribes (or urban Indian health programs) are operating IHS programs.

IV.B.6.a amend, as follows:

Support care delivered to eligible AI/AN Veterans served at VA facilities and through IHS, Tribes or Tribal health programs.

Section 405(c) expressly provides for reimbursement by VA “where services are provided through the Service, an Indian tribe, or a tribal organization . . .” The express inclusion of references to Tribes and Tribal organizations was one of the most significant changes to the statutory authority regarding sharing arrangements and should be reflected affirmatively in these provisions of the 2010 MOU regarding development of payment and reimbursement policies and mechanisms.¹¹

IV.B.12 amend, as follows:

12. To accomplish the broad and ambitious goals of this agreement through the development of a joint Implementation Task Force (to include Tribal representatives from each IHS Area) to identify the strategies and plans for accomplishing the tasks and aims of this agreement, including:
 - a. Development of joint workgroups (including Tribal representatives) for both short-term and ongoing work necessary to accomplish the aims of this agreement.
 - b. Regular meeting of IHS, and VA, and Tribal leadership at multiple levels ~~in the organizations~~ to review progress and set priorities.
 - c. An annual report by IHS and VA of activities accomplished under the auspices of the agreement, which shall be submitted prior to final publication to Tribes and Tribal and urban Indian health programs for comment and which shall include the comments submitted in the final publication.

IV. insert a new subsection C, as follows:

- C. To fulfill the policies of the United States, as stated in the IHCIA and ISDEAA, the VA and IHS agree to collectively and individually actively engage with Tribes and Tribal or urban Indian health programs through individual interactions and negotiations and through consultation. To assure this MOU is interpreted and implemented consistent with the policies of the

¹¹ We discuss issues about reimbursement and payment in greater detail in a later section of these comments.

United States, the following terms will apply to all provisions of this MOU.

1. A Tribe or Tribal or urban Indian health program, in its sole discretion, may include, in any sharing agreement between it and VA and/or IHS any standard, pre-approved language agreed upon by VA and IHS.
2. Neither VA nor IHS may refuse to negotiate a sharing agreement with a Tribe or Tribal or urban Indian health program because the Tribe or Tribal or urban Indian health program does not exercise the right under subsection C.1 to include “standard pre-approved language,” or because such entity rejects language that would have the effect of limiting rights and authority granted it under the IHCIA or ISDEAA.
3. Representatives of Tribes and Tribal and urban Indian health programs shall be included in all negotiations between IHS and VA of any standard pre-approved language for sharing agreements between the IHS and VA and in other collaborative activities, such as those described in Section 7.b of this MOU.
4. Tribes and Tribal and urban Indian health programs may enter into sharing agreements among themselves (with or without the direct participation of IHS or VA) if doing so will enhance their ability to improve services to AI/AN veterans.

The reasons for the new subsection should be obvious from the content. Without provisions that reflect these points, there is substantial risk that the 2010 MOU and terms negotiated for sharing agreements between IHS directly-operated programs and VA would be read as binding on Tribes and Tribal health programs, notwithstanding the unique circumstances of the Tribes and Tribal health programs and the policies adopted by Congress to encourage Tribal program autonomy and a government-to-government relationship between Tribes and Tribal health programs and agencies of the United States.

Practically, these provisions are also important. Many Tribal health programs are using non-RPMS based electronic health records and other health information technology. Terms relevant to IHS may not be relevant to them. The IHCIA and ISDEAA grant many Tribes and Tribal health programs, and even urban Indian health programs, privileges and exemptions from laws that might otherwise generally apply. A Tribe or Tribal or Urban Indian health program should not be compelled to exchange one set of rights for another.

The proposed new C.4 is intended to recognize the fact that cooperation among Tribal and urban Indian health programs regarding services to AI/AN veterans may also expand access, particularly to specialty services.

