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"Native American Veterans: Ensuring Access to VA Health Care and Benefits"

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Good afternoon, Chairman Tester, Ranking Member Moran, and Members of the Committee. I am Roselyn Tso, Director of the Indian Health Service (IHS). Thank you for the opportunity to testify on Native Veterans' access to the Department of Veterans Affairs (VA) health care. The IHS mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. As an agency within the Department of Health and Human Services (Department), the IHS provides federal health services to approximately 2.7 million American Indians and Alaska Natives from 574 federally recognized tribes in 37 states, through a network of over 680 health care facilities, including hospitals, clinics, health stations, and other facility types.

The American Indian and Alaska Native (AI/AN) population experiences health and other disparities that disproportionally affect their quality of life. American Indians and Alaska Natives have an average life expectancy that is five years shorter than that of the general U.S. population, and they are more likely than people of other races or ethnicities to experience social and economic difficulties that may impact their health or wellness, such as lower income, lower education levels, and higher unemployment.[1]

As health needs change and new approaches to care emerge, the IHS, VA, and their tribal partners will continue to combine their expertise, resources, and efforts to help the nearly 145,000 AI/AN veterans living in the United States.[2] The IHS and VA's Veterans Health Administration (VHA) continue work to provide eligible AI/ANAI/AN veterans with access to care closer to their homes, promote cultural competence and quality health care, and focus on increasing care coordination, collaboration, and resource-sharing between the agencies.

In the late 1980's, Congress directed the IHS and VA to explore the feasibility of entering into an arrangement for sharing of medical facilities and services, as required by the Indian Health Care Improvement Act (IHCIA).[3] The results of this collaboration led to our initial MOU in 2003. The Patient Protection and Affordable Care Act of 2010 permanently reauthorized the IHCIA, and authorized IHS to enter into (or expand) arrangements for the sharing of medical facilities and services between IHS, Indian Tribes, Tribal organizations , and VA.[4] The law also directs VA to reimburse the IHS, Indian tribes, or tribal organizations for the services provided to eligible beneficiaries of VA. More recently, Congress amended the statute to direct VA to reimburse Urban Indian organizations for the services provided to eligible beneficiaries of VA, and to clarify that this section includes Purchased/Referred Care[5].

Since implementing this provision in 2012, VA has reimbursed over $186 million for direct care services provided by IHS and Tribal Health Programs (THP), covering approximately 15,000 AI/AN veterans. Currently, IHS and VA operate under a national reimbursement agreement, inclusive of 74 IHS federal facilities. Likewise, VA has entered into 119 individual reimbursement agreements with THP, and 1 Urban Indian Organization facility.

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[1] IHS Disparities Fact Sheet, April 2018: https://www.ihs.gov/newsroom/factsheets/disparities/.
[2] VA Veteran Population Projection Model, 2018: https://www.va.gov/vetdata/veteran_population.asp.
[3] Indian Health Service and Department of Veterans Affairs health facilities and services sharing (25 U.S.C. § 1680f).
[4] Sharing arrangements with Federal agencies (25 U.S.C. § 1645).
[5] Section 1113 of the Consolidated Appropriations Act of 2021 (25 U.S.C. § 1645(c)).

In March 2019, the Government Accountability Office (GAO) released a report entitled, *VA and Indian Health Service: Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans* (GAO-19-291). In its report, GAO recommended that VA and IHS revise the MOU and related performance measures to ensure consistency with key attributes of successful performance measures, including having measurable targets.

We are also working with VA on implementing newly enacted legislation, including an exemption from most VA health care copayments for Indian and urban Indian Veterans added to section 1730A of title 38, United States Code, by the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (Public Law 116-315) and clarifications related to Purchased/Referred Care (PRC) added to section 405(c) of the Indian Health Care Improvement Act (25 U.S.C. 1645) by the Proper and Reimbursed Care for Native Veterans Act (Public Law 116-311).

IHS-VA MOU

In October 2021, the IHS and VHA announced a new memorandum of understanding (MOU) aimed at improving the health status of AI/AN) veterans. The MOU establishes a framework for coordination and partnering between our federal agencies to leverage and share resources and investments in support of our mutual goals. We entered into an initial MOU in February 2003 to improve access and health outcomes for AI/AN veterans and subsequently updated the MOU in October 2010. We believe this newly signed MOU builds on nearly two decades of experience and will continue to support our objective to improve access and health care outcomes for AI/AN veterans. The new MOU identifies four mutual goals:

1. Access - Increase access and improve quality of health care and services for the benefit of eligible Al/AN veteran patients served by VHA and IHS. Effectively leverage the strengths of VHA and IHS at the national, regional, and local levels to support the delivery of timely and optimal clinical care.

2. Patients - Facilitate enrollment and seamless navigation for eligible Al/AN veterans in VHA and IHS health care systems.

3. Information Technology - Facilitate the integration of electronic health records and other Health Information Technology systems that affect the health care of Al/AN veterans.

4. Resource Sharing - VHA and IHS will improve access for their patient populations through resource sharing, including technology, providers, training, human resources, services, facilities, communication, reimbursement, etc.

Now that we have executed a new MOU, we have begun the process of creating a new operational plan that will identify operational goals and performance metrics. We are currently seeking input from Tribes and Tribal Organizations through Tribal Consultation as well as conferring with Urban Indian Organizations on a draft operational plan. Conducting annual

Tribal Consultation and Urban confer will be essential to ensuring ongoing involvement by Tribal leaders and Urban Indian Organization leaders with the MOU.

Recently, VHA established an Office of Tribal Health, which will coordinate and lead the MOU partnership on the VHA side. Additionally, on September 27, 2022, the National Indian Health Board (NIHB) hosted an in-person Tribal Consultation session on the MOU Operational Plan and Reimbursement Agreement in Washington, DC, and following up on the in-person Tribal Consultation session, the NIHB also held a virtual VHA and IHS Tribal Consultation on October 11, 2022 and an Urban Confer session on October 25, 2022.

On December 5, 2012, VHA and IHS entered into an agreement for reimbursement for direct health care services (Reimbursement Agreement) to facilitate reimbursements from VA to IHS operated facilities for certain health care services provided to VHA-enrolled AI/AN veterans who are eligible to receive services at the IHS. Similarly, VHA has entered into numerous individual reimbursement agreements with THP for certain health care services provided to VHA-enrolled AI/AN veterans who are eligible to receive services at their facilities. The IHS is not a party to any agreement between VHA and a THP.

Since 2012, the Reimbursement Agreement between the IHS and VHA has been amended four times. While the first two amendments extended the period of the agreement, the first substantial change occurred in June 2018 through an amendment to the Reimbursement Agreement that extended the period of the agreement and added a section on Pharmacy Services to clarify formulary and outpatient pharmacy services.

In September 2020, both agencies amended the Reimbursement Agreement to clarify the definition of the term "direct care services" to include services provided through telehealth; to clarify language in the quality section of the agreement relating to certification and accreditation requirements; to extend the period of agreement an additional 2 years beyond the existing term, through June 30, 2024; and to add a new section for reimbursement for care or services provided by the IHS through a contract established by the IHS (i.e., the IHS Purchased/Referred Care program) for health care provided outside of the facility during the COVID-19 emergency period that meets certain conditions. Moving forward, both of our agencies will continue to work together to review and identify needed updates to the Reimbursement Agreement consistent with current law.

In addition to the aforementioned MOU, VA and the IHS signed a memorandum of agreement and an interagency agreement (IAA) in October 2020, for VA to support the IHS during the COVID-19 public health emergency (PHE). The agreements permitted VA to provide hospital care and medical services for IHS non-veteran beneficiaries in VA facilities and provide staff, supplies, equipment, and consumables for IHS facilities. As a result, IHS entered into agreements with 11 VA medical centers (VAMC) to accept IHS patients and entered into six agreements to accept deployment teams for necessary staff support of nurses and x-ray technicians.

The IHS and VHA continue to deliberate on adjusting consultation and confer plans to increase national awareness of the goals of the MOU in order to gather meaningful input.

Health Information Technology Modernization

In 2020, IHS launched a multi-year effort to modernize our health information technology (IT) systems for IHS, tribal, and urban Indian health care programs. The Health IT Modernization program will replace our Resource and Patient Management System (RPMS) electronic health record (EHR), which handles everything from patient registration to billing insurance.

IHS and VA collaborate on Health IT Modernization through the Federal Electronic Health Record Modernization (FEHRM) to share lessons learned, artifacts, methods, and experiences through monthly updates and participation in the IHS executive steering committee.

IHS and VA completed an interoperability pilot in 2021 to ensure our new technology would effectively share data to support coordination and quality of care enhancements for Native veterans who utilize both systems of care.

After significant Tribal Consultation and Urban Confer, IHS decided to replace RPMS with a commercial solution. On August 4, 2022, IHS took an essential next step in the Health IT Modernization by releasing a Request for Proposals (RFP) for commercial products to replace RPMS, including the complex work of implementing, training, and supporting the new solution across the country. The new EHR will connect isolated data and improve health care coordination for patients throughout Indian Country, creating a sustainable system for future generations over the next several years.

The IHS remains firmly committed to improving quality and access to health care for AI/AN veterans. We appreciate all your efforts in helping us provide the best possible health care services to the veterans we serve.

Thank you. I am happy to answer any questions you may have.