United South and Eastern Tribes, Inc.

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Submitted via email to:
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January 14, 2015

Tracy Parker Warren
Office of Public and Intergovernmental Affairs
Office of Tribal Government Relations
U.S. Department of Veterans Affairs
810 Vermont Avenue NW, Room 1068
Washington, DC 20420

Re: Comments of the United South and Eastern Tribes, Inc. on Notice of Tribal Consultation: Section 102(c) of the Veterans Access, Choice, and Accountability Act of 2014

Dear Ms. Warren,

The United South and Eastern Tribes, Inc. (USET) is pleased to provide the Department of Veterans Affairs (VA) with the following comments in response to the agency's December 30, 2014 tribal consultation notice requesting feedback on the feasibility of expanded reimbursement agreements between the Indian Health Service (IHS) and the VA for the provision of direct care services to non-American Indian or Alaska Native (AI/AN) veterans under Section 102 of the Veterans Access, Choice, and Accountability Act of 2014.

USET is a non-profit, inter-tribal organization representing 26 federally recognized Indian Tribes from Texas across to Florida and up to Maine.[1] Both individually, as well as collectively through USET, our member Tribes work to improve health care services for American Indians. Our member Tribes operate in the Nashville Area of the IHS, which contains 36 IHS and Tribal health care facilities. Tribal members may receive health care services at IHS facilities, as well as in Tribally-operated facilities operated under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

Introduction

USET applauds the VA for incorporating the input of Tribal governments and organizations as it implements the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146), which will impact the delivery of health care to IHS eligible populations. Veterans, like many Indian communities suffer from health disparities, including a disproportionate amount

[1] USET member Tribes include: Alabama-Coushatta Tribe of Texas, Aroostook Band of Micmac Indians of Maine, Catawba Indian Nation of South Carolina, Cayuga Nation of New York, Chitimacha Tribe of Louisiana, Coushatta Tribe of Louisiana, Eastern Band of Cherokee Indians of North Carolina, Houlton Band of Maliseet Indians of Maine, Jena Band of Choctaw Indians of Louisiana, Mashantucket Pequot Indian Tribe of Connecticut, Mashpee Wampanoag Tribe of Massachusetts, Miccosukee Tribe of Florida, Mississippi Band of Choctaw Indians, Mohegan Tribe of Connecticut, Narragansett Indian Tribe of Rhode Island, Oneida Nation of New York, Passamaquoddy Tribe at Indian Township of Maine, Passamaquoddy Tribe at Pleasant Point of Maine, Penobscot Indian Nation of Maine, Poarch Band of Creek Indians of Alabama, Saint Regis Mohawk Tribe of New York, Seminole Tribe of Florida, Seneca Nation of New York, Shinnecock Indian Nation of New York, Tunica-Biloxi Tribe of Louisiana, and the Wampanoag Tribe of Gay Head (Aquinnah) of Massachusetts.

chronic conditions and limited access to adequate care. For this reason, we encourage the collaboration of the VA and IHS for care for two of America's most vulnerable populations. USET would like to extend its support for the expansion of reimbursement agreements between the VA and IHS health delivery system, as we believe the Veterans Choice Program, in partnership with IHS will lead to an increase in access to care for veterans, increased revenues for the underfunded Indian health care delivery system, support additional services provided to all patients, and promote greater collaboration between two similarly situated federal direct service providers. As the two agencies evaluate the feasibility of expanded agreements between the IHS and the VA pursuant to section 102(c) of P.L. 113-146, we urge the VA and IHS to continue to consult with all of Indian Country each step of the way as P.L. 113-146 is implemented and reimbursement agreements are developed and/or revised.

Feasibility of Expanded IHS-VA Reimbursement Agreements

The Indian health care delivery system, including both IHS and Tribally operated facilities, is well-positioned to provide direct care services to eligible non-Indian veterans on a voluntary basis[2]. A majority of the IHS and Tribal facilities have an existing benefits coordination infrastructure in place that supports billing to other federal programs (as well as private insurance), including Medicare and Medicaid. Though in general this care is delivered to American Indian and Alaska Native (AI/AN) people, many facilities already treat a variety of non-Indian patients due to their relationship with the Tribal community (i.e. spouses, adopted or foster children, and non-Indian women pregnant with an eligible Indian's child). Through provisions within the Indian Health Care Improvement Act (IHCIA), some Tribally-operated facilities even treat insured members of the local non-Indian community as an additional source of third-party revenue. These facilities often fill critical gaps in access, as they are frequently among the only local healthcare options in rural America.

In addition, the IHCIA already provides for the reimbursement of services provided to eligible veterans within the Indian Health System. Under section 405(c) of the IHCIA as amended and enacted by the Affordable Care Act, the VA is required to reimburse the IHS, an Indian Tribe, or a Tribal organization for services provided to beneficiaries eligible for services from either Department.[3] Over two years ago, IHS and VA signed a national agreement, which implemented a portion of this provision by allowing IHS to be reimbursed for direct care services provided to eligible AI/AN veterans. With many AI/AN veterans living far from the nearest VA facility, this agreement allows our veterans to receive the care to which they are entitled in a culturally competent environment without unnecessary expense. It has proven beneficial at IHS facilities and for those Tribal facilities who have successfully negotiated their own reimbursement agreements with the VA. These agreements are poised to serve as the foundation for expanded agreements under P.L. 113-146.

It is important to note, however, that as the VA seeks to expand the scope of these agreements, many USET Tribes have yet to successfully negotiate reimbursement agreements with their local VA facilities. Although officials at VA and IHS headquarters maintain that the national agreement is a floor rather than a ceiling, many local VA offices in the USET region will not entertain additional or alternate language. USET requests that the VA issue a directive to all of its local offices clarifying the nature of the national agreement and instructing officials to work with Tribes to implement agreements that reflect local needs.

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[2] Under Section 813 of the Indian Health Care Improvement Act, Tribes and Tribal Organizations may elect, but are not required, to provide health care services to non-beneficiaries.

[3] Section 405(c) of the IHCIA reads: "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).

The implementation of P.L. 113-146 is also an opportunity for the VA to revisit the types of services that are reimbursed. The current agreements limit reimbursement to direct care services provided by IHS and Tribal programs. Limiting reimbursement limits the amount and type of care AI/AN veterans are able to receive, as all IHS and Tribal facilities refer outside the Indian Health System for care through the Purchased/Referred Care program (PRC). We maintain that this limitation runs counter to the plain language of Section 405(c), which provides for reimbursement "where services are provided *through* the [Indian Health] Service, an Indian Tribe, or a Tribal organization …" (emphasis added) without limitation to direct services. It is also in conflict with Section 2901(b) of the Affordable Care Act, which specifies that health programs operated by the Indian Health Service, Indian Tribes, Tribal organizations, and Urban Indian organizations are payers of last resort.[4] Congress clearly intended through these provisions to shield IHS and Tribal contract health service dollars from being used to pay for services when other sources of funding are available, including funding from VA. With this in mind, we believe any expanded agreements should include reimbursement for the full range of services that the Indian Health System provides.

Conclusion

USET appreciates the opportunity to provide comments. As the VA implements the Veterans Access, Choice, and Accountability Act of 2014, USET stands ready to assist in ensuring that the VA delivers on its promise to our veterans, both Indian and non-Indian. We see these systematic changes as an opportunity for collaboration, dialogue, and lasting transformation, and look forward to an improved partnership. Should you have questions or require additional information please do not hesitate to contact Ms. Liz Malerba, USET Director of Policy and Legislative Affairs, at (202) 624-3550 or by e-mail at lmalerba@usetinc.org.

Sincerely,

Brian Patterson
President

Kitcki A. Carroll
Executive Director

CC: USET member Tribes
Wanda Janes, USET Deputy Director
Dee Sabattus, USET THPS Director
Liz Malerba, USET Policy and Legislative Affairs Director
Hilary Andrews, USET Health Policy Analyst
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"Because there is strength in Unity"

[4] 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."