V.A. This subsection imposes a requirement on VA and IHS to comply with applicable laws. We agree this is important, but are concerned that it may be read as if all of the laws applicable to IHS are equally applicable to Tribes and Tribal health programs. That is not the case. For instance records of an Indian Tribe (including medical records) are not Federal records for purposes of chapter 5 of title 5 of the United States Code, which includes the Privacy Act.¹² To address this concern, we recommend amending this section by adding at the end:

To the extent Tribes and Tribal health programs are not subject to one or more of the laws applicable to VA or IHS, nothing in this MOU shall be interpreted to make participation in this MOU contingent on agreeing to comply with such law or regulation.

We also note that this Section fails to include the new Section 805 of the IHCIA, “Confidentiality of Medical Quality Assurance Records; Qualified Immunity for Participants.” It is codified at 25 U.S.C. 1674. We recommend that it be added to the list of laws since it provides specific protections for IHS, Tribal and urban Indian health programs.

V.B. This subsection requires VA and IHS approval for care rendered under the MOU that is part of a study, research grant, or other test and subjects such approval on all IHS and VA research protocols. No mention is made of Tribal approval or protocols where the care is being rendered in a Tribally-operated health programs. We recommend the following amendment:

Care rendered under this MOU will not be part of a study, research grant, or other test without the written approval of ~~both IHS, and VA, and the Tribe or Tribal health program (as applicable)~~ subject to all appropriate ~~IHS, and VA, and Tribal~~ research protocols (as applicable). Approval and protocols shall be applicable only to the extent that the care is provided by one of the named entities or in a program operated by one of the named entities.

V.C. This subsection requires cooperation between VA and IHS in the event of claims, complaints or suits relating to care rendered under the MOU. There is no mention of cooperation with Tribes and Tribal health programs. We recommend the following amendment:

VA and IHS agree to cooperate fully with each other in any investigations, negotiations, settlements or defense in the event of

¹² 25 U.S.C. 450j(o)(1) and 458aaa-5(d)(1).

a notice of claim, complaint, or suit relating to care rendered under this MOU. This same cooperation will be extended to Tribes and Tribal and urban Indian health programs that may be providing or receiving services under this MOU.

V.D. This subsection provides assurance that this MOU will not result in reduction of services or priorities for care “provided to the Veteran population or IHS service population.” Although it may be implicit, we recommend adding “or Tribal” after “IHS” so that the protection of Tribal service populations is explicit in the MOU.

V.E. This subsection says VA to provide IHS employees with access to VA automated patient records and for IHS to reciprocate. Both are subject to applicable Federal confidentiality and security laws and policies. There is no mention of Tribal health program employees who would have the same need as IHS in locations where a Tribe or Tribal organization is carrying out the IHS program. We recommend the following amendment to the first sentence:

VA will provide IHS and Tribal health program employees with access to VA automated patient records maintained on VA computer systems to the extent permitted by applicable Federal confidentiality and security laws and policies.

We also urge that VA and IHS identify any confidentiality or security laws or policies that they believe would act as a barrier to making records available under this section of the MOU. Seamless access to health records is an important cornerstone to assuring comprehensive, consistent care for AI/AN veterans who receive some of their care in the Indian health system and some through VA.

V.F. This subsection addresses FTCA coverage. We recommend that it be amended as follows:

The IHS and VA, which ~~Both parties to this MOU~~ are Federal agencies, and Tribes and Tribal organizations carrying out programs of the IHS and their employees are covered by the Federal Tort Claims Act, 28 U.S.C. 1346(b), 2671-2680, in the event of an allegation of negligence. It is agreed that any and all claims of negligence attributable to actions taken by IHS or VA pursuant to this MOU will be submitted to legal counsel for both parties for investigation and resolution. Claims of negligence attributable to actions taken by a Tribe or Tribal organization pursuant to this MOU will be tendered for Federal Tort Claims coverage according to applicable statutes and regulations.

VII. Effective Period. This section addresses annual review by IHS and VA. As we have commented earlier we believe Tribal representatives need to be active participants. We recommend that it be amended, as follows:

VA and IHS, with participation by representatives of Tribes and Tribal and urban Indian health programs, will review the MOU annually to determine whether terms and provisions are appropriate and current.

Reimbursement by VA for Services Provided by an Indian Health Provider. Section IV.B.6 of the MOU provides the barest acknowledgement and framework for fulfilling the new duty of VA to reimburse the IHS, an Indian Tribe or Tribal organization “where services are provided through the Service, an Indian Tribe, or a Tribal organization to beneficiaries eligible for services from [VA], notwithstanding any other provision of law.”¹³ The responsibility to provide reimbursement became effective March 23, 2010, with the passage of the ACA. To date it has not been implemented.

The failure to implement the reimbursement provision of the law is troublesome on at least two levels. First, it deprives Indian health providers of the resources necessary to expand the scope of services they can provide to AI/AN veterans. Secondly, it raises potential compliance issues. Medicaid is generally the payer of last resort, except for Indian health programs. Typically, Medicaid programs require providers to bill all other potential payers, such as Medicare and VA, prior to billing Medicaid. For example, the Alaska Medicaid program provider billing manuals spell out expressly how claims for Medicaid enrollees who are also veterans eligible for VA benefits are to be handled. It requires the provider to “[b]ill VA first and receive a formal denial (in writing) from VA or receive a Medicaid Denial Letter.”¹⁴ Failure to comply with billing requirements can lead to serious audit and compliance issues for providers, including Indian health providers.

Development of the payment and reimbursement policies should be an extremely high priority and Tribes and Tribal health programs should be involved in the effort. We recommend certain principles be considered to guide the work.

- AI/AN veterans should have the option to obtain care from either the VA or an Indian health program. If the Veteran chooses an Indian health program, that program should be reimbursed even if the service could have been provided by a VA facility or program in the same community.
- AI/AN veterans should never be *required* to delay care or travel to another community to obtain care if there is an Indian health program provider able to provide the care, and reimbursement should be provided to the Indian health program.

This is a critical concern given that AI/AN reservations, villages, and other communities are often extremely isolated and may not be located anywhere near a VA facility. Requiring AI/AN veterans to travel far from home to receive VA-reimbursed care is extremely costly for the VA, can exacerbate medical problems due to delayed diagnosis

¹³ Section 405(c), 25 U.S.C. § 1645(c).

¹⁴ Alaska Medical Assistance Program, *Physician Provider Billing Manual*, I-22 (downloaded December 28, 2010, http://medicaidalaska.com/Downloads/Providers/BillingManual_Physician.pdf).

and care, and may be medically prohibitive altogether based on an individual's condition. Further, such geographically distant facilities will rarely, if ever, offer the kind of culturally appropriate care that AI/AN veterans require, a necessity which is specifically noted in Section IV(B)(8) of the MOU. This cultural unfamiliarity alone can result in AI/AN veterans failing to seek services through the VA system and does a tremendous disservice to our veterans.

- Reimbursement should be made by VA for services provided by any licensed or certified provider, including certified community health aides, including behavioral health aides and practitioners and dental health aides and dental health aide therapists,¹⁵ in order to assure the availability of services to veterans living in the most remote communities and to address shortages in the number of providers.
- Reimbursement should be made for services delivered through telehealth and telemedicine applications (live and store-and-forward) in order to reduce unnecessary travel costs and provide for greater access to all levels of care in the most remote communities and specialty care in a much broader range of Indian health programs.
- Any prior authorization or other VA policies that limit reimbursement to non-VA providers should be expressly waived so long as the AI/AN veteran is obtaining medically necessary care in an Indian health program.
- Reimbursement for services provided by Tribal health programs should be made without requiring any prior agreement between the Tribal health program and the VA.
- Reimbursement should be made according to the Medicaid rates published annually in the *Federal Register* for Indian health programs. Section 401(d) of the IHCIA allows Tribal health programs to directly bill for, and receive payments for, health care items and services provided by such programs for which payment is made under titles XVIII, XIX, or XXI of the Social Security Act or from any other third party payor.¹⁶ Under Section 401(d)(3)(A), the Secretary shall implement any administrative changes that may be necessary to facilitate any such direct billing and reimbursement.

These provisions, as well as sections 321(a) and 322(b) of the Public Health Service Act,¹⁷ and Public Law 83-568,¹⁸ invest the IHS director with the authority to set payment rates for inpatient and outpatient medical care provided by Indian health facilities for Medicare and Medicaid beneficiaries and beneficiaries of other Federal programs. These rates are published annually in the *Federal Register*.¹⁹ As there is no authority suggesting that the VA reimbursement payments required under IHCIA Section 405(c)

¹⁵ See, Section 119 of the IHCIA, as amended by Sec. 111 of S. 1790 and further amended by Sec. 10221(b) and (e).

¹⁶ 42 U.S.C. § 1641.

¹⁷ 42 U.S.C. §§ 248, 249(b).

¹⁸ 42 U.S.C. § 2001(a).

¹⁹ The rates for FY 2010 are found at 75 Fed. Reg. 33,890, 34,147 (June 16, 2010).

are meant to deviate from these carefully determined fee schedules, VA should adhere to these rates when making reimbursement payments to Tribal health programs.

Fully and immediately implementing section 405(c) will not only reduce VA transportation costs and help avoid delays in treatment, but will ultimately create significant efficiencies that will positively affect VA and Indian health providers. Ultimately, reimbursement could diminish or eliminate the need or desire for duplicative health programs and facilities between IHS and VA. Although some Tribes and AI/AN veterans may wish to maintain separate IHS and VA facilities, a decision that VA and IHS should respect, that should be the Tribes' choice, and not their burden.

Improved AI/AN Veteran Enrollment and Screening for VA Benefits and Services. A critical issue facing AI/AN veterans is their persistent under-enrollment in the VA benefits programs to which they are entitled. Stated goals of the MOU include increasing access to services and benefits, improving coordination of care, and training benefits coordinators. To combat the problem of under-enrollment and achieve the goals of the 2010 MOU, in **Section IV.B.1** actions are proposed to expand the Tribal Veterans Representative program into the Indian health system and to provide cross-training in eligibility. We endorse these improvements and appreciate IHS and VA's current efforts to further these goals and the various pilot projects and special agreements among VA, IHS, and Tribes and Tribal health programs that specifically target VA-eligible AI/ANs in order to enroll them in VA health programs. However, they are insufficient to overcome the problem. We recommend more specific actions be considered.

- VA should work with Area Indian Health Boards and Tribes to publish simplified eligibility enrollment explanations that are culturally and linguistically tailored to the Tribal member audiences. The pamphlets should clearly identify who is eligible for VA benefits, how eligibility is determined, how an eligible AI/AN veteran can apply for VA benefits, and any applicable appeals process in the event that enrollment is denied.
- VA should develop standard, uniform documentation that identifies an individual as eligible for VA benefits. Should VA policies or regulations differ between types or levels of eligibility, the documents should clearly differentiate between the different service levels. VA should also fund any necessary training that Indian health providers require to be able to quickly and accurately intake VA-eligible AI/ANs seeking services at Indian health facilities.
- VA should fund outreach and enrollment efforts by Tribes and Tribal health programs willing to carry out such activities on behalf of the VA.
- VA should provide written materials and training that can be used by AI/AN Veterans and Indian health providers to determine the range of services that VA facilities and programs provide to VA beneficiaries, as well as services that are reimbursable by VA even if performed by a third party provider. This will improve coordination of care and referral from IHS and Tribal health programs to VA programs when the AI/AN Veteran chooses the VA system for care or the Indian health system cannot provide the services needed by the AI/AN Veteran.

Cultural Awareness and Competence. “Attention to cultural issues” is certainly a first step in achieving improved cultural awareness and competence, however more is needed. VA facilities and programs where AI/AN veterans are being served need to have specific training. We recommend amending **Section IV.B.8** by adding a new paragraph, as follows:

- c. Orientation and training for VA personnel in cultural awareness and competence, preferably by members of the Tribes being served by the VA personnel.

Training and Sharing. A number of the actions proposed in Section IV are intended to promote cross-training, innovations, improvements in models of care and other practices that will support optimal care for AI/AN Veterans whether they are receiving care in a VA, IHS or Tribal health program. In addition to the cultural awareness training discussed above regarding Section IV.B. 8 of the 2010 MOU, we recommend:

- VA should provide specialized training to Indian health programs in health problems particularly prevalent among veterans, such as screening, diagnosis and treatment of post-traumatic stress disorder and brain trauma, and treatment and physical rehabilitation of veterans who have suffered physical injuries that create temporary or permanent limitations. These programs are especially important where there are behavioral health components of the AI/AN veteran’s condition that affect not only the veteran, but others in the family or community.
- VA should seek training for its behavioral health providers from specialists in serving AI/ANs with mental health or substance abuse issues, including how to work with the family and community in a culturally appropriate way to provide support for the veteran and his or her family.

Temporary Assignment of Commissioned Officers to the VA. Section IV.B.10.f provides for temporary assignment of Commissioned Officers to the VA. We are somewhat concerned about this. While we recognize the cross-training opportunities presented in clauses i and ii, reassignment of Commissioned Officers for “service delivery,” as provided in clause ii could exacerbate the staffing problems experienced in both IHS directly-operated and Tribally-operated health programs, by reducing the pool of Commissioned Officers available to provide services in Indian health programs.

Similarly, we are concerned about the standards under which assignments to VA for rapid force deployments and other Public Health Service emergency staffing may occur under clause iii. We appreciate that VA has special responsibilities to respond to regional and national public health crises. However, AI/AN populations are often particularly vulnerable due to their generally poorer health status and limited access to alternative resources for health care. Shifting Commissioned Officers away from Indian health programs to assist VA in meeting its

responsibilities may have the unintended consequence of creating other health delivery issues or leaving an Indian health program unable to respond adequately to the public health emergency. We believe such assignments should only be made after a finding by the Secretary that the health delivery needs of the Indian health program will not be compromised and that such assignments should be of time-limited duration.

Requirement for Consultation. As our substantive comments show, the implementation measures of this MOU have the potential to profoundly impact the operation of Indian health programs. As VA and IHS proceed in carrying out any specific activities identified in the MOU, these agencies should be sure to develop Tribal work groups or other processes by which Tribal representatives can actively participate in the actual development of any programs or regulations. While we appreciate the opportunity to comment on the implementation of the MOU, mere post-implementation commenting will not suffice with regard to the planning of any formal programs and policies or official regulations. Tribes and Tribal organizations and their representatives must be actively involved from the outset.

Specifically, Section IV(B)(12) of the MOU calls for the creation of a Joint Implementation Task Force to identify the strategies and plans for accomplishing the tasks and aims of this agreement. This task force should include at least one representative selected by each of the twelve IHS areas. Task force members should be included in all meetings between IHS and VA leadership involving the determination of priority areas within the MOU and any actions regarding implementation.

Finally, we recommend that VA ensure that it integrates information gathered from its various pilot and focus groups, and other such outreach programs, to help inform and guide the implementation of the MOU. While we commend IHS and VA for their collaboration, completing the goals of the MOU accomplishes little if those responsible for its administration in the various IHS areas are not engaged directly with Indian health providers and VA regarding outreach, enrollment, services, and payment.

Thank you for the opportunity to make these comments. We look forward to being able to be even more directly involved in future work between IHS and VA. Please do not hesitate to contact me or Jennifer Cooper, NIHB Legislative Director (JCooper@nihb.org, 202-507-4040), if we can provide additional information.

Sincerely yours,



Reno Keoni Franklin
Chairman, National Indian Health Board