

National Indian Health Board



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March 5, 2015

Director
Regulation Policy and Management (02REG)
Department of Veterans Affairs
810 Vermont Ave. NW, Room 1068
Washington, D.C. 20420

RE: RIN 2900–AP24, Expanded Access to Non-VA Care through the Veterans Choice Program

To whom it may concern,

I write on behalf of the National Indian Health Board (NIHB)¹ to comment on the Interim Final Rule (Interim Rule) issued by the Department of Veterans Affairs (VA) concerning Expanded Access to Non-VA Care Through the Veterans Choice Program.² Thank you for the opportunity to comment on this Interim Rule.

The current Interim Rule seeks comment on the VA's proposed regulations implementing section 101 of the Veterans Access, Choice and Accountability Act of 2014 (the Act),³ under which eligible Veterans may elect to receive hospital care and medical services from

¹ Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (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 who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

² 79 Fed. Reg. 65,571 (Nov. 5, 2014).

³ Pub. L. No. 113-146, 128 Stat. 1754, 1755-65 (2014).

eligible non-VA entities and providers.⁴ As the VA notes, eligible non-VA entities under the statute include both IHS providers and Federally-Qualified Health Centers (FQHCs), the latter of which by definition includes “[o]utpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination and Education Assistance Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.”⁵

We appreciate the VA’s recognition of the role that IHS, Tribes and Tribal organizations, and urban Indian organizations (I/T/U) providers will play in the expansion of Veteran care to non-VA facilities under the Act. In light of the high number of AI/AN Veterans,⁶ and the rural and remote locations in which many IHS and Tribal facilities are located, Tribes and Tribal organizations are keenly aware of the special health needs of Veterans (both AI/AN and otherwise) and of the important role that I/T/U providers play within the overall context of Veteran care. The NIHB therefore wishes to reiterate a number of the points that it raised in a previously-submitted comment on the VA’s Dear Tribal Leader letter dated December 30, 2014, regarding Tribal Consultation on Section 102(c) of the Act.⁷ We elaborate below.

⁴ Section 101 does not modify the VA’s previously existing authorities to furnish care through non-VA providers, but instead enhances VA’s options to furnish care that is timely and available in veterans’ communities. 79 Fed. Reg. at 65, 572.

⁵ 79 Fed. Reg. 65,579 (citing 42 U.S.C. 1396d(1)(2)(B)); *see also* 128 Stat. 1756.

⁶ In a recent report on AI/AN service in the armed forces, the VA acknowledged that although AI/ANs “serve at a high rate and have a higher concentration of female Servicemembers than all other Servicemembers,” they also “have lower incomes, lower educational attainment, and higher unemployment than Veterans of other races,” and are “more likely to lack health insurance and to have a disability, service-connected or otherwise, than Veterans of other races.” UNITED STATES DEPARTMENT OF VETERANS AFFAIRS, AMERICAN INDIAN AND ALASKA NATIVE SERVICEMEMBERS AND VETERANS 2 (Sept. 2012).

⁷ Among other things, the NIHB (1) urged the VA to establish direct communication with Tribal and urban health programs regarding all aspects of its implementation of CHOICE and other VA initiatives; (2) include Tribes and urban health programs at the same table with IHS when considering new model language or agreements to streamline I/T/U contracting with VA to provide services to AI/ANs; (3) include Tribal and urban health programs when identifying and developing the performance metrics for both VA and IHS under their Memorandum of Understanding; and (4) 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. The NIHB incorporates these comments by reference here.

Section 813 of the Indian Health Care Improvement Act (IHCIA) authorizes Tribes and Tribal organizations to electively to provide health care services to non-beneficiaries.⁸ 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.⁹ 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.¹⁰

Congress enacted the Act in part out of recognition 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 the Veteran to obtain care. For Veterans in rural areas, the closest health care facility is often an Indian health care program operated directly by an IHS or Tribal health program, which, when paired with the disproportionately high number of AI/AN Veterans, makes these programs both particularly familiar with the unique nature of Veteran health care and well suited to provide Veterans with health services in partnership with the VA. Congress's inclusion of I/T/U facilities in section 101 of the Act underscores its understanding of the role of I/T/Us within the overall VA care system.¹¹

For example, and notwithstanding their limitations (discussed in the NIHB's previous letter to the VA), recent written agreements 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 such agreements have resulted in significantly greater access to timely, local health services for both AI/AN and non-AI/AN Veterans, and have helped partially address

⁸ 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.

⁹ Section 405(c) provides: "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).

¹⁰ 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).

¹¹ Urban Indian programs, while not rural, frequently are also FQHCs and may be able to offer access to urban Veterans who otherwise might not be able to be seen within the requisite time periods.

the funding shortfalls endemic to the I/T/U system through the introduction of new revenue streams, thus further increasing access to and quality of care.

In light of the critical role that I/T/Us play in the provision of Veteran care, and the pivotal role and honored position that Veterans hold within AI/AN communities, it is important that the VA take steps to ensure the inclusion of Tribal and urban health programs within its overall consultative and regulatory framework. Specifically:

- The VA states in the Preamble to the Interim Rule that it will “to the maximum extent practicable and consistent with the requirements of section 101, use existing sharing agreements, existing contracts, and other processes available at VA medical facilities prior to using provider agreements” under section 101.¹² In order to speed I/T/U provision of services to VA-eligibles, the NIHB urges that the VA follow through with this comment and use existing sharing agreements with I/T/U facilities to implement section 101, rather than requiring such facilities to negotiate entirely new agreements. Reliance on the preexisting agreements is also supported by the fact they are entered into under the authority of not only 25 U.S.C. § 1645(c) (from the Indian Health Care Improvement Act), but also under 38 U.S.C. § 8153. As is noted in the Preamble to the Interim Rule, “[n]othing in this rulemaking modifies VA’s existing authority to furnish non-VA care, such as under 38 U.S.C. 1703, 1725, 1728, 8111, or 8153.”¹³
- As noted in the NIHB’s previous letter, while IHS plays an important role in the funding and support of tribal and urban Indian health programs, IHS cannot speak for those programs, particularly given that Tribal health programs, and to a lesser extent, urban Indian programs, are able to exercise significant flexibility not available to IHS directly-operated health programs. As such, the VA must recognize prior to instituting any consultation on the implementation of these regulations there may be circumstances in which opportunities exist for Tribes to offer services or programs that the IHS cannot. The former must be included in any negotiations or consultation to the same extent as IHS.

Thank you so much for your consideration of our recommendations. Please do not hesitate to contact our Director of Policy and Advocacy, Richard Litsey, at rlitsey@nihb.org with any additional comments or questions.

Sincerely,

¹² 79 Fed. Reg. 65,579.

¹³ *Id.* at 65,573.

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A handwritten signature in blue ink, appearing to read 'Lester Secatero', with a stylized flourish at the end.

Lester Secatero
Chair, NIHB