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NATIVE VETERANS' ACCESS TO HEALTHCARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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NATIVE VETERANS' ACCESS TO HEALTHCARE

WEDNESDAY, OCTOBER 30, 2019

U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
Washington, DC.

The subcommittee met, pursuant to notice, at 10:06 a.m., in room 210, House Visitors Center, Hon. Julia Brownley [chairwoman of the subcommittee] presiding.

Present: Representatives Brownley, Lamb, Cisneros, Sablan, Dunn, Bergman, and Steube.

Also present: Representatives Takano, Haaland, Cunningham, Gallego, and Gianforte.

OPENING STATEMENT OF JULIA BROWNLEY, CHAIRWOMAN

Ms. BROWNLEY. Good morning and welcome to the Subcommittee on Health's hearing on Native Veterans Access to Care.

Before we begin, a little business, and I would like to request unanimous consent for Congresswoman Haaland Congressman Gallego to join us for today's hearing.

Without objection—oh, and Congressman Gianforte to join us for today's hearing as well. We welcome the three Members on the committee and three additional Members to today's committee, and I appreciate your attendance very much.

Today is a historic day in Washington, DC. as it is the first time in at least 30 years that either chambers' Veterans' Affairs Committee has held a hearing solely on the health care needs of our Native Veterans. I know Mr. Bergman had a hearing in his district, but this is the first one in Washington, DC. in 30 years.

American Indian and Alaska Native Peoples have served in the United States Armed Forces since the Revolutionary War, and served without being acknowledged as citizens until 1924. Native People serve at consistently higher rates than any other racial or ethnic group. The rates are even greater for Indian and Alaska Native women, who serve as disproportionately higher rates than Native men and non-Native women.

This hearing is different than most this committee holds as it is an examination not only of VA and the health status of Native Americans, but of VA as a part of a Federal Government that has a solemn duty to uphold trust and treaty obligations to tribal people.

In exchange for land and resources, the United States promised members of Indian tribes safety, economic opportunity, and health care. The Federal provisions of health care is not a handout, it is

a payment on a debt, and that debt, sadly, has continuously been defaulted on by the United States.

It is essential that we recognize this Federal obligation does not stop at the doors of the Indian Health Service (IHS), it is an obligation of all parts of our Government. For that reason, we have called this hearing to hear from tribes and tribal organizations to learn how the VA is meeting its Federal Trust Responsibility and where do they need to do better.

We know that while Native People serve more than anyone else, they have the lowest health status of any other race or ethnicity in the United States. Native Veterans are more likely to have service-connected disabilities, experience sexual assault and post-traumatic stress, and die by suicide.

In 2010, the VA and Indian Health Service (IHS) established a Memorandum of Understanding (MOU) to improve the health status of American Indian/Alaska Native Veterans through coordination, improved services, and resource sharing between VA, IHS, and federally recognized tribes.

This year, VA and IHS plan to revise the 2010 MOU. We would like to check in on the progress made over the past 9 years; what went well, what did not, and what is needed in the new MOU to ensure we truly are improving the health status of American Indian and Alaska Native Veterans.

Before we move on to our first panel, I want to express to you my great disappointment that Dr. Stone, who will be the signatory of this new MOU, is not here today to speak to these issues. Secretary Wilkie spoke many times this summer, with several dozen news articles to show for it, that Native Veterans' access to health care is one of his top priorities.

Now, while I do not doubt that, I do not doubt his commitment of the program offices, I do not doubt that the commitment of the program officers here today, I know that the—I am sorry.

Now, while I do not doubt the Secretary's commitment, I am concerned about the progress we are making in a successful conclusion to a negotiation with the MOU.

With that, I would like to recognize Acting Ranking Member General Bergman for 5 minutes for any opening remarks he may wish to make.

OPENING STATEMENT OF JACK BERGMAN, ACTING RANKING MEMBER

Mr. BERGMAN. Thank you, Chairwoman Brownley. It is an honor to be with you all today and filling in for Dr. Dunn, who is the ranking member, and he and I sat down and chatted about the importance of this hearing. As you all know, he had a conflict, but he will be here as soon as he can.

In the meantime, it is a great, again, honor to be here in his place to recognize the committed service of so many of our American Indian and Alaska Native Veterans. There is perhaps no better hearing that we could be having as we prepare to return to our districts for the Veterans Day time period here than the hearing we are having today.

The numbers show that there is no other ethnic group that steps up to serve the United States in the United States Armed Forces

more than Native Americans. My district, the First District of Michigan, is home to eight federally recognized tribes, and their deeply embedded patriotism and commitment to service is a credit to our community and an inspiration to all.

As we will learn this morning, Native Veterans often face unique barriers to care and we still have a long way to go in ensuring that they receive the care, benefits, and services that they deserve as veterans.

I look forward to hearing about how the Department of Veterans Affairs is working with Indian Health Service, tribal organizations, and other important stakeholders, many of whom are represented here today, to identify, break down, and eliminate the barriers to success.

I am glad to hear that VA is actively working on a new memorandum of understanding with IHS, but that MOU will only be effective if; number one, it includes measurable metrics and improved coordination of care, particularly where referrals to specialty care services are concerned; number two, is developed with a direct involvement and engagement of those will be most impacted by it, that is, the Native American Veterans themselves; and, three, is supported by an ongoing commitment to cultural respect, sensitivity, and trust and relationship-building.

I appreciate the many tribal nations and communities that are represented here today either as witnesses or through the statements for the record that have been provided. I am very much looking forward to listening to your testimony today, and I want you to know that your service has not and will never be forgotten. Thank you for that.

With that, I yield back.

[Audio malfunction in hearing room.]

Ms. BROWNLEY.—Andrew C. Joseph, Jr., Immediate Past Member-at-Large and Portland Area Representative for the National Indian Health Board. Next we have Kevin J. Allis, Chief Executive Officer for the National Congress of American Indians, followed by Ms. Sonya Tetnowski, Vice President of the National Council of Urban Indian Health.

In addition, we are joined by Chief William F. Smith on behalf of Alaska Native Health Board. Finally, Chief Marilynn Malerba on behalf of the Indian Health Service Tribal Self-Governance Advisory Committee.

With that, I now recognize Mr. Joseph for 5 minutes, and welcome.

STATEMENT OF ANDREW C. JOSEPH, JR.

Mr. JOSEPH. Good morning, Chairman Brownley and members of the subcommittee. On behalf of the National Indian Health Board, thank you for the invitation to testify on health services for Native Veterans.

[Speaking native language.] Badger is my name, I am Andy Joseph, Jr. I am an enrolled member of the Confederate Tribes of the Colville and I am an Army veteran. I can speak firsthand about ongoing challenges in Native Veterans' health.

Native Veterans have served in every U.S. military conflict of the past 200 years, yet today's hearing is the first ever on health care access for Native Veterans. Thank you for this step.

On behalf of the National Indian Health Board and as a veteran, I am disappointed that Secretary Robert Wilkie and Rear Admiral Weoki [phonetic] will not be here today. Both Secretary Wilkie and the Rear Admiral have spoken about their desire to better serve the health needs of Native Veterans and we are counting on them and this Administration to Native Veterans.

The Federal Government has a dual responsibility to Native Veterans on one obligation because of our political status as Native people and one because of our military service. Our people served in the military at higher rates than any other ethnicity in America. We continue to hold up our end of the bargain.

There are many challenges that Native Veterans face in receiving quality health care. Please allow me to share some policy recommendations. All equally important, these are discussed in detail in our written testimony.

One, tribal consultation can help remedy many issues for Native Veterans. We invite the VA to engage in regular tribal consultation with the Native Veterans.

Two, there are limited options within the VA for culturally appropriate programs and services tailored for Native Veterans; that needs to change.

Three, make advance investments directly to tribes for Native Veterans mental health care. Native Veterans are twice as likely as other veterans to return home with post-traumatic stress disorder. Depression, alcohol and drug use disorders are significantly higher among our veterans. The same is true with suicide. These issues and transition from active service back home needs sufficient investment.

Four, we ask the VA committee to actively support advance appropriations for the Indian Health Service and other programs. Our people are still suffering from the most recent 35-day government shutdown. It has been a decade since the VA has benefited from advance appropriations, it is IHS's turn. We ask you for your active support.

Five, Indian Health Services is a payer of last resort. We strongly recommend that Congress makes explicit in law that VA is required to reimburse IHS and tribes for services under purchase and referred care.

Six, Congress should exempt Native Veterans from co-pays and deductibles consistent with trust responsibility for health care for all Native people.

Seven, when it comes to health IT modernization, Congress must ensure parity in appropriations and technical assistance to tribes to ensure interoperability between the VA and IHS. It is shameful that Native Veterans are forced to hand carry health records between their IHS and a VHA provider.

Eight, we need a tribal technical advisory committee to the VA. We strongly request that the VA committee favorably act on the bipartisan H.R. 2791, introduced by Representative Haaland.

Nine, tribal leaders and veterans continue to request that the VA create written guidelines and policies to clarify referral process

under the VA and IHS memorandum of understanding; the VA has yet to do so. This recommendation was also made in 2019 Government Accountability Office.

In conclusion, on behalf of the National Indian Health Board, thank you for holding this important hearing. We have a long way to go together to improve care for Native Veterans, we will serve as the—and this way as well.

Thank you.

[THE PREPARED STATEMENT OF ANDREW C. JOSEPH, JR. APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Mr. Joseph.

[Audio malfunction in hearing room.]

STATEMENT OF KEVIN J. ALLIS

Mr. ALLIS. Thank you. Chairman Brownley and Acting Ranking Member General Bergman, and members of the subcommittee, on behalf of the National Congress of American Indians (NCAI), I would like to thank you for holding this important hearing today to discuss the many issues affecting Native Veterans across health care.

I really do appreciate the comments that everybody has made here today and also Mr. Joseph. There is a commonality, there are many things we will touch on together, which shows that we start from a strong foundation of being on the same page.

I serve currently as the Chief Executive Officer of NCAI and I am an enrolled member of the Forest County Potawatomi Community in Northern Wisconsin. I look forward to working with members of the subcommittee and other Members of Congress to better fulfill the Federal Government's commitment to provide for the well-being of American Indian and Alaska Native Veterans when they return home.

Founded in 1944, NCAI is the oldest and the largest national organization composed of tribal nations and their citizens. Tribal leaders created NCAI in response to termination and assimilation policies that threatened the existence of tribal nations.

Since then, NCAI has fought hard to protect and enhance tribal treaty rights, sovereign rights, secure tribal traditional laws and customs of our tribal nations, promote the common understanding of tribal nations' roles in the family of American Governments, and improve the quality of life of all Native Americans across the country.

American Indians and Alaska Natives, as mentioned here already, have a long history of distinguished service to this country. Per capita, American Indians and Alaska Natives serve at a higher rate in the Armed Forces than any other group of Americans that have served in all the Nation's wars since the Revolutionary War. In fact, in periods when we were not even U.S. citizens, our American Indian Natives participated as veterans for this country. Despite this esteemed service, Native Veterans have lower personal incomes, higher unemployment rates, and are more likely to lack necessary health insurance.

The Federal Government's responsibility, as you mentioned, to provide quality health care to Native Veterans comes from two places: their service to this country and the Federal obligations

that are owed to Indian country due to giving up so much land back in the last two centuries. The United States must honor its commitments to Native Veterans by ensuring Federal policy addresses its unique needs. There is no way to accomplish this, though, without us being at the table and being in the conversations where decisions are made.

Right now, the Department of Veterans Affairs and the Indian Health Service are negotiating a new memorandum of understanding that will impact Native Veterans for many years to come. The VA and IHS must ensure that Indian country has a voice in these discussions, so that this next MOU fully addresses the need Native Veterans have regardless of whether they are living on rural reservations or in major urban areas.

Ensuring Native Veterans are getting the health care they deserve requires communication and cultural competency. On the ground, this means streamlining processes for tribal nations to become tribal veterans service organizations that provide access to culturally appropriate assistance for Native Veterans when they are pursuing VA benefit claims. In Washington, DC. it means passing and implementing legislation that will ensure Native Veterans' voices are heard by the highest offices in the VA.

Accordingly, I encourage you all and every member of this subcommittee to support H.R. 2791, the Department of Veterans Affairs Tribal Advisory Committee Act of 2019. This bipartisan legislation, which was introduced by Congresswoman Deb Haaland, and would establish a tribal advisory committee to advise the Secretary on how to improve programs and services for American Indian and Alaska Native Veterans.

In addition, to improving engagement with Native Veterans, Federal policymakers must make it easier for Native Veterans to access health care through increased coordination between the VA and IHS system.

For reasons ranging from cultural competency to significantly reduced travel times, Native Veterans often prefer to receive care at IHS, tribal or Urban Indian Organization facilities. Therefore, NCAI calls on Congress and the Administration to ensure referrals through the Purchase Referred Care Program and services provided to Native Veterans by Urban Indian Organizations are reimbursable by the VA.

Additionally, we must eliminate VA's co-sharing for Native Veterans, as the Federal Government has treaty and trust obligations to provide health care to American Indian and Alaska Native people.

Finally, I want to briefly emphasize the importance of advance appropriations for IHS and the Bureau of Indian Affairs. IHS is often responsible for providing health care to Native Veterans, and access to IHS and VA facilities often depends on services provided by the BIA. Protecting funding for these agencies from uncertainties in the Federal budget process will improve access to vital health care for Native Veterans

I want to close my testimony by expressing my sincere gratitude for the service and sacrifice of all the veterans, especially our Native Veterans, many of whom are tribal leaders across Indian coun-

try. It is incumbent upon us all to ensure the Federal Government to honor its solemn commitments to Indian country.

Thank you again for this opportunity to testify and I would be happy to answer any questions when it is over.

[THE PREPARED STATEMENT OF KEVIN J. ALLIS APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Mr. Allis.

I now recognize Ms. Tetnowski for 5 minutes.

STATEMENT OF SONYA M. TETNOWSKI

Ms. TETNOWSKI. Good morning. My name is Sonya Tetnowski. I am an enrolled member of the Makah tribe, a U.S. Army Veteran Paratrooper, and the CEO of the Indian Health Service of Santa Clara Valley. I am also the Vice President of the National Council of Urban Indian Health (NCUIH) and the President of the California Consortium of Urban Indian Health. Urban Indian Organizations (UIOs) provide high-quality, culturally competent care to urban Indians, which consists of about 75 percent of all American Indians and Alaska Natives (AI/AN).

I would like to thank Chairwoman Brownley, Mr. Bergman, and other distinguished members of the subcommittee for holding this important hearing.

It is my pleasure to testify today regarding H.R. 4153, the Health Care Access for Urban Native Veterans Act. We ask that the Department of Veterans Affairs fully implement the VA and IHS MOU, and reimbursement agreement for direct care services. This action would allow UIOs to be reimbursed for providing health care to AI/AN veterans. Most AI/AN veterans live in urban areas and would benefit from the culturally competent care provided by UIOs.

Despite the history between tribal people and the United States Government, American Indians and Alaska Natives continue to serve this country at a higher rate than any other group in the Nation. We have a responsibility to protect the land of our ancestors, respect their teachings, and pass that knowledge on to generations that follow us. I am sad to report that according to a 2014 Minority Veterans Report conducted by the National Center for Veterans Analysis and Statistics, it clearly states that American Indians and Alaska Natives have the highest poverty rate and the highest uninsured rate. This seems out of balance. We serve, we protect, but yet we struggle to have parity in the system.

We ask you to help us complete the Indian Health Service/Tribal Health Program/Urban Indian Organization (I/T/U) system of care. In order to begin to address the health disparities of urban Native communities, I ask that this committee take into account the national health care spending average of $9,523 and the $19,228 that VA spends in Santa Clara County per patient served, compared to the $3,688 currently allocated to me to serve that same patient. UIOs are efficient and effective, and we deserve parity.

We also ask that medication delivery and dispensing be included in the agreement this time, as many of our veterans are homeless and do not have addresses to receive their medication. As these are our community members, we do what we can to help them overcome these obstacles.

The balance of traditional and Western medicine is vital to the healing of many of us, which is why my UIO, the Indian Health Center of Santa Clara Valley, provides an annual Wiping of the Tears ceremony, so that my fellow soldiers and I can stand together and grieve and heal as only another soldier would understand. For many urban Indians, the UIOs are the only place where they can receive cultural and traditional services.

Bring parity to the system and together let us wrap our soldiers in culturally competent care, help us strengthen our I/T/U system of care.

Again, NCUIH strongly recommends, pursuant to Section 405(c) of the Indian Health Care Improvement Act, that the VA-IHS MOU include reimbursement for care provided by the UIOs.

I would like to present you with this medicine, which consists of abalone shells, sage, cedar, and sweet grass to remind you what traditional medicine has done for me and my fellow soldiers. Our traditions keep us grounded and provide that support needed to heal the invisible wounds that we all have from serving and protecting this country.

With that, I ask you to support my work and the work of all Urban Indian programs to bring support for that healing to our communities.

Thank you for holding these hearings today and for the committee's support of parity in the I/T/U system of care and H.R. 4153. My full testimony has been provided for the record and thank you again for the opportunity to speak.

[THE PREPARED STATEMENT OF SONYA M. TETNOWSKI APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. Tet—Tetnowski——

Ms. TETNOWSKI. Tetnowski.

Ms. BROWNLEY.—I am not sure why I am having a hard time with that, but I am. I apologize, but I do also want to thank you for your service. Being a paratrooper is—just it is amazing and thank you very much.

I now recognize Chief Smith for 5 minutes.

STATEMENT OF CHIEF WILLIAM SMITH

Chief SMITH. [Speaking native language.] Chief Bill.

Good morning, my name is Chief Bill, Chief of Eyaks. My mother was the last full-blooded Eyak speaker, my father was a World War II veteran. I am also the Vice President of the Valdez Native Tribe, Executive Committee member of the Alaska Native Health Board and Vice Chair of the National Indian Health Board, and a Vietnam Vet.

On behalf of the Alaska Native Health Board, thank you, Chairman Brownley, Ranking Member Dunn, and distinguished members of the House Committee on Veterans' Affairs Subcommittee on Health for the opportunity to speak with you today. For the record, I have provided a written statement, which gives more background and details on the issues that I can share with you today. I hope mostly to honor our veterans, lift our government-to-government relationships between tribes and Federal Government involved in the Federal Trust Responsibility, and provide a description of the Alaska Tribal Health System and our Tribal Sharing Agreements.

I too am also disappointed that today we are not sitting with Rear Admiral Weocki or Secretary Wilkie or Dr. Stone for this important hearing recognizing the government-to-government relationship and to start a strong partnership between the tribes and the VA and Indian Health Service. It is my hope that we will continue to have tribal representatives on the IHS VA MOU team.

In our written comments, we also provide details on issues including, but not limited to, support of H.R. 2791 and S. 524, Department of Veterans Affairs Advisory Committee Act of 2019, including tribal representatives on Indian Health Service and the VA leadership team on renewing the MOUs reflecting the government-to-government relationships; review and revise of the VA Tribal Consultation Policy; build parity between the VA and the Indian Health Service; exempt Native Veterans from co-pay and deductions in recognition of the unique political status of American Indians and Alaska Natives on the Federal Trust Responsibility; and I support the Tribal Veterans Representative model.

I would like to start with the Tribal Sharing Agreement. Before the agreement, Alaska Veterans only had six points of access for care through the VA in an area that would cover the Lower 48 from coast to coast, and from the northern borders to the southern borders. Most vets went years, if not decades without care. After signing the agreement, veterans for the first time had access to care closer to home, from six locations to over 200, with little or no capital expense carried out by the VA, and even non-Native Veterans can be served at a Veterans Hospital that we have in Alaska.

As I was at the Alaska—recently at the Alaska Native Federal AFN meeting in Fairbanks, tribal delegates shared with the VA a need to go out to the cabins. When I say go out to the cabins, when the VA comes to Alaska they usually go to the hubs, Kotzebue, Fairbanks, Anchorage, and they say everything is good. What the veterans would like to see is them fly into Dillingham, get off the plane in Dillingham, get down to a skiff and go up river 50 miles, get out of that skiff at 50 miles, and go on a snow machine or a four-wheeler or dog sled and talk to the veteran in the cabin that has not got his share, that has come home from Vietnam, come home from Iraq, Afghanistan, and everything else, and ask him if he is Okay, because they are out there. I for one as a Vietnam Vet took 35 years to talk to my brother that was there before I was, or to even get care from the VA.

We support the Tribal Veteran Representative, the one way to help develop outreach, but support the Tribal Sharing Agreements, offer direct access to care with providing veterans with their families. That is the only way we are going to get the veterans out of the woods is through the Tribal Veterans Representatives, their aunts, their uncles, their kids that are going to tell that veteran this is a new VA; this is something that they can come home to, this is something that will welcome and take care of them.

Like I say, it took me 35 years to seek help, and I talked to my brother and he was there. It was a fireworks in Anchorage on the Fourth—I mean New Year's Eve and he was sitting there watching it, next thing you know he was on the deck. He was not there, he was back in Vietnam, he was out there on patrol and those were not fireworks, those were bombs and everything else coming in.

That is what we have. We are still 19 years old, we are still in Vietnam; we come home, but Vietnam come home with us and, not only did that, Agent Orange come home with us. If we had to build a Vietnam wall from the people that passed away since then with Agent Orange exposure, that wall would be tenfolds.

In conclusion, many veterans have broken the faith of the VA system, some have not accessed care in decades, like I said. Tribes in Alaska and across the Nation are working with the VA to help restore their faith. In Alaska, we have over 34,000 vets enrolled and out of an estimated 75,000 to 90,000 vets. More work needs to be done to reach the brothers and sisters when we work together with the VA and Health Service through consultation, with recognition of the strength of their tribes and Tribal Health Organizations bringing it to the table.

An important step would be to allow us for longer Tribal Sharing Agreements periods, support continuous care over time, allow for Tribal Representatives to join the leadership teams reflected in the government-to-government relationships, and will provide the best results for the meeting and need to honor our veterans.

Alaska Native Health Board thanks the subcommittee and looking forward to further support of members and their work on the veterans health care issues, and the Alaska Native Health Board welcomes any questions.

Thank you.

[THE PREPARED STATEMENT OF CHIEF WILLIAM SMITH APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you. Thank you very much, Chief Smith, and I thank you also for your service to our country.

Last, but not least, I now recognize Chief Malerba for 5 minutes.

STATEMENT OF MARILYNN MALERBA

Ms. MALERBA. [Speaking native language.] Good morning, Chairwoman Brownley, Acting Ranking Member General Bergman, and members of the subcommittee.

[Speaking native language.] My name is Chief, Many-Hearts-Lynn Malerba of the Mohegan Tribe. On behalf of the Indian Health Service Tribal Self-Governance Advisory Committee, it is a great honor for me to present our testimony before you today. Our formal written testimony has been submitted to the subcommittee for the record.

Native Veterans, as you have heard, have a uniquely special status with the United States. Our American Indian and Alaska Natives have fought for the U.S. Armed Forces in every war since colonial times; in fact, 39 Mohegan men fought at Bunker Hill. In exchange for the cession of lands, treaties between our Native governments and U.S. included health care for our people. As warriors for this Nation, Native Veterans are deserving of the best health care we can provide.

The VA reports that there are 145,000 Native Veterans living in the United States with an average life expectancy 4 years shorter than the general U.S. population and who are more likely than other veterans to experience social and economic difficulties that impact their health.

Tribal nations that elect to administer health programs and services under a self-governance agreement to their citizens are effective, because tribal nations know the needs of their communities and are in the best position to provide culturally appropriate solutions to address those local needs. However, Tribal Health Programs (THPs) are limited due to limitations imposed by the VA.

In recognition of the shared responsibility to provide better care, an MOU between the U.S. VA and IHS was implemented to access VA funding for services provided to our Native Veterans. There is a tremendous opportunity for all to work collaboratively to update the MOU and identify components that will ensure Native Veterans receive timely access to quality health care, the services that they are owed.

The Tribal Self-Governance Advisory Committee (TSGAC) strongly advocates for the following improvements. Veterans often require additional specialty services that are not available at IHS or THPs. If a Native Veterans needs a referral, that same patient must then be seen within the VA system before a referral can be secured. Veterans are then forced to maneuver a very complex health care system. Our recommendation is that the VA should accept referrals made by IHS and THPs and to ensure best services to our veterans. Further, the VA should include Purchased Referred Care (PRC) in the IHS THP reimbursement agreements to eliminate rationing of health care and delays in care.

Native Veterans who seek health care services at a VA facility are assessed with copayments, which is in direct opposition to the Federal Trust Obligation; we recommend the discontinuation of this practice.

The VA does not accept provider credentialing from THPs. Our recommendation is that they be accepted by the VA to ensure care coordination is effective and efficient.

IHS and THPs have significant workforce challenges due in part to most facilities being located in rural and remote locations. Our recommendation is that IHS and tribes be included in the planning of GME pilot program to ensure that any future regulations or policies work optimally in Indian country.

Only those IHS and Tribal Health Programs that use the Resource and Patient Management System (RPMS) system have access to CMOP, the Consolidated Mail Order Pharmacy. We recommend that information technology systems experts from both VA and IHS ensure that all systems used by Tribal Health Programs are compliant and compatible with the CMOP system.

The TSGAC is supportive of quality measures that provide further tracking of meaningful outcomes; however, we oppose the prospect of developing either data reporting requirements that affect reimbursements to IHS and THPs or that require new collection of data and reporting systems. Our recommendation is the VA and IHS work together and consult with tribes to develop evaluation measures for assessing the progress toward MOU goals.

Additionally, the VA should not oppose any additional quality programs upon IHS THPs because it is burdensome, costly, and unnecessary due to the fact that there are already quality requirements in place.

The VA belongs to a National Health Information Exchange and it reported to the GAO this year that IHS and THPs could join the exchange to access information about common veteran patients; however, IHS reported to GAO that testing and on-boarding costs to participate were prohibitive. We recommend that local VA health care facilities work with their local THPs to ensure health information can be exchanged through local health information exchanges rather than one national health exchange.

We recommend that the VA work in coordination with tribes to establish a tribal advisory board, because we know that those are effective forms to resolve issues in a government-to-government fashion.

In March 2019, the GAO reported that the MOUs signed by the VA and IHS lacked sufficient measures for assessing its goals. We recommend that Federal agencies focus their limited resources on actions that improve the health of Native Veterans by ensuring that the measures are focused on health care outcomes. They should be measured, developed, and agreed upon jointly.

In closing, the VA, IHS and Tribal Health Programs have made progress and have demonstrated a willingness to improve quality access to care for our Native Veterans, deservedly so, but as you see in our statement, there still are significant opportunities for improvement.

[Speaking native language.] I thank you very much for hearing my comments today.

[THE PREPARED STATEMENT OF MARILYNN MALERBA APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Chief Malerba.

I first want to recognize Chairman Takano has joined us. Chairman Takano chairs the Full VA Committee. Welcome, and thank you for being here.

Would you like to make any comments?

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN, FULL COMMITTEE

Mr. TAKANO. Just an opening statement.

Good morning and thank you so much, Congresswoman Brownley, for holding this important hearing.

I want to thank our witnesses from the National Indian Health Board, the National Congress of American Indians, the National Council on Urban Indian Health, the Alaska Native Health Board, and the IHS Tribal Self-Governance Advisory Committee. To those of you who served, thank you for your service.

It is critical that this subcommittee hears your voices and the voices of the tribal members that you represent. While we know Native Americans serve at higher rates than anyone else, they also endure the lowest health status of anyone else. This, frankly, is a national shame and a terrible violation of the Trust Responsibility the United States Government is obligated to uphold. We must do better.

VA must do more to ensure the goal of improving the health status of American Indian and Alaska Native Veterans is accomplished. I am disappointed to see that Under Secretary Dr. Stone is not here. While I commend the work of the program officers here

to testify, I know the needs of all Native Veterans cannot be met by these three program offices alone. This must be a priority VA-wide.

Again, I can not thank you enough for sharing your time with us, and I assure you that as part of my VA 2030 Vision this committee is dedicated to ensuring marginalized veterans are receiving access to the health care and benefits that they have earned. This is just the beginning of this committee's work on these issues.

I yield back, Madam Chair.

Ms. BROWNLEY. Thank you, Chairman Takano, and, again, thank you for joining us this morning.

I will recognize myself for 5 minutes for questions. I wanted to open by just saying that our Native Veterans, in my opinion, should be receiving actually the very best health care in our country, because they have been promised from two sources their health care, both from our country in our commitment to the health care of our Native Indians, including our Native Veterans, in addition to VA's commitment to our Native Veterans. If you compile those two pieces together, you should be getting the very best health care in our country, and clearly that is not the case.

It is very clear to me that there is much to work on and much to improve upon, which leads me to the place of the upcoming MOU. All of you have talked about issues, including the Advisory Committee that Ms. Haaland is leading on, issues around co-pays, issues about reimbursements for services, the duplicity of services that have been received, but all of these components need to be ironed out and worked through in this new MOU. We have learned a lot over the last 9 years and now it is time to really rectify that through a successful negotiations with the MOU.

My question is for each and every one of you on the panel. I want to and this committee wants to be assured that you are at the table for these negotiations. If you could comment on that for me, whether you feel assured that you will be at the table or you have concerns about being at the table.

I can just start with—I am sorry, I do not have my glasses on—we can start Chief—Mr. Joseph.

Mr. JOSEPH. Well, I am glad that you are asking the question and, you know, and part of the testimony, with the IHS funded the way that it is, it is discretionary and the recent, you know, Government shutdowns that I spoke to in my testimony really impact the services that would be provided to any of our veterans that come to our facilities, be it IHS or a tribal facility. It would be really good to be at the table, you know, when they are making those recommendations.

I testified in the Senate Committee on Veterans, you know, prior to the MOU being put in there and one of my asks was that the VA set up an Office of Indian Affairs in the VA, and they did that. Then the second one was to have the VA deploy doctors and nurses to our facilities, because the IHS is so far behind in actually having health care providers to provide the services, and the H.R. system that they deal with is causing a lot of issues, you know, on getting good quality providers that come to IHS facilities. There is——

Ms. BROWNLEY. Mr. Joseph, thank you. I only get 5 minutes myself, so I want to hear from all of the others on the panel——

Mr. JOSEPH. Okay.

Ms. BROWNLEY.—but I want to make sure whether you have a sense of whether you would be at the table for these negotiations around the MOU.

Mr. JOSEPH. I imagine that the National Indian Health Board would definitely have someone at the table there. Thank you.

Ms. BROWNLEY. Thank you.

Mr. Allis.

Mr. ALLIS. Yes, Chairwoman. My answer is, I certainly hope so. I do not feel comfortable right now with the situation and, as Mr. Joseph mentioned, there are other organizations that certainly are plugged into this.

I will say this, consultation should be going on right now about this. It has been the practice where, you know, these things get put together, these agreements get shaped, and then they bring them to Indian country after the decisions have already been made. I also note that the March 2019 GAO report mentioned that there used to be 12 work groups that discussed this and tribes only participated in three of them, but at least they were participating. Now there are three work groups and there is no tribal participation.

There is some level of concern for us there that in the crafting of this language addressing the issues that we all addressed today and that you acknowledge are properly being discussed at the table.

Ms. BROWNLEY. Thank you, sir.

Ms. Tetnowski.

Ms. TETNOWSKI. Thank you. We would welcome the opportunity to sit on the panel and be a part of a working group to discuss the parity issues that we continue to have in serving our Native Veterans in the urban community.

Thank you.

Ms. BROWNLEY. Thank you very much.

Chief Smith.

Chief SMITH. Yes, that would be the right thing to do if we could be on the panel to help, because when we had the MOU in Alaska with the VA, they come to the Alaska Native Health Board and we had consultation. I can tell you right now that it worked out great, because my doctor I have had with the Indian Health Service for 15 years and with the VA I have had three doctors in 1 year. My doctor knows me at the Indian Health Service, but the VA also needs to pick up their fair share, because it is something that I earned and it can make our Indian Health Service money go a lot further for those that are on it.

Yes, if I could be there, I will be there.

Ms. BROWNLEY. Thank you, Chief Smith.

Chief Malerba.

Ms. MALERBA. I hope so, but I am not sure that that is the case. I do not know that we have been given any assurances about that, but I will say this, consultation is more than just asking the question; consultation is actually doing something with the information you received during consultation. Had the VA and I just listened to the previous consultations around these topics, we probably

would not be sitting with you today talking about the ways that we can improve this program.

Ms. BROWNLEY. Thank you so much.

I have very little time left, but I do want to mention that a constituent of mine in my district is a dual user of VA and the Santa Barbara Indian Clinic—I am from California—and he uses as it seems like a lot of Native Veterans do, he uses the clinic, the Indian clinic for his primary care and then uses the VA for his specialty care. We know that his records are not going back and forth, and they seem to have—the VA providers specifically have limited to know understanding of his cultural needs. In fact, he told me and he told my staff that when he went to the VA, the VA staff responded by "I did not know Indians lived in this city."

This whole issue of cultural competency and a welcoming from the VA I think really does need to be addressed and I certainly would like your feedback on it, but my time has expired, but we can have further conversations about that offline.

I now welcome Dr. Dunn and recognize Dr. Dunn for 5 minutes. Thank you for joining us.

Mr. DUNN. Thank you very much, Madam Chair, and I apologize for being tardy. We have another committee meeting scheduled precisely at the same time.

I want to thank General Bergman for sitting in for me. Thank you very much, General Bergman.

With that, I will yield the remainder of my time to General Bergman.

Mr. BERGMAN. Thank you. Thank you, Dr. Dunn, and thank you, Chairwoman Brownley.

You know, God puts us where he wants and when he wants us there, it is up to us to figure out the why. Listening to your comments, I know why I was here today pinch-hitting for Dr. Dunn at the beginning is to hear your words.

Chief Smith, thank you for your service, welcome home. As I look at our fellow Vietnam Veterans, because you mentioned something that—the Vietnam wall—I am not going to ask you to provide comment, but I am guessing I will maybe get some nodding of heads that maybe—not maybe, I know for a fact that, as a country, if we had started welcoming our brothers and sisters home 50 years ago, we would not have some of the mental health, depression, suicidal issues we have amongst our veterans period from Vietnam, but especially those tribal members.

Right now we are trying here in the committee as a whole to get the Improve Act, which is a bipartisan bill that Representative Chrissy Houlahan and I have put out there to get it to the committee, to get it—to get it out there, so that we can reach out to, I am guessing your tribal members are the majority of that 70 percent of the veterans outside the VA systems who take their lives on a daily basis, and the purpose of the Improve Act is to reach out and make contact with you and your tribal members.

Now, having said that, when you try to put something into place, we have a lot of acronyms in the world and, you know, I like logjam. We all can visualize what a logjam is. Well, in this case, it is layers of Government is the log. When we start putting in new layers, we do not necessarily increase output and better results.

Would any of you care to comment on what is preventing the VA and the tribes from sitting down and hammering out for specific credentialing metrics, so we can get providers credentialed in both sides? Anyone care to comment?

Chief SMITH. I know when I meet with the VA and I meet with the Indian Health Service what I tell them to do is to tear down their towers. They have got to work together, that is the most important thing. To me, I see two different towers, just like I see with the VA, there are three, but the VA and the Indian Health Service needs to remove all other walls and start working together to help our Native Veterans.

Like you say on our Vietnam brothers and sisters, yes, it is nice to be welcomed home and that is why we are there when the rest of our brothers and sisters do come back from war, because we will never want that to happen to any other generation ever again.

My main thing is, they started the listening sessions, but it needs to go farther than that. They need to tear their walls down and work together to help our people.

That is my opinion.

Mr. BERGMAN. Thank you very much. You know, I yield back. As—well, before I yield back, we have already made some progress in my district with trying to figure out ways—you got the Tribal Health Clinic, you got extra office space, you got different things, why ca not we combine Indian Health Service, VA services? Because when you live in not only a rural district, but a remote district, that can be a center of health care for the entire population run by the tribe.

Anyway, thank you. I appreciate the time and thank you for allowing me to be in here, and I yield back.

Ms. BROWNLEY. Thank you very much.

Mr. Cisneros, you are recognized for 5 minutes.

Mr. CISNEROS. Thank you, Madam Chairwoman. Thank you all for being here today.

You know, I became aware of a report of a Native American Marine Corps veteran who was denied being put on the transplant list for a kidney and the reason that was given was a cognitive impairment basically, because I guess a test that he was given saying that he would not remember, be able to remember the care that he needed to be able to provide to himself. After investigation, he did eventually get the transplant and get on the list, but it took so long because of this. What they found out when they investigated was that there was—the reason he was denied was because of this cognitive impairment, but really what it was was a barrier, either a language barrier or a cultural barrier.

Have you all seen other examples of this where people are being denied treatment, especially whether it be a kidney or a liver, something that they need, because of this cultural bias? Anyone.

Chief SMITH. I do not know if it was the culture and everything else, but I know that it was too late for my brother, because he needed his lungs. He passed away in 2017. We could not get him healthy enough in Alaska to transport him to the Lower 48 secondary to Agent Orange exposure. He took his last breath and his lungs just quit working, and he did not get well enough to be able to have me transport him down to Seattle to get a new set of lungs.

There are things in there like, oh, you need to get down—he was at 209, he had to get down to 200 pounds, they said. For nine pounds, my brother—my brother could have lived 5 more years with a new set of lungs, but we could not get him well enough when he went downhill to get him down to Seattle to get a new set of lungs.

That is all I can say. He was—he was my hero.

Mr. ALLIS. Congressman, no specific situations, but the scenario that you point out is common across Indian country in a lot of different areas. When you look at not taking—you know, agency folks or the Government not taking the time to look at the uniqueness of these communities, you know, not only the location, but the traditional customs and culture, and the language barriers that could exist that are not taken into consideration. It is definitely an issue with treating our veterans, especially that might have, you know, brain injuries or head injuries and revert to their traditional languages because it is much easier to communicate, because that is how they were raised.

We see this with health care, we see it with voting, we see it with, you know, signing up. All that kind of stuff is we need people to pay more attention and to take the time to learn about the uniqueness of our communities in a way where they can connect, we can connect, and things can get accomplished.

Mr. CISNEROS. Yes, ma'am.

Ms. MALERBA. Well, and I think that that is what we were talking about before. When we have to refer somebody outside of our system, you do not have anyone helping them to navigate that system, whereas if you are within the Tribal Health Program or the IHS system, you will have people there that are culturally competent, that can understand what some of the barriers are to that person accessing care, and sometimes it is that they just have a reluctance to go outside their own community.

I think that that is why we want to make sure that we do not have to send them back into another system for a referral to care, because chances are likely that they would not access that, they will just give up and they would not access that care.

Mr. CISNEROS. Right. Just—I have got one minute left here, but just to followup on some other things. You have all talked about the MOU between the VA and IHS. In some of these remote areas where there is no VA, you know, and veterans are going there to seek services, have we had situations because of lack of the MOU where they have been denied services or that the VA has said we are not going to pay for that service because they are not enrolled?

Anybody can answer that one. Go ahead, yes.

Ms. TETNOWSKI. We have had situations where the VA would not accept our referral. Similar to what Chief Malerba was talking about is that the VA—it is hard enough to get our veterans to come to any facilities to seek that additional support and once we have to then transfer them out of our facilities into another system without a patient navigator or a tribal navigator inside the system, we tend to lose them in the process. Many times, even as an urban facility, our nearest VA hospital is about an hour and a half to two hours away, and so during that time without that referral accept-

ance we lose them in the process, because they do not want to go again.

It is like a lot of the response that I get is, I already went through those tests with you, why do I have to go there and do it again, and that is a fair statement. We should be able to transfer our medical records into the VA system and not put our community members through that again.

Mr. CISNEROS. Right.

Ms. MALERBA. One of the things with the MOU is that it limits the services that non-Native Veterans can access at IHS, even though typically we would allow certain services covered. They do not allow non-Native pregnant women with Native children to access care there, even when they are connected to the veteran, and especially in cases where the IHS and THP are the only facility in close proximity to the veteran.

We think that we need to make sure that all services are covered and that they are not limited, because in some cases those are the only facilities that are available.

Mr. ALLIS. If I may make one more comment? This is the importance of really look at the regulatory burdens that are in the way of tribes with respect to tribal veterans service organizations and being able to put those up, the tribes have to go through so much. They have to establish and fund an organization before somebody can get accredited, be able to manage that, and work with the community folks on going through the process of their claims and tracking their services.

There really needs to be a look at that.

Mr. CISNEROS. All right. Go ahead, Chief Bill.

Chief SMITH. Yes, the other thing too is, like Alaska has over 70 to 90,000 veterans and only 30,000 of them are registered for the health care. A lot of them are Vietnam Vets and a lot of them that have not trusted the VA enough to come back to the system, and that is where you need to have the tribal veterans, our veterans being able to talk to them and saying that this is the new VA. They earned everything that they had, but they have never trusted the VA enough to come back to the table, and that is half our veterans up in Alaska are still in the bush and still need to come home.

Mr. CISNEROS. Right. Well, I am out of time, but thank you all for your answers. Thank you.

Ms. BROWNLEY. Thank you, Mr. Cisneros.

Mr. Lamb, you are recognized.

Mr. LAMB. Thank you, Madam Chairwoman, and thank you to all the witnesses for making this long trip here to educate us.

I had a question to begin with for Chief Smith. In your testimony I noticed you talked about exempting tribes and THPs from the establishment and consolidation of the community care networks; are you referring to under the MISSION Act?

Yes, sorry, I did not mean to catch you off guard there.

Chief SMITH. Yes.

Mr. LAMB. Could you just talk me through, to the extent you are able, what impact you see the MISSION Act as having on the Alaskan system and on your tribes and community, if any. If you think there should be interaction based on the MISSION Act or if every-

thing is supposed to be separate, I am just trying to see where you stand on that. Thank you.

Chief SMITH. As a veteran from the MISSION Act to the Choice program to everything else, it is just another thing coming down the pike to us. As a veteran, we just have to see how it is going to work out, because what we need is health care and, like we have been talking about, health care between deals. Because I can get my blood tests for my diabetes secondary to Agent Orange exposure and I can get it at Indian Health Service and it costs thousands of dollars, and I have to go right across the street to the VA in Anchorage and get the same tests, and I have to travel 300 and some miles to get my nearest VA. That is a little bit shorter than my dad did. My dad had to go to Portland, Oregon from Cordova, Alaska to the VA when he passed away.

As a veteran, you know, the MISSION Act, the Choice program, everything else, what the veteran needs to do is being able to treat where the veteran knows he is going to get the best service for himself, for himself or herself. Is that closer to home? Just like we were talking about the MOUs, if you lived in Dutch Harbor, Alaska, it cost you over 1500 bucks to fly one way into Anchorage and then you need an escort, and then that is the VA is picking it up, but if you get treated right at Dutch Harbor, if you get treated with your doctor, you do not have to pay that travel cost and that veteran gets treated closer to home. Not everybody likes to go to the big village just to spend the day.

Mr. LAMB. Yes. Well, I think what I was trying to figure out was, could the MISSION Act—and anyone can answer this, if they have an opinion—could the MISSION Act be a vehicle for basically saving you that trip and helping you get care in your actual community if the VA had already made that provider part of their network, is that a possibility or is there something that prevents that?

Chief SMITH. It would be a very good possibility, but last time I used my VA Choice when I first got given my VA card, I had to have a scope job and it cost me 1500 bucks by using the VA myself. I have no—I needed it in writing first that the VA is going to pick up the bill, because I tried it and so has a lot of other veterans.

We need to be able to know that they are going to take care of us.

Mr. LAMB. It all goes to how the network is designed and implemented.

If we could—Ms. Tetnowski and Chief Malerba, and then I will probably be out of time.

Ms. TETNOWSKI. Just a quick comment on that. The Choice system tends to be the place where the VA refers us to and at the end of the day, more often than not, it is already out of money. We end up with what happened to Chief Smith there where they want you to go there, but it is not available. Again another barrier. Now it becomes the veteran's responsibility to cover those costs and they are supposed to be receiving this service as part of their benefits for service.

Mr. LAMB. Okay, got it. Thank you.

Chief Malerba.

Ms. MALERBA. I think that is where credentialing comes into play. If there was reciprocity and full faith and credit for the THPs and IHS provider, then there would be no barrier.

Mr. LAMB. Right. Whether that happened through an MOU or the MISSION Act, I guess that is what I was trying to figure out, does it make a difference, it sounds like probably not.

Mr. Joseph.

Mr. JOSEPH. You know, I think it would be really good if, you know, an MOU or the act, if you pass an act that would shift the funds directly to IHS or to tribes to allow our providers to be able to provide for our veterans.

Like Chief Smith talked about, some of our veterans, you know, were forced to go to war and drafted, and they do not trust VA. The new VA sounds really good, but, you know, a lot of our people want to be seen at home by the providers that they are used to. And if you compare the IHS budget to what the VA gets per patient, you would see a big, big difference and the need for the IHS to have the funding. I spoke about the Government shutdown and impacts there.

Mr. LAMB. Right, I noticed those numbers in your testimony as well. Thank you very much. I am out of time.

Madam Chairwoman, I yield back.

Ms. BROWNLEY. Mr. Gianforte, welcome. You have just sat down, but because we are trying to go back and forth, you are recognized.

Mr. GIANFORTE. Thank you, Chair. First, I want to thank you and the ranking member for letting me join this hearing. Thank you for our panelists here today, so we can learn more about this subject.

I appreciate the opportunity to speak with you regarding Native American veterans' access to health care. Native Americans make up nearly 10 percent of Montana's population and they overwhelmingly answer the call to serve. This is why I have introduced the bill in front of us today, to ensure our Native Veterans have access to the care that they deserve.

In 2012, the Indian Health Service of the Department of Veterans Affairs established a reimbursement agreement which allowed rural IHS providers to supplement VA care. In classic Washington bureaucratic fashion, Urban Indian Health Centers were left out of the agreement. In Montana, Urban Indian Health Centers provide care to 60 percent of Native Americans who are not located on a reservation.

My bill, the Health Care Access for Urban Native Veterans Act, will ensure that our Native Veterans have access to care that works best for them and will cut wait times at VA clinics for all veterans.

This committee has worked tirelessly to ensure we keep our promise to our veterans who have sacrificed so much for this country and my bill continues this good work.

Ms. Tetnowski, Urban Indian Centers receive limited funds from IHS to provide their services. What would be the impact on these urban centers if they were to receive reimbursement from the VA?

Ms. TETNOWSKI. Thank you so much. The impact would be significant. As you stated yourself, 60 percent in Montana receive

services at their local urban center, same goes with my facility in Santa Clara County.

We provide support, we have 41 Urban Indian Health Centers throughout the Nation, and these centers provide that support where a tribal facility may not be located. In most cases these urban centers are located in places where relocation centers occurred, so that was the purpose of creating our Urban Health Centers. I think the impact would continue to allow us to provide that culturally competent care and increase our ability to meld both traditional and Western medicine to provide the support that our veterans need in these urban centers.

Mr. GIANFORTE. Okay. We have five of these centers in Montana, in Missoula, Great Falls, Billings, Butte, and Helena. If this bill became law, you are saying they would be able to better care for our Native Veterans. Okay.

One follow-on question, if I could. What has been done to leverage telehealth in any of these centers? Is that something that you are looking at and what impacts have you had?

Ms. TETNOWSKI. We have attempted to get through the process to allow telehealth to be available in our urban centers, but many of our urban health centers have capacity to continue to serve. Telehealth, other than specialty care, may not be necessary. Most of them have behavioral health services, we have medical and dental and other support services inside our facilities, but telehealth would add additional ability to get that specialty care to those urban centers.

Mr. GIANFORTE. Yes. This is—I have been advocating for telehealth, because we have many rural communities, we can not have——

Ms. TETNOWSKI. Yes.

Mr. GIANFORTE.—every specialist in every community. Telehealth is a way to provide better care at higher quality. I would just——

Ms. TETNOWSKI. It would be a wonderful way also for us to continue to partner with our local tribal communities as well to provide support for each other——

Mr. GIANFORTE. Again——

Ms. TETNOWSKI.—because we are one community.

Mr. GIANFORTE.—not to substitute for local care, but it is just an enhancement.

I just want to thank the chair and ranking member again for letting me join this hearing today, and I yield back the remainder of my time.

Ms. BROWNLEY. Thank you, Mr. Gianforte, and I thank you for raising the important issue around our Native Veterans who live in cities, because I think it is abundantly clear that we are not servicing them the way they need to be serviced and we have got a lot of work to do in that area, so thank you for bringing that up.

Mr. Sablan, you are recognized for 5 minutes.

Mr. SABLAN. Yes, thank you very much, Madam Chair. Thank you very much for holding today's hearing.

To the witnesses, I know what it is to fly a distance to come to Washington. I live the furthest away from Washington, DC. as a member here. I live out in the Northern Mariana Islands and that

part of a place called Micronesia. That is a bunch of over 3,000 islands spread out over the size equal to, if not larger than, the 48 contiguous states. We talk about remoteness, yes, I am very remote as well. Thank you for coming.

A friend of mine, actually a personal friend who lives on Saipan actually is on contract with a company that he is a physician's assistant and he provides his services, he is on contract and assigned to a part of Alaska where he serves, he provides health—medical services to residents of that particular—so far away removed, I think he said you can actually see Russia from where he is at. I do not know if it is just for Native Americans, but I think he said it is for the residents of that village. A smaller area, but so far removed.

I looked at the fact sheets about some of the culture Native Americans have, we have the very same culture where say if my father were to be giving me a lecture on something, even if he is—I think he is wrong, I would have to keep my mouth shut and allow him to tell me what is on his mind. For many times I think—I thought I was smarter than him and now I know that actually, no, he was smart, much, much smarter than I am.

You know, our history is so far back that we go through oral history, that when Western civilization was still trying to find the spices so they could cure their meat, my people were already traversing the wide-open ocean based on nothing but the stars and the currents, and they were traveling. When Ferdinand Magellan got lost at sea, he landed on Guam. One of the things he found, according to the log of the—was rice, that we had rice in the Mariana Islands when rice was supposed to be exclusive to Asia. But so much of your culture is in my culture.

Let me also thank the chairwoman, because I think this is one of the very few times when we have a hearing for the Native Americans. I am not fully immersed in the VA issues for Native Americans. I am immersed, much more immersed in the issue of the Indian education. I chaired the subcommittee on elementary and secondary education, and the BIE, the Department of Interior's Bureau of Indian Education. The services they provide in terms for Native Americans is a disgrace, it is a shame. Where there would be school facilities in some of the coldest part of the country and they would have buildings that have heaters that do not work or that they would not have enough tables and desks for students, and the schools are in a complete lack of maintenance, and it is a disgrace. If the VA provides as much service to Native Americans as they do for their BIE, then we got a lot of work ahead of us.

I came here to thank you for being here today. I am also actually in a markup on higher education, so I will need to leave, but I just came to thank you guys for—all of you for being here.

I know that there is a VA representative in the room, so we have got a lot of work to do.

Thank you, Madam Chair, for holding today's hearing. I yield back.

Ms. BROWNLEY. Thank you, Mr. Sablan. I had the privilege to travel to the American territories with you, including going to your home in the Mariana Islands. I will just say that there are very many parallels in terms of the challenges of delivering health care

in our territories very similarly to the challenges we are facing with our Native Veterans.

Mr. SABLAN. Right.

Ms. BROWNLEY. We have a lot of work——

Mr. SABLAN. Madam Chair, if I may interrupt, if I may. Actually—and I am not taking credit for what happened, but it was not until I got elected to this office that the VA actually set up a VA fee-based, contracted a physician to provide services to veterans.

Sir, you are right, our Vietnam Veterans, for some reason they refuse to sign up with VHA. I have had research fairs. When Choice happened, I brought the CEO of Choice, we had 20 providers, we increased that to 81, but for some reason, sir, my Vietnam Veterans also and others after Vietnam, they do not want to sign up for VHA. I am having a really tough time trying to get a Community Based Outpatient Clinic (CBOC) established in my district, but I am not going to give up.

Thank you, everyone.

Madam Chair, I am being disrespectful, that is not allowed in my culture and in Native American culture, but I apologize profusely and I thank you.

Ms. BROWNLEY. Very respectfully, your time has expired.

[Laughter.]

Ms. BROWNLEY. And I will now recognize Dr. Dunn.

Mr. DUNN. Thank you very much, Madam Chair.

Chief Smith, during my time in service in the Army as a Sergeant, I interacted with a number of different IHS systems around the country and one that seemed to work better than most, in fact quite well, was the health and dental services in Alaska, and it strikes me that that is an area where there are more challenges, not less challenges than perhaps in other areas.

I wonder if you would address for us, you know, what you do to integrate that kind of care, make that work so well in Alaska and many different tribes, a lot of area to cover, both urban and remote, and what can we learn, what can we take away from that for the rest of the country?

Chief SMITH. Talk to us, consult, and work with the Indian tribes to work with the health services. That seems to work, I know when Susan Yeager come to the last Alaska Native Health Board to talk about health issues.

You know, we are trying to do things like dental aides to start a program, so we can teach our people how to do it, because there is not enough dentists up in Alaska to take care of everybody. We have dental aides that go out and take care of our kids with teeth.

I mean, when I was a kid, they just put a temporary filling in with the stainless steel pins, and about a week later the temporary nikem-pucki [phonetic] that they put in there dissolved, and then you had to take a file and file off the little stainless steel pins, and now today you can get new teeth and better care. One dentist told me, he says, if he could do something for the villages, he would stop at the airport and he would destroy every can of pop that was ever delivered out there. I agree with him, it is education. They just need to know that it is better to drink the water than it is to drink the soda and, you know, it is back to nature and back to our ideals.

I just want to make one comment to this gentleman over here about Vietnam Vets. It is probably because of the way we were treated when we come home and it is hard to bring a veteran back to the table, a Vietnam Vet. It takes another vet to talk to him and it takes another grandchild or whatever to drag that grumpy old Vietnam Vets out of the woods saying you have got to come back, because you are dying and this is the reason, and they can actually help you today, and welcome home.

Up in Alaska, just consulting with tribes and deals on health care, because with the Alaska Native Health Board we have 229 tribes, and we talk together to work on our health issues. I know down here you are trying to follow some of our programs that we started up there and it works. The only thing that I would appreciate is, if it works in Alaska and you bring it down here, do not do too many changes and send it back to Alaska, because we already worked out the bugs.

[Laughter.]

Mr. DUNN. Thank you very much, Chief. I appreciate those insights. I was just—I remember being sort of impressed with how well it was working there. Obviously, there are some hiccups and you have highlighted that. Thank you very much.

With that, Madam Chair, I yield back.

Ms. BROWNLEY. Thank you, Dr. Dunn.

Welcome, Mr. Gallego. I understand that you have questions for the second panel, so we are going to proceed there.

I want to thank the panel for being here, each and every one of you, we appreciate it very, very much. Your testimony helps to really raise all of the issues that need to be wrestled with and helps to raise awareness, not only for this committee, but for the entire Congress on the issues that we face. We appreciate your presence very, very much. Thank you.

I will excuse you and the second panel will join us.

[Pause.]

Ms. BROWNLEY. Thank you to the second panel for being here this morning. We are joined by Dr. Kameron Matthews, the Deputy Under Secretary for Health for Community Care for the Veterans Health Administration, accompanying her is Dr. Thomas Klobuchar, the Executive Director of the Office of Rural Health of the Department of Veterans Affairs; and Stephanie Birdwell, the Director of the Office of Tribal Government Relations at the VA. Joining us from Indian Health Service is Benjamin Smith, the Deputy Director for Intergovernmental Affairs.

With that, I now recognize Dr. Kameron Matthews for 5 minutes. Welcome.

STATEMENT OF KAMERON MATTHEWS

Dr. MATTHEWS. Good morning, Chairwoman Brownley, Ranking Member Dunn, and members of the subcommittee, tribal leaders and tribal representatives. I appreciate the opportunity to discuss how care at the Department of Veterans Affairs and our partnership with Indian Health Service positively impact our Native Veterans.

I am accompanied today by colleagues Ms. Stephanie Birdwell, Director for the Department of Veterans Affairs Office of Tribal

Government Relations, and Dr. Thomas Klobuchar, Executive Director for Veterans Health Administration Office of Rural Health.

I would like to tell you a little bit about my background, as you can understand why health care for Native Veterans is so important to me. I am a family physician from outside Philadelphia that has focused my career on helping vulnerable populations. From my work in correctional health to community health centers, I value the relationship with primary care, and seek to expand access to care for those communities that are faced with disadvantages and inequities.

I have trained and worked in Chicago and I am very familiar with urban health issues, racial and ethnic health disparities, and the impact of social determinants for health. As an advocate for my patients and communities, I am here now at the VA to listen, learn, and serve those who have served our Nation.

Of a special note, I am proud to have visited the Alaska Native Tribal Medical Center in May 2018 and was indeed impressed by its amazing services.

As Secretary Wilkie has shared during his meetings with Native American veterans and tribal leaders across the country, our goal at VA is to shorten the distance between people in need of veterans' services. While the Secretary and Executive in Charge could not be here today, I am proud to be here on behalf of the Department discussing such a vital group within our veteran population.

Native Americans have participated in every American conflict dating back to the Revolutionary War, and they serve in the military at a higher per capita rate than any other ethnic group. The importance of Native servicemembers has only grown in this country over time, and we strive to honor this community with the quality, culturally competent care that they deserve.

As Secretary Wilkie recently stated, we at VA will continue to provide vital reimbursements to tribal health programs and Indian Health Service. To that end, a memorandum of understanding originally signed in 2003 and updated again in 2010, established the Indian Health Service and VA can coordinate, collaborate, and share resources between the departments.

This partnership resulted in the establishment of shared goals and, in order to achieve said goals, VHA has piloted and subsequently adopted several programs. In 2012, VA started establishing reimbursement agreements with Indian Health Service and 114 tribal health programs so far in order to address access to care, achieve effective partnerships, and ensure the availability of resources.

In addition to these reimbursement agreements, local VA medical centers have established, where appropriate, several agreements with tribal health programs and Indian Health Service facilities to deliver tele-mental health to Native Veterans.

The program serves tribal communities through Indian Health Service facilities in Alaska, Montana, Wyoming, and Oklahoma. The Office of Rural Health, Veterans Rural Health Resource Center in Salt Lake City has an active portfolio of innovations in Native Veterans health care, including the creation of a Rural Veteran Tribal Navigator Program that will connect Native Veterans with the benefits and care they have earned.

Furthermore, the VA Video Connect pilot program is currently being deployed nationwide. VA Video Connect will allow rural Native Veterans to access VA health care in their homes or local communities via cellular or wireless capabilities. The Office of Rural Health is currently working to tailor this program to Native Veterans communities, creating a model that will weave together Western medicine, traditional Native healing, and rural Native community strengths through four main components: mental health care, technology, care coordination, and a tailored implementation/facilitation strategy.

In addition to these programs, the office is also piloting programs to establish tribal VHA partnerships in suicide prevention, and developing content regarding Native Veterans in the VA Community Provider Toolkit.

While the 2010 MOU has opened the door to these great successes, the March 2019 GAO report cites challenges in obtaining the MOU goals, specifically around establishing targets for outcome metrics to assess progress. Thus, in Fiscal Year 2019, VHA and Indian Health Service MOU leadership agreed that the 2010 MOU was no longer meeting the agency's needs and required modification to create the flexibility needed to move the interagency relationship forward to a new level.

To address the shortcomings associated with the 2010 MOU metrics noted by GAO, VA and IHS have brought in metrics experts from each agency to the MOU development process.

Once the draft is finalized and tribal consultation, most importantly, is complete, the process of creating new targets and metrics to meet the requirements outlined by GAO will take place as new programs and pilots are developed under the new instrument.

We are confident that the evolution of this MOU will be successful, as it is happening in tandem with the MISSION Act. This transformative legislation will entail the most comprehensive change in VA's history. The MISSION Act consolidated community care programs, as you know, to make it easier for all veterans, families, community providers, and employees to navigate.

The health and well-being of our Nation's veterans is of utmost importance. We strive consistently to provide high-quality care to all veterans, and continue to make significant strides in enhancing the practice and culture of the Department to be more accessible to our Native Veterans. Working with many diverse sovereign tribes is essential to successfully achieve the goals of the MOU. VA is committed to ensuring that our goals align with IHS and that the needs of our Native Veterans are met.

I apologize for going over and I do thank the committee for hosting this hearing. I want to thank the tribal leaders and tribal representatives, and all valued partners here who joined today.

My colleagues and I prepared to answer any questions that you have.

[THE PREPARED STATEMENT OF KAMERON MATTHEWS APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Dr. Matthews.

I now recognize Mr. Smith.

STATEMENT OF BENJAMIN SMITH

Mr. SMITH. Good morning, Chairwoman Brownley, Ranking Member Dunn, and members of the subcommittee. My name is Benjamin Smith, I serve as the Deputy Director for Intergovernmental Affairs at the Indian Health Service. Thank you for the opportunity to testify on Native Veterans' access to health care.

I want to begin with the Indian Health Service mission, which 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, the Indian Health Service provides Federal health services to approximately 2.6 million American Indians and Alaska Natives from 573 federally recognized tribes in 37 states through a network of over 605 health care facilities that include hospitals, clinics, health stations, and other facility types.

The American Indian and Alaska Native population experiences health and other disparities that disproportionately affect their quality of life. American Indians and Alaska Natives have an average life expectancy of 5 years shorter than that of the U.S. general population, and 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 educational levels, and higher unemployment.

As health needs change, new approaches to care emerge. The Indian Health Service, the Department of Veterans Affairs, and our tribal partners will continue to combine expertise, resources, and efforts to assist the nearly 145,000 American Indian and Alaska Native Veterans living in the United States.

The Indian Health Service and the Veterans Affairs Veterans Health Administration continue to work to provide eligible American Indian and Alaska Native Veterans with access to care that is closer to their homes, promote cultural competence and quality health care, and focus on increasing coordination, collaboration, and resource sharing between our agencies.

One way that we are doing this is by revising the Indian Health Service and VA memorandum of understanding that was most recently updated in 2010. We have a goal to revise the MOU by fall of 2020 and to look at updating the related performance measures, and we plan to do this using consultation and by conferring with urban Indian organizations.

We want to underscore that this collaboration really started back in the late 1980's when Congress directed both of our Federal agencies to explore the feasibility of entering into an arrangement for sharing of medical facilities and services, and this requirement was actually memorialized in the Indian Health Care Improvement Act. Our results were reported to Congress and our coordination led to an initial memorandum of understanding that was executed in 2003.

After close to a decade of collaboration, we updated the memorandum of understanding in 2010, and in that same year the Patient Protection and Affordable Care Act was enacted and permanently reauthorized the Indian Health Care Improvement Act. This act authorized the Indian Health Service to enter in or expand arrangements for the sharing of medical facilities and services be-

tween Indian Health Service, Indian tribes and tribal organizations, and the VA. The law directs the VA to reimburse the Indian Health Service, Indian tribes, or tribal organizations for services provided to eligible beneficiaries of either department in the respective facility.

Since implementing this provision in 2012, and that is the reimbursement agreement authority that I am citing to, VA has reimbursed over $103 million for direct-care services provided in either Indian Health Service or tribal health programs, covering approximately 10,645 unique American Indian and Alaska Native Veterans.

Currently, Indian Health Service and VA operate under a national reimbursement agreement, so that includes over 70 of our Federal IHS-operated facilities. As we just heard, there are 114 tribal health programs that have entered into individual reimbursement agreements under this authority to be reimbursed for direct care services.

We believe in the five main goals, which are to increase access to care and services for American Indians and Alaska Native Veterans; to promote patient-centered collaboration and communication; to improve health promotion and disease prevention; and to consult with tribes at the regional and local levels; and to ensure appropriate resources are identified and available.

We look forward to any questions that you may have as we are here today before this committee.

Thank you.

[THE PREPARED STATEMENT OF BENJAMIN SMITH APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you very much. Thank you both for your testimony and I will recognize myself for 5 minutes.

The first question I have is to Dr. Matthews. In your written testimony, you said that "in early Fiscal Year 2019 the VHA and IHS leadership team agreed that the 2010 MOU was no longer meeting the agency's needs and required modifications to create the flexibility to move the interagency relationship forward to a new level."

You said that the leadership team drafted a new MOU and conducted a first-listening session with tribal leaders on May 15th of 2019.

Then you go on to say that that tribal input from the session was incorporated into the draft MOU and so—and as this additional input is now being considered for inclusion in the draft MOU.

I am curious to know, what was that input? You said that you got a lot of input, but you did not say what the input was.

Dr. MATTHEWS. Great question. I am going to defer to my colleague, Dr. Klobuchar.

Dr. KLOBUCHAR. Thank you for that question. The tribal consultation was conducted in concert with the Indian Health Service in Albuquerque, and many of the questions that came up were around inclusion of urban Indian health care in the umbrella that the MOU will provide for the creation of new programs. There was also some focus on referred care that, while we have not incorporated that into the MOU itself, it will certainly be a program or a look that the VA will take as they move forward under the new MOU, which, again, is just an umbrella for the creation of new pro-

grams, methods for consultation, and so on and so forth, ongoing consultation.

I think those are the—that is the important elements that made it into the new draft of the MOU was around the inclusion of urban Indians and around the importance of ongoing consultation as we move forward.

Ms. BROWNLEY. When you talk about the referral, you are talking about the Native Veteran going to an IHS facility and then needs specialty care, and then has to go back to the VA, repeat the same process again to ensure that they get specialty care, but you are not sure whether that is going to be actually in the drafted MOU or not?

Dr. KLOBUCHAR. It would be a program that we would report on under the umbrella MOU.

One of the issues—and if I can go into some detail on the MOU itself—one of the issues that we found with the 2010 MOU was that many of its provisions we had either fulfilled or we found that they had been overcome by events. When we took the decision to redraft the MOU, the idea was to create a broader, more general MOU that would allow us to create new programs underneath the MOU and would satisfy the GAO findings around reporting and targets and outcomes, and so on and so forth. Those individual programs will take place and be reported on under that broader MOU.

Did that answer your question, ma'am?

Ms. BROWNLEY. More or less.

Dr. KLOBUCHAR. Okay.

Ms. BROWNLEY. I just want a short answer and to followup on this MOU process and how important it is going to be. I want to hear from the VA some assurances that our Native Veterans will be at the table with you through that negotiation.

Dr. MATTHEWS. Yes, you have our assurances.

Ms. BROWNLEY. Thank you. Dr. Matthews, also on this, the issue that has been raised about this referral again piece, you said that one of the obstacles, I guess, is that you may lose track of the care of the veteran. I do not know, that just seems to me not a really good obstacle, because I think if you are doing the reimbursements and everything that you are supposed to do, you should have track of where the veteran is, whether it is in an IHS facility or within a VA facility. Obviously you have heard the concerns around this and why many veterans will then just not pursue the specialty care that they need, and certainly, from a taxpayer perspective simply, it is duplicative and unnecessary.

Can you speak to that?

Dr. MATTHEWS. I definitely can. It is an excellent question and one that I agree as a clinician, the duplication of—honestly, how VA has formally handled referrals from any of our partners outside of VA is untenable. Especially under the MISSION Act, we see ourselves really as a coordinator of care at the bequest of the veterans. In helping them receive care through the First Nations, through their partners, we definitely see that as the veteran is staying at the center and needing to coordinate that care.

I agree that the referral of a veteran back to the VA for repeat visits or procedures is unnecessary and that we actually hope to find through tribal consultations we can work through those issues,

we can develop a referral process that is more administrative so that we can track.

The issue currently about paying reimbursements, whether that is directly to the community provider or to the tribe themselves, I think we can work through through consultation. We do want to take the veteran out of the middle of that, we do not want repetitive services, and I think we can move to really support the tribes through establishing appropriate referral guidelines, actually as was discussed during the first panel.

I admit that prior to now it has not been streamlined, but as you guys have given us the authority to consolidate the community care programs and simplify those processes, I think we have a real path forward.

Ms. BROWNLEY. As you try to wrestle with that, will you wrestle with the co-pays?

Dr. MATTHEWS. Oh, definitely, yes. I think that needs to be acknowledged. We currently do not charge co-pays for veterans being seen under the reimbursement agreements, it is when they have to return to the VA or are seen in community care they are charged a co-pay, but no veteran seen under the reimbursement agreements are charged co-pays.

Ms. BROWNLEY. We do not believe that the veteran should receive—require the co-pay in the other circumstance.

Dr. MATTHEWS. Understood, and I commit to looking into that issue.

Ms. BROWNLEY. Thank you.

My time is up. Dr. Dunn, you are recognized.

Mr. DUNN. Thank you very much, Madam Chair.

Most of the witnesses have cited concerns regarding specialty care, referral care, and I want to address that. Let me see if I can back out of the weeds a bit and ask some basic questions.

I think this is to Mr. Smith, you tell me if I am wrong, does the VA accept referrals for VA specialty care made by the IHS and THP?

Mr. SMITH. I will defer to our VA colleagues on that question.

Dr. MATTHEWS. I am sorry, Dr. Dunn, just to clarify the question, a referral coming from the——

Mr. DUNN. From the IHS——

Dr. MATTHEWS. Yes.

Mr. DUNN.—for specialty care to the VA, are those patients accepted?

Dr. MATTHEWS. Those referrals are accepted. I can not necessarily speak for every facility's procedures at this point, as they are currently being streamlined as to whether or not they may require a visit, but those referrals are accepted.

Mr. DUNN. Is that only for veterans or for any patient from the IHS?

Dr. MATTHEWS. For——

Mr. DUNN. Veterans in the VA.

Dr. MATTHEWS. Veterans in the VA, yes.

Mr. DUNN. You have got some patients in the IHS——

Dr. MATTHEWS. Right.

Mr. DUNN.—and they get referred for specialty care to the VA, if they are a veteran, they are accepted by the VA?

Dr. MATTHEWS. An enrolled veteran, yes.

Mr. DUNN. If they are not a veteran?

Dr. MATTHEWS. No.

Mr. DUNN. That is interesting to me, because when we were in the service, I mean, we treated the Army, we treated the IHS patients no matter whether or not they were veterans. Is that something that has gone away?

Dr. MATTHEWS. That is not something that is currently included within our reimbursement agreements, no, sir.

Mr. DUNN. Is the VA—all right. Things have changed since I was on active duty, apparently.

How well coordinated is the MISSION Act by use of the MISSION Act with the IHS referrals to the VA? Can the VA then enact the MISSION Act for these IHS patients, the ones they do accept?

Dr. MATTHEWS. Yes, their eligibility can be verified, determined, and the veteran then of course has choice based on their eligibility to opt in or out of community care.

Mr. DUNN. They get straight through the system, as good as the system is, right?

Dr. MATTHEWS. Right.

Mr. DUNN. All right, so that is an interesting thing.

All right. Well, I will yield back with that, Madam Chair. Thank you.

Ms. BROWNLEY. Thank you, Dr. Dunn.

Welcome, Mr. Gallego, and you are recognized for 5 minutes.

Mr. GALLEGO. Thank you, Chairman Brownley, for holding this hearing and for allowing me to join on the dias.

I was very lucky to serve with many Native American Marines in Iraq and I know firsthand the patriotism and bravery they have shown in service to this Nation, not just in current conflicts, but in the past. That is why as Chairman of the Subcommittee for Indigenous Peoples it has been very frustrating to see over and over again how our Federal Government is failing Native Americans and Native Veterans, namely that our trust and treaty responsibilities are not being upheld.

Ms. Matthews, a yes-or-no question: are you familiar with the Federal Government's unique trust responsibility where it concerns Native Americans?

Dr. MATTHEWS. Yes, I am.

Mr. GALLEGO. Great. Then you also know that providing Native Americans with health care free of cost is part of this legal trust responsibility, for which rests in the treaty powers in Article II of the U.S. Constitution, and is confirmed by numerous laws and Supreme Court decisions.

Between 1778 and 1868, the U.S. ratified almost 400 treaties, many of which explicitly guaranteed tribes health care, in addition to all proper care and protection, in return for the seizure and occupation of their land.

I have three examples of such treaties with me right now that I would like permission to enter into the record in case our witnesses would like to consult them later.

Ms. Matthews—thank you.

[THE TREATIES APPEARS IN THE SUBMISSIONS FOR THE RECORD]

Mr. GALLEGO. Ms. Matthews, given this well-documented legal responsibility to provide health care to Native Americans free of cost, would you agree that it is a breach of our trust responsibility to charge cost-sharing payments to Native Veterans when they receive care at the VA?

We have had this discussion going on prior to this.

Dr. MATTHEWS. I would agree it is an issue that we need to look into as we do currently charge co-pays.

Mr. GALLEGO. Okay. With what I just told you, so would you agree that—are we violating that trust then? I know you are going to look into it, I heard you say that before, but do you agree that we are violating our trust responsibilities in that case?

Dr. MATTHEWS. I would agree that VA is following its own regulations to charge co-pays, we do not currently have an exception on the books.

Mr. GALLEGO. The highest regulation there is are treaties approved by Congress, so I would hope you would actually understand that and send it back to your leadership.

Moving on. Ms. Matthews, given this well-documented legal responsibility to provide health care to Native Americans free of cost, would you—sorry.

Skipping forward. Myself and sovereign tribes think it is a pretty clear violation and that is why I am introducing Native American Veteran Pact Act, to prohibit the VA from charging copayments to Native Veterans in line with our treaty obligations.

Well, I am thankful for all the witnesses here and I know this is not an easy subject, I know it involves a lot of jurisdictional issues. I am disappointed that the VA Secretary and the Under Secretary for Health, the leaders that actually signed the MOU that impacts Native Veterans' ability to receive care declined to attend today's hearing. Instead, Ms. Matthews, you are accompanied by the Director of your Office of Rural Health.

As a Representative from Phoenix, Arizona, it is home to one of the largest urban Indian populations in this country. I am concerned about the VA's lack of attention to urban Indians in the MOU and, despite over 70 percent of indigenous people living in urban areas today—and I do use the VA for services too, so I actually—physically, actually will see this—there is no program office responsible for ensuring that the goals of the VA-IHS MOU reach urban Native Veterans.

Just two more questions, Ms. Matthews. In what specific ways is the VA prepared to strengthen a new MOU when it comes to improving access to care for urban Indian veterans?

Dr. MATTHEWS. I would have to defer actual questions about the MOU to Dr. Klobuchar, but before he speaks, we are definitely committed to working closely with the urban Indian health organizations and even enrolling them, as some of the questions earlier, under the MISSION Act into our new networks, we truly believe in working with these organizations.

Mr. GALLEGO. Mr. Klobuchar—Dr. Klobuchar.

Dr. KLOBUCHAR. The current State of the draft MOU includes urban—mention of urban Indian services in the text of the MOU.

Mr. Smith, do you want to make any comment on that?

Mr. SMITH. Yes, I think the most important point about the MOU is it really is the expression of how our Federal agencies intend to collaborate to achieve these goals. Where we have heard most of the areas of confusion arise are some of the goals around executing some of the new authorities, such as reimbursement authority, for example, equating that reimbursement authority to the MOU itself. The goals of expressing ourselves as Federal agencies and our mutual goal to collaborate together is not the same thing as entering into a binding agreement to reimburse for certain services. We are trying to make that distinction as we go through this.

Mr. GALLEGO. Thank you. I yield back my time.

Ms. BROWNLEY. Thank you, Mr. Gallego, and thanks for being here and advocating, and also thank you for your service to our country.

Well, there are no other members here for further questioning. Before I conclude, I know, Ms. Birdwell, we did not ask any questions of you, but I recognize and the committee recognizes the good work that you have been doing and accomplish. So we thank you for that and we thank you for your service.

Ms. BIRDWELL. Thank you, Chairwoman, I appreciate that.

Ms. BROWNLEY. Also I want to acknowledge the good work that you and the Office of Tribal Government Relations have done to facilitate the relationships between tribes and VA and the Office of Community Care for facilitating reimbursement agreements. As been already said, but over 10,000 Native Veterans have received culturally competent care in their tribal or IHS program and been relieved of potentially grueling and dangerous journeys to the VA. This is critical to ensuring veterans are not hesitating to pursue treatment, and the work of rural health is certainly not lost on me. Your research and grant programs are important, but you are three offices with specific responsibilities solely to Indian country and we need the same kind of focus for veterans who live in our cities and urban areas.

The MOU to improve Native Veterans' care was not specific to rural tribes or Indians receiving care on reservations, it was to improve all Native Veterans' health status. These veterans must be a priority in every program office and that must be led by VA leadership. You three alone cannot direct the services and programs necessary to improve Native Veterans' health status across the board.

This new MOU, which is going to be extremely important, will be approved by the Secretary and signed by the Under Secretary. You are part of the institution and not part of its leadership, but we are going to count on your leadership to convey to the Secretary and to the Under Secretary everything that has been raised here today and what will be important from our perspective and for our Native Veterans across the country, what is important to them to be in this MOU.

We have heard a lot today regarding—Ms. Haaland is not here, she had to leave to go to another committee hearing, but I am sure, if she were here, she would be asking about the advisory committee and how important that will be as we move forward. Co-pays, reimbursement of services, duplicity of services, urban Indian services, these are all issues that we hope are specifically addressed in this

MOU as we move forward. I am going to count on you to pass that along and I want to assure you that this committee will be watching closely.

This is extremely important to us. We know we have a long journey ahead; we have made some progress, but we still have a lot of work ahead of us to do.

As I said, we will be watching closely, and I thank you all for being here, we appreciate it very much.

I will ask if the ranking member would like to offer any closing remarks?

Well, without that, again, thank you again for being here.

With that, all members will have 5 legislative days to revise and extend remarks, and include extraneous materials.

Without objection, the subcommittee stands adjourned.

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

PREPARED STATEMENT OF ANDREW JOSEPH JR.

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee, thank you for holding this important hearing on health care access for Native Veterans. On behalf of the National Indian Health Board (NIHB) and the 573 federally recognized sovereign Tribal Nations we serve, I submit this testimony for the record. The Federal Government's trust responsibility to provide quality and comprehensive health services for all American Indian and Alaska Native (AI/AN) Peoples extends to every Federal agency and department, including the Department of Veterans Affairs (VA).

By current estimates from the VA, there are roughly 146,000 AI/AN Veterans, with Native Servicemembers enlisting at higher rates than any other ethnicity nationwide. Indeed, the Department of Defense continues to acknowledge the indispensable role of AI/AN Servicemembers throughout American history. Native Veterans are highly respected throughout Indian Country, in recognition of what they have sacrificed to protect Tribal communities and the United States. Yet despite the bravery, sacrifice, and steadfast commitment to protecting the sovereignty of Tribal Nations and the entire United States, Native Veterans continue to experience among the worst health outcomes, and among the greatest challenges in receiving quality health services.

Over the course of a century, sovereign Tribal Nations and the United States signed over 300 Treaties requiring the Federal Government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those Treaties-including for provisions of quality and comprehensive health resources and services-have been reaffirmed by the United States Constitution, Supreme Court decisions, Federal legislation and regulations, and even Presidential executive orders. These Federal promises have no expiration date, and collectively form the basis for what we now refer to as the Federal trust responsibility. Moreover, the United States has a dual responsibility to Native Veterans-one obligation specific to their political status as members of federally recognized Tribes, and one obligation specific to their service in the Armed Services of the United States.

In 1955, Congress established the Indian Health Service (IHS) in partial fulfillment of its constitutional obligations for health services to all AI/ANs. The IHS is charged with a similar mission as the VHA as it relates to administering quality health services, with the exception of the following differences: (1) the Federal Government has Treaty and Trust obligations to provide health care for all American Indians and Alaska Natives; (2) IHS is severely and chronically underfunded in comparison to the VHA, with per capita medical expenditures within IHS at $4,078 in Fiscal Year (FY) 2017 compared to $10,692 in VHA per capita medical spending that same year [1]; and (3) unlike IHS, the VHA has been protected from government shutdowns and continuing resolutions (CRs) because Congress enacted advance appropriations for the VHA a decade ago.[2]

Health Outcomes among Native Veterans and AI/ANs Overall

Destructive Federal Indian policies and unresponsive human service systems have left Native Veterans and their communities with unresolved historical and intergenerational trauma. From 2001 to 2015, suicide rates among Native Veterans increased by 62 percent (50 in 2001 to 128 in 2015).[3] In Fiscal Year 2014, the Office of Health Equity within VHA reported significantly higher rates of mental health disorders among Native Veterans compared to non-Hispanic White Veterans, includ-

[1] The full IHS Tribal Budget Formulation Workgroup Recommendations are available at https://www.nihb.org/docs/04242019/307871__NIHB%20IHS%20Budget%20Book__WEB.PDF

[2] See 38 U.S.C. 117; P.L. 111–81

[3] VA, Veteran Suicide by Race/Ethnicity: Assessments Among All Veterans and Veterans Receiving VHA Health Services, 2001-2014 (Aug. 2017) (citing CDC statistics).

ing in rates of PTSD (20.5 percent vs. 11.6 percent), depression symptoms (18.7 percent vs. 15.2 percent), and major depressive disorder (7.9 percent vs. 5.8 percent).[4]

Native Veterans are 1.9 times more likely to be uninsured than non-Hispanic White Veterans, and are significantly more likely to delay accessing care due to lack of timely appointments and transportation issues.[5] Among all Veterans, Native Veterans are more likely to have a disability, service-connected or otherwise.[6] Native Veterans are exponentially more likely to be homeless, with some studies showing that 26 percent of low-income Native Veterans experienced homelessness at some point compared to 13 percent of all low-income Veterans.[7] There exists a paucity of Native Veteran specific health, housing, and economic resources and programs that are accessible and culturally appropriate. It is essential that the VHA work with IHS and Tribes to create more resources specifically for Native Veterans.

According to IHS, AI/ANs born today have a life expectancy that is on average 5.5 years less than the national average.[8] In states like South Dakota, however, life expectancy for AI/ANs is as much as two decades lower than for Whites. Health outcomes among AI/ANs have either remained stagnant or become as AI/AN communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. According to the Centers for Disease Control and Prevention, in 2016, AI/ANs had the second highest age-adjusted mortality rate of any demographic nationwide at 800.3 deaths per 100,000 people.

In addition, AI/ANs have the highest uninsured rates (25.4 percent); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50 percent higher). AI/ANs also have the highest Hepatitis C mortality rates nationwide (10.8 per 100,000); and higher rates of chronic liver disease and cirrhosis deaths (2.3 times that of Whites). Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for AI/ANs. For instance, from 1999 to 2015 AI/ANs encountered a 519 percent increase in drug overdose deaths-the highest rate increase of any demographic nationwide.[9] All of these health determinants of health and poor health status could be dramatically improved with adequate investment into the health, public health and health delivery systems operating in Indian Country.

The VA's Veteran Outreach Toolkit lists AI/ANs as an "at-risk" population, citing this troubling suicide rate. Additionally, AI/ANs grapple with complex behavioral health issues at higher rates than any other population—for children of AI/AN veterans, this is compounded by the return of a parent who may suffer from post-traumatic stress disorder (PTSD). Outreach events for AI/AN communities should be a VA priority to increase wellness, decrease stigma, and prevent suicide. It is essential that the VHA continue to engage with Tribal leaders, through consultation, to assist in carrying out these activities.

Funding Levels for IHS versus VHA: The Need for Advance Appropriations

1. Tribes and NIHB strongly urge Congress to pass bipartisan legislation that would enact advance appropriations for Indian programs

By the most recent estimates, federally operated IHS facilities, Tribally operated health facilities and programs, and urban Indian health programs collectively serve roughly 2.6 million AI/ANs nationwide. In comparison, the VHA serves roughly 6.9 million Veterans through 18 regional networks. In Fiscal Year 2019 discretionary appropriations for IHS equaled roughly $5.8 billion; in comparison, spending within the VHA totaled over $76 billion. In effect, this means that while the VHA service

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[4] Lauren Korshak, MS, RCEP, Office of Health Equity and Donna L. Washington, MD, MPH, Health Equity-QUERI National Partnered Evaluation Center, and Stephanie Birdwell, M.S.W., Office of Tribal Government Relations

[5] Johnson, P. J., Carlson, K. F., & Hearst, M. O. (2010). Healthcare disparities for American Indian veterans in the United States: a population-based study. Medical care, 48(6), 563-569. doi:10.1097/MLR.0b013e3181d5f9e1

[6] U.S. Department of Veterans Affairs. (2015a). American Indian and Alaska Native Veterans: 2013 American Community Survey. Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/AIANReport2015.pdf

[7] US Department of Housing and Urban Development, US Department of Veterans Affairs, National Center on Homelessness Among Veterans. Veteran Homelessness: A Supplemental Report to the 2010 Annual Homeless Assessment Report to Congress. Washington, DC.2011:56

[8] Indian Health Service. 2018. Indian Health Disparities. Retrieved from https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf

[9] Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas—United States. MMWR Surveill Summ 2017;66(No. SS–19):1-12. DOI: http://dx.doi.org/10.15585/mmwr.ss6619a1

population is roughly only three times the size of the Indian health system, its discretionary appropriations are approximately 13 times higher than for IHS.

According to the IHS Tribal Budget Formulation Workgroup, IHS appropriations must reach nearly $38 billion-phased in over 12 years-in order to fully meet current health needs. In other words, even if today IHS were fully funded at the level of need identified by sovereign Tribal Nations, it would only equal half the total Fiscal Year 2019 discretionary appropriation for the VHA. Indeed, the Federal Government's continued abrogation of its trust responsibility for health services for AI/ANs is clearly exemplified by the gravity of the divide in health funding for the VHA versus IHS.

Although the IHS budget has nominally increased by 2–3 percent each year, these increases are barely sufficient to keep up with rising medical and non-medical inflation, population growth, facility maintenance costs, and other expenses. According to a 2018 report by the Government Accountability Office (GAO–19–74R), from 2013 to 2017, IHS annual spending increased by roughly 18 percent and per capita spending increased by roughly 12 percent; in comparison, annual spending under the VHA increased by 32 percent and per capita spending increased by 25 percent during the same time period.[10] The widening gap in funding levels between IHS and the VHA only serves to perpetuate the disproportionately higher levels of health disparities experienced by Native Veterans and AI/ANs overall.

Unequivocally, the U.S. Federal Government has a moral and ethical obligation to ensure all U.S. Veterans can access quality health services-and it must continue to honor this responsibility. But the U.S. also has a Trust obligation to ensure all AI/ANs, including Native Veterans, can receive quality health services, that it continuously fails to honor. It is long past due for the Federal Government to make good on its constitutional obligation to Native Veterans an all AI/AN Peoples.

The discrepancies do not end with chronic underfunding of IHS. Of the four major Federal healthcare entities, IHS is the only one subject to the devastating impacts of government shutdowns and continuing resolutions (CRs). This is because Medicare and Medicaid receive mandatory appropriations, and the VHA was authorized by Congress to receive advance appropriations nearly a decade ago. As a result, the VHA has been insulated from every government shutdown, CR, and discretionary sequestration over the past decade. While it is true that no sector of government is fully spared by the repercussions of endless shutdowns and CRs, those repercussions are neither equal nor generalizable across all entities. In fact, the worst consequences are levied on Indian Country.

For instance, during the 2013 Federal budget sequester, the IHS budget was slashed by 5.1 percent—or $221 million-levied on top of the damage elicited by that year's government shutdown. In fact, IHS was the only federally funded healthcare entity that was subject to full sequestration because Congress had already exempted the VHA when it authorized it to receive advance appropriations. Once again, during the most recent 35-day government shutdown-the Nation's longest and most economically disastrous-IHS was the only Federal healthcare entity to be shut down. While direct care services remained non-exempt, providers were not receiving pay. Administrative and technical support staff-responsible for scheduling patient visits, conducting referrals, and processing health records-were furloughed. Contracts with private entities for sanitation services and facilities upgrades went weeks without payments, prompting many Tribes to exhaust alternative resources to stay current on bills.

Several Tribes shared that they lost physicians to hospitals and clinics not impacted by the shutdown. Some Tribal leaders even shared how administrative staff volunteered to go unpaid so that the Tribe had resources to keep physicians on the payroll. These are just a few examples of the everyday sacrifices and ongoing struggles that widen the chasm between the health services afforded to AI/ANs and those afforded to the Nation at large. While it is impossible to measure the full scope of adversity brought on by the 35-day government shutdown, one reality remains clear-Indian Country was both unequivocally and disproportionately impacted.

In 2018, GAO released a report examining the benefits of authorizing advance appropriations for the IHS and thus establishing parity between IHS and the VHA (GAO–18–652). The report outlined how Congress has been forced to use short-term or full-year CRs in all but four of the last 40 years. In fact, only once in the past two decades-in Fiscal Year 2006-has Congress successfully passed the Interior, Environment, and Related Agencies appropriations package (which funds IHS) before the end of the fiscal year. As a result, year after year, the Indian health system

[10] Government Accountability Office. 2018. Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs. Retrieved from https://www.gao.gov/assets/700/695871.pdf

is curtailed from making meaningful improvements toward the availability and quality of health services and programs, further restraining efforts to advance quality of life and health outcomes for AI/ANs.

While a CR is always preferable to a government shutdown, they are not devoid of obstacles that directly impact patient care. Because of budget authority constraints under a CR, IHS is prohibited from initiating any new activities or projects that were not expressly authorized or appropriated in the previous fiscal year. In addition, under a CR, IHS must exercise significant precaution over expenditures, and is generally limited to simply maintain operations as opposed to improve them. When you compound the impact of chronic underfunding and endless use of CRs, the inevitable result are the chronic and pervasive health disparities seen across Indian Country. As such, **Tribal Nations and NIHB strongly urge Congress to pass bipartisan legislation that would authorize advance appropriations for Indian programs**.

Lack of IHS and VHA Care Coordination and Reimbursement Agreements

1. NIHB recommends that Congress clarify statutory language under section 405(c) of the Indian Health Care Improvement Act and make explicit the VHA's requirement to reimburse IHS and Tribes for services under Purchased/Referred Care (PRC).

By law, an AI/AN Veteran is eligible for services under both the VHA and IHS. A 2011 report showed that approximately one-quarter of IHS-enrolled Veterans use the VHA for health care, commonly receiving treatment for diabetes mellitus, hypertension or cardiovascular disease from both Federal entities.[11] According to the VA, more than 2,800 AI/AN Veterans are served at IHS facilities.[12] In instances where an AI/AN veteran is eligible for a particular health care service from both the VA and IHS, the VA is the primary payer. Under section 2901(b) of the Patient Protection and Affordable Care Act (ACA), health programs operated by the IHS, Tribes and Tribal organizations, and urban Indian organizations (collectively referred to as the "I/T/U" system) are payers of last resort regardless of whether or not a specific agreement for reimbursement is in place.

Section 407(a)(2) of the Indian Health Care Improvement Act (IHCIA) reaffirms the goals of the 2003 Memorandum of Understanding (MOU) between the VHA and IHS established to improve care coordination for Native Veterans. In addition, during permanent reauthorization of IHCIA, section 405(c) was amended to require the VHA to reimburse IHS and Tribes for health services provided under the Purchased/Referred Care (PRC) program. In 2010, the VHA and IHS modernized their 2003 MOU to further improve care coordination for Native Veterans by bolstering health facility and provider resource sharing; strengthening interoperability of electronic health records (EHRs); engaging in joint credentialing and staff training to help Native Veterans better navigate IHS and VHA eligibility requirements; simplifying referral processes; and increasing coordination of specialty services such as for mental and behavioral health.

According to a 2019 GAO report (GAO–19–291), since implementation of the 2010 MOU, the VHA has reported entering into 114 signed agreements with Tribal Health Programs (THPs), along with 77 implementation agreements to strengthen care coordination. While a single national reimbursement agreement exists between federally operated IHS facilities and the VHA, THPs continue to exercise their sovereignty by entering into individual agreements with the VHA. From 2014 to 2018, those reimbursement agreements with THPs alone increased by 113 percent.

VA reimbursements to IHS and THPs overall during that same time period increased by 75 percent, reaching $84.3 million in total. Yet these increased reimbursements still represent just a fraction of 1 percent of the VA's annual budget. While recent increases in the quantity of agreements and reimbursements demonstrates a positive trend, there continue to be significant challenges in care coordination between the VHA and IHS. The 2019 GAO report highlighted three overarching challenges related to care coordination: ongoing issues in patient referrals between I/T/U facilities and the VHA; significant problems in EHR interoperability; and high staff turnover within both VHA and IHS. These complications continue to stifle Native Veterans' access to health care, erodes patient trust in both IHS and VHA health systems, and obstructs efforts to improve health outcomes.

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[11] Kramer, BJ, Wang M, Jouldjian S, Lee ML, Finke B, Saliba D. Healthcare for American Indian and Alaska native veterans: The roles of the veterans health administration and the Indian Health Service. Medical Care.

[12] VA/IHS listening session held on May 15, 2019

These issues are exacerbated by VHA claims that no statutory obligation exists for reimbursement of specialty and referral services provided through IHS or THPs. To clarify, the VHA currently reimburses IHS and THPs for care that they provide directly under the MOU. Despite repeated requests from Tribes, the VA has not provided reimbursement for PRC specialty and referral care provided through IHS/THPs. This is highly problematic, as AI/AN Veterans should have the freedom to obtain care from either the VA or an Indian health program. If a Veteran chooses an Indian health program, that program should be reimbursed even if the service could have been provided by a VA facility or program in the same community.

But because that doesn't happen, it creates greater care coordination issues and burdensome requirements for Native Veterans. For example, if a Native 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 VHA is paying for the same services twice, first for those primary care services provided to the Veteran in the IHS or THP facility, and then again when the patient goes back to the VHA for the same primary care service to then receive a VHA referral. This is neither a good use of Federal funding, nor is it navigable for veterans. In order to provide the care that Native Veterans need, many THPs are treating Veterans or referring them out for specialty care and paying for it themselves so that they can be treated in a timely and competent manner. For those Veterans that do go back to the VHA for referrals, there is often delayed treatment and a significantly different standard of care provided.

As a step toward mitigating the confusion surrounding reimbursement for care provided by the VHA, NIHB recommends the VHA include PRC in future IHS/THP reimbursement agreements, so that there is no further rationing of health care provided by IHS and THPs to Native Veterans and other eligible AI/ANs. Ultimately, however, NIHB recommends that Congress clarify the statutory language under section 405(c) of IHCIA and make explicit VHA's requirement to reimburse under PRC.

2. NIHB also strongly supports the GAO recommendation that the VHA work with IHS to create written policy or guidelines to clarify how referrals from IHS and THP facilities to VHA facilities for specialty care should be managed, and to establish specific targets for measuring action on MOU performance measures.

The GAO report cited how, for example, facilities reported conflicting information about the processes for referring Native Veterans from IHS or Tribal facilities to VHA, and VA headquarters officials confirmed that there is no national policy or guide on this topic. One of the leading collaboration practices identified by GAO is to have written guidance and agreements to document how agencies will collaborate. Without written policy or guidance documents on how referrals should be managed, neither agency can ensure that VHA, IHS, and Tribal facilities have consistