



December 22, 2015



The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman,

Enclosed, as required by Section 102(c) of Public Law 113-146, the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), is a joint report by the Department of Veterans Affairs (VA) and Indian Health Service (IHS) on the feasibility and advisability of entering into certain agreements or contracts for the reimbursement by the Secretary of the costs of direct care services provided to Veterans by IHS, Tribal Health Programs (THP), or Urban Indian Health Programs (UIHP).

The information gathered and analyzed in this report documents sustained progress by VA and IHS in providing and expanding care to Veterans.

Similar letters have been sent to the leaders of the Senate Committees on Veterans' Affairs.

Sincerely,

A handwritten signature in blue ink, appearing to read "Robert A. McDonald".

Robert A. McDonald
Secretary of Veterans Affairs

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Robert G. McSwain
Principal Deputy Director
Indian Health Service

Enclosures



December 22, 2015



The Honorable Corrine Brown
Ranking Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congresswoman Brown,

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Robert G. McSwain
Principal Deputy Director
Indian Health Service

Enclosures



December 22, 2015



The Honorable Johnny Isakson
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

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Robert G. McSwain
Principal Deputy Director
Indian Health Service

Enclosures



December 22, 2015



The Honorable Richard Blumenthal
Ranking Member
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Senator Blumenthal,

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Enclosures

Department of Veterans Affairs (VA) and Indian Health Service (IHS)

Report on Enhancement of Collaboration Between the Department of Veterans Affairs and the Indian Health Service

Introduction

The Veterans Health Administration (VHA) delivers health care to nearly 9 million Veterans. A key component of that health care delivery is the use of non-VA medical care when urgent/emergent situations arise, when services are not available within the VA network of facilities, when medical centers' capacity does not allow Veterans to access care in a timely manner, and/or when geographic distances negatively impact access to health care. Access to health care is a critical component of providing excellent health services to our Veterans, and the non-VA medical care program improved access by expanding health care options for Veterans.

The IHS is an agency within the Department of Health and Human Services and is responsible for providing health care services to American Indians and Alaska Natives (AI/AN). In addition to IHS direct service sites, health care services are provided by tribes and tribal organizations at tribally-operated tribal Health Program (THP) facilities as authorized by the Indian Self-Determination and Education Assistance Act. IHS also provides funding through grants and/or contracts to approximately 33 Urban Indian Health Programs (UIHP) located across the United States for the provision of health care services to urban Indians who are eligible under the Indian Health Care Improvement Act (IHCIA).

This report provides a summary overview of the reimbursement agreements established between VA, IHS, and THPs during the past three years and uses the reimbursement agreement framework as a point of reference to discuss opportunities for leveraging the health care delivery network across Indian Country. Consideration of UIHPs as access points for health care services offered to eligible, enrolled Veterans – both AI/AN and non-AI/AN Veterans – is also discussed in this report.

Current VA, IHS and THP Collaboration

VA and IHS currently collaborate in health care delivery and coordination for AI/AN Veterans. On March 5, 2012, VA and IHS began soliciting input from tribal leaders on a draft reimbursement agreement between VA and IHS. The draft agreement proposed the underlying terms and conditions for reimbursement of direct care services by VA to IHS facilities, and later formed the underlying terms and conditions for reimbursement to THPs, should tribes elect to enter into an agreement with VA. On December 5, 2012, a national Reimbursement Agreement for Direct Health Care Services was signed between IHS and VHA. Under this national agreement, VA reimburses IHS facilities for direct health care services provided to eligible AI/AN Veterans. This national agreement was used as guidance for establishing a template

for individual THPs choosing to enter into a direct care services reimbursement agreement with VA. In Alaska, because of the rural nature of the state and the limited presence of VA facilities, VA and the Alaska THPs agreed to expand the agreements to cover both Native and non-Native Veterans. As of January 2015, the national agreement between IHS and VA covers 108 IHS facilities, and VA has successfully negotiated **81** direct care services reimbursement agreements with THPs. Total reimbursements since December 5, 2012, exceeded **\$24** million covering over **5,500** eligible Veterans.

VA does not currently have separate reimbursement agreements with UIHPs. As of the writing of this report, two UIHPs, located in Oklahoma City, Oklahoma and Tulsa, Oklahoma, are, however, covered under the national agreement between VHA and IHS. Both sites were permanently designated as IHS service units with the passage of the Affordable Care Act on March 23, 2010. Other UIHPs do not currently have this IHS service unit designation. Additionally, we note that IHS contract and grant funding for UIHPs may be used only to service urban Indians who are eligible under the IHClA, and UIHPs can provide services to non-Indian Veterans only with other, non-IHS resources. Therefore, separate contracts with UIHPs would be required in order for VA to reimburse UIHPs for direct care services provided to Veterans.

Section 102(c) Report

This report, required by section 102(c) of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), assesses the advisability and feasibility of entering into agreements or contracts with IHS, THPs, and UIHPs for purposes of providing health care services to all eligible enrolled Veterans. In doing this assessment, VA and IHS considered the following:

- A. Wait times for Veterans--Veterans with appointment wait times of greater than 30 days from the clinically indicated date could benefit from the health care delivery network located across Indian Country to include UIHPs, depending on available capacity. Providing direct care services to non-Indian Veterans through IHS, THPs and UIHPs could increase access and diminish wait times for Veterans. Such expansion would only be advisable in instances where it will not result in a reduction of services or harmful impact for IHS eligibles as required by the IHClA at 25 United States Code, section 1645(b).

Most IHS, THP, and UIHP sites reviewed reported wait times far less than 30 days for the following types of care:

- primary and specialty care
- dental
- behavioral
- alcohol/ substance abuse
- rehabilitation

- B. Distance from the nearest VA facility: Consideration was given to the geographic location of Veterans who reside 40 miles or more from the nearest VA facility.

Analysis of the geographic locations of Veterans who reside more than 40 miles from the closest VA facility determined that approximately 100,000 non-Indian Veterans could benefit from utilizing IHS and THP facilities to meet their health care needs, as IHS and THP facilities are more conveniently located for these non-Indian Veterans. Utilizing UIHP facilities may also benefit Indian and non-Indian Veterans who reside near UIHP facilities. Because of shorter wait times for health care offered by IHS, THP, and UIHP facilities, these facilities could provide more convenient, timely access to direct health care services for Veterans who choose to receive their care at IHS, THP or UIHP facilities. For THP and UIHP facilities, existing contracting mechanisms through non-VA care programs could be utilized to provide direct care services to non-Indian Veterans.

VA could realize multiple benefits from expanding care for non-Indian Veterans through health programs located across Indian Country. For example, VA could pay less in travel benefits for eligible Veterans who travel shorter distances to a closer IHS, THP, or UIHP facility.

- C. Interest and Capacity by IHS and THPs: tribal consultation facilitated by VA indicates that some THPs have both the interest and capacity to provide care to all eligible enrolled Veterans in their community.

On December 29, 2014, VA initiated tribal Consultation on section 102(c) of the Choice Act and sent out a corresponding tribal leader letter. The comment period closed on January 14, 2015. Feedback and responses from tribes have been varied, with some comments expressing interest in expanding health care services to include non-Indian Veterans while others focus on concerns regarding the capacity of both IHS and THP facilities to expand services in locations where existing services may be limited. Any expansion of care to non-Indian Veterans at IHS and THP facilities would need to occur in close collaboration and consultation with the tribes served by the local IHS and THP facilities and in such a way that it does not result in a reduction of services or harmful impact for IHS eligibles.

- D. Interest and capacity by UIHPs: Depending on capacity and need at the local level, UIHP facilities may potentially serve as health care access points for Veterans. VA facilities requiring additional capacity and UIHPs with the interest, capacity, and sufficient resources to expand their service delivery to a diverse Veteran population could provide direct care services to Veterans at UIHPs through existing contracting programs.

Conclusions

As a direct response to the questions raised by section 102(c) of the Choice Act and based on the success of the existing relationships between VA, IHS, and 67 THP facilities in providing care to AI/AN Veterans and health care services for non-native Veterans in Alaska, VA and IHS jointly advise that it is feasible and advisable for VA to utilize IHS and THP facilities to provide direct health care services to both eligible Indian and non-Indian Veterans in areas where additional capacity is needed and where it will not result in a reduction of services or harmful impact for IHS eligibles.

For approximately 100,000 non-AI/AN Veterans, utilizing IHS and THP facilities for direct care services, and Veterans' utilization of UIHP facilities, could mean additional access to VA-supported health care closer to home. For VA, it means expanding access to care and reducing appointment wait times.

February 2015
Tribal Consultation Report
Section 102(c)
of the
Veterans Access, Choice, and Accountability Act of 2014

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Acknowledgements

Thank you to the tribal leaders, Veterans service providers, and Alaska Native and American Indian (AI/AN) tribal members, who generously provided input in response to the Notice of Tribal Consultation (Notice) published in the Federal Register on December 30, 2014. We value your comments and we look forward to continuing to build upon the partnership between the United States Department of Veterans Affairs (VA) and each sovereign tribal government in bringing honor and providing services to AI/AN Veterans.



Introduction

On December 30, 2014, VA published a Notice in the Federal Register and sent a “Dear Tribal Leader Letter” requesting perspectives and advice in the form of written comments concerning section 102(c) of the Veterans Access, Choice, and Accountability Act of 2014. Specifically, VA sought comments regarding the feasibility and advisability of Indian Health Service (IHS) and Tribal Health Programs (THPs) entering into agreements with VA for reimbursement of the costs of direct care services provided to eligible Veterans who are non-AI/AN. The comment period ended on January 14, 2015.

Responsive Comments

VA received 25 written comments from tribal entities in response to the Notice. Most commenters overwhelmingly support IHS and THPs entering into reimbursement agreements with VA for the cost of health care to eligible non-AI/AN Veterans. Some of the submissions posed questions but did not provide a position on feasibility and advisability. The majority of the submissions clearly expressed a position in support of agreements with VA for reimbursement of the costs of direct care services provided to non-AI/AN Veterans. Some commenters reported that they currently have agreements in place and receive reimbursement for health care services provided to non-AI/AN Veterans. None of the comments opposed entering into such agreements or expressed that it would not be feasible or advisable.

Fourteen commenters explained that, under section 813 of the Indian Health Care Improvement Act,¹ tribes and tribal organizations have discretion to provide health care services to non-IHS beneficiaries and that many tribal health programs already serve non-AI/AN patients. These commenters further explained that in many rural areas, tribal health services are the only providers. In non-rural areas, patients can access more health care services to meet the needs of their employees and for the recruitment, development, and retention of health care providers. The commenters also explained that such a model of health care ensures that families and households with AI/AN members and non-AI/AN members have access to care and that Veterans have benefitted immensely as a result of the partnership between IHS, VA, and tribal health care facilities. These commenters generally reported success in providing expanded access to Veterans. For example, one commenter stated, “Our extremely positive

¹ 25 United States Code, Section 1680c.

experience negotiating and implementing this agreement and our continuing collaboration with the Alaska Veterans Affairs Health Care System inform our comments.” Some of these commenters recommended providing tribal and urban Indian health programs the opportunity to review and comment on the draft report submitted to Congress.

Some commenters also recommended that each tribal government have the opportunity to negotiate the terms of their independent agreements, including taking an active role in developing any template or boiler-plate language. The commenters stated this would allow for program autonomy and would respect the sovereignty of each tribal government. Some also recommended using existing agreements, where practicable, and suggested developing performance metrics.

Another commenter viewed expanding reimbursement agreements to include health care services provided to non AI/AN patients “as an opportunity to increase services, expand on the ability to provide services to a specific targeted population, and a chance for an increase in billing revenue.” The commenter expressed concern, however, about the funding for IHS and stated that Indian Health Service, Tribal, and Urban Indian Health Programs will be forced to draw upon already underfunded agencies to expand programs, services, functions, and activities to non-Natives. The commenter explained that although tribally operated health care programs already have the discretion to provide health care services to non-IHS eligible beneficiaries if doing so does not compromise care to IHS eligible beneficiaries, an issue could arise “if non-Natives and IHS eligibles are competing for the same scarce resources.” The commenter recommended additional funding to IHS hospitals, clinics, and behavioral health programs. The commenter also recommended forward funding to better help plan for services and to help tribes better assess budgetary shortfalls. The commenter stated, “Government authorization for one fiscal year in advance will help budgetary decisions . . . [and] eliminate the need for IHS to operate under Continuing Resolutions.”

One tribe commented that they currently serve their entire local community and indicated that they would like to enter into a reimbursement agreement with VA for the provision of health care to non-AI/AN patients. This tribe is the only health care facility available in their region and the nearest VA facility is a long distance away.

Another commenter supported the expansion of reimbursement agreements because it would increase access to care for Veterans, revenues for the Indian health care delivery system, support services to all patients, and collaboration between Federal health care providers. This commenter also explained that many providers

currently have reimbursement agreements in place that allow for reimbursement for the care of non-AI/AN patients and that such providers often fill critical gaps in access, particularly in rural locations. This commenter expressed concern, however, that some regional VA offices will not consider additional or alternate language from what VA has provided in the template agreement. The commenter recommended that VA allow for additional and alternate language in all reimbursement agreements to accommodate regional needs. The commenter also expressed concern that the current reimbursement agreements limit reimbursement to direct care services provided by IHS and THPs. The commenter explained that such limitations also constrain the amount and type of care that AI/AN Veterans may receive because IHS and tribal facilities make referrals outside the IHS system for care through the Purchased/Referred care program (also known as PRC) and the limitation violates the law.

One individual commenter stated: “I think it would help out the native indian veterans in Indian country and Alaska natives.”

VA received a comment from the Executive Director of a health center comprised of clinics that are tribally operated under the Indian Self-Determination Act and deemed a Federally Qualified Health Center funded by Health Resources and Services Administration. This center is located more than 80 miles from the nearest VAMC and serves every member of the community. The commenter supported reimbursement agreements for non-AI/AN Veterans and suggested that, although some facilities may not have the capacity to provide health care services to non-AI/AN Veterans, tribes should have the opportunity to individually decide whether to contract because that decision should be site-specific.

One commenter recommended including Urban Indian Health programs.

Non-Responsive Comments

VA received the following brief recommendation from one commenter: “Increase efforts to reassure Veterans that they will not lose access to the VA medical centers by utilizing [IHS] and/or tribal medical facilities through this program.” The commenter did not provide a position on the feasibility and advisability of entering into reimbursement agreements for costs of direct care services provided to eligible non-AI/AN Veterans. One commenter posed a number of questions, but did not provide any comment on the issue presented. VA also received a comment concerning the method VA uses to measure miles and the time associated with receiving an appointment for medical care. Another commenter submitted a copy of responses relating to a previous tribal

consultation involving the Memorandum of Understanding (MOU) between VA and the Indian Health Service that express how the MOU has affected health care for Native Veterans. One commenter requested information on eligibility for entering into a reimbursement agreement with VA.

Conclusion

Based upon the feedback received, VA concludes that tribal leaders and tribal organizations overwhelmingly support entering into reimbursement agreements for direct care services provided to eligible non-AI/AN Veterans and that they find it feasible and advisable. Based on the commenters' recommendations and consistent with the policy and procedure associated with the current reimbursement agreement, it is recommended that VA approach this matter individually with each THP as some have more interest and more capacity than others, as expressed by tribes during this consultation.