National Indian Health Board

Submitted via: http://www.regulations.gov

July 30, 2018

Director, Office of Regulation Policy and Management
Department of Veterans Affairs
Room 1063B
810 Vermont Avenue NW
Washington, DC 20420

RE: Notice of Request for Information Regarding Health Care Access Standards

Dear Director:

On behalf of the National Indian Health Board (NIHB), I write to submit comments in response to the Department of Veterans Affairs (VA) request for information regarding health care access standards.

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.

The United States federal government's trust responsibility to provide health care to all AI/AN extends across all departments and agencies and includes VA, as such we appreciate the opportunity to respond to the VA's request for information but we remind the VA of its duty to conduct Tribal Consultation prior to the development of any proposed rule or policy affecting Tribes.

Background

The Indian Health Service (IHS) is a federal health care program with a similar status to the U.S. Department of Veterans Affairs (VA) with the exception of the following differences: (1) American Indians and Alaska Natives (AI/ANs) have treaty rights for the provision of health care; (2) IHS is severely underfunded in comparison to other federal health care programs, for example the VA medical spending per patient is $8,759 compared to $3,332 IHS medical

spending per patient[1]; and (3) Unlike other federal mandatory health programs, IHS is subject to sequestration and funded through discretionary funds, which are not increased with population growth, inflation, nor new technology.

Underfunded from the start, IHS continues to provide limited direct care services to 2.2 million AI/ANs. Today, IHS is a network of over 679 hospitals, clinics, and health stations located on or near Indian reservations. A little over half of the IHS budget, (56%) goes directly to Tribal communities who operate their own health systems under contracts and compacts authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA).[2] In addition, IHS and Tribal Health Programs (THPs) utilize provider networks to provide specialty services to American Indian/Alaska Native (AI/AN) veterans. These networks are critical in providing care to veterans living in rural and remote areas.

Discussion

American Indian and Alaska Natives (AI/ANs) serve in the U.S. military at higher rates compared to any other race, yet they are underrepresented among Veterans who access the services and benefits they have earned. AI/AN Veterans are also more likely to lack health insurance and have a disability, service-connected or otherwise, than Veterans of other races.[3] It is critical that AI/ANs Veterans not fall through the cracks and that they have access to the best care possible, whether that is through the Indian health care system or through the VA. Unfortunately, many AI/AN Veterans do not have faith and trust in the VA after past experiences and delays in enrollment, denial of care, or lack of access to VA services. As a result, Tribal memoranda of agreements (MOAs) and engagement with the Tribal health system, including the Indian Health Service, Tribes, and Tribal organizations, as well as urban Indian organizations provides a method for the federal government and agencies to preserve and build on the existing relationships that the VA has with IHS and Tribal Health Programs.
The VA currently reimburses IHS and THPs for primary care under the IHS/VA Memorandum of Understanding (MOU), but the VA has not provided reimbursement for specialty and referral care provided by IHS/THPs. This creates care coordination issues and burdensome requirements for the AI/AN veteran patient. For example, if an AI/AN veteran goes to an IHS or THP for service and needs a referral, the same patient must be seen within the VA system before a referral can be secured. This means the VA is paying for the same services twice, first for those primary care services provided to the veteran in the IHS or THP facilities, and then again when the patient goes back to the VA for the same primary care service to receive a VA referral. This is a not a good use of federal funding, nor is it navigable for veterans. In order to provide the care that AI/AN veterans need, many THPs are treating veterans or referring them out for specialty care and paying for it themselves so that veterans can be treated in a timely and competent manner. For those veterans that do go back to the VA for referrals, there is often delayed treatment and a significant different standard of care that is provided. Therefore we

[1] National Tribal Budget Formulation Workgroup's Recommendation on the Indian Health Service Fiscal Year 2020 Budget 8 (2018)
[2] These are often called "638" programs in reference to ISDEAA which is P.L. 93-638
[3] United States Department of Veterans Affairs, American Indian and Alaska Native Service Members and Veterans 2 (September 2012).

recommend that Section 405(c) of the Indian Health Care Improvement Act[4] be fully implemented and that the VA provide reimbursement for specialty care provided through referrals from IHS and THPs.

As discussed above, the federal government has a unique trust responsibility to AI/AN Veterans, like all AI/ANs. In recognition of this, AI/ANs do not have copays or deductibles for services received at an Indian health facility. Additionally, this was recognized in the Patient Protection and Affordable Care Act (ACA), which includes language at Section 1402 to exempt all AI/ANs under 300% of the federal poverty level from co-pays and deductibles on plans purchased on the health insurance Marketplace and all AI/ANs are exempted from copays and deductibles if they have a referral from from an IHS or THP. Like IHS and the marketplace, the VA is another means by which the federal government upholds its trust responsibility to AI/ANs. The Veterans' Administration should similarly exempt AI/AN Veterans from copays and deductibles in the VA system in recognition of the federal trust responsibility.

Many AI/AN Veterans experience various challenges in receiving VA health care benefits in remote environments. IHS and Tribal Health Programs provide exceptional culturally competent medical care closer to home. NIHB supports efforts to promote and expand upon putting AI/AN Veterans in control of how, when, and where they wish to be served quality health care services. NIHB recommends that the VA provide additional outreach and advocacy resources to ensure that AI/AN Veterans are aware of various health care benefits available in their community. NIHB supports VA efforts to expand access to medical care in Indian Country and for other rural areas using telehealth.

Conclusion

Thank you for this opportunity to provide comments and recommendations for the VA on Health Care Access Standards. NIHB hopes that the VA, in the spirit of its commitment to fulfilling its Tribal consultation policy and shared interest in improving AI/AN Veteran access to quality health care, will work with Tribes to advance access to quality health care for our Veterans. Please contact NIHB's Director of Federal Relations at ddelrow@nihb.org or (202) 507-4072 if there are any additional questions or comments on the issues addressed in these comments.

Sincerely,

Vinton Hawley
Chairman, National Indian Health Board

[4] 25 U.S.C. § 1645(c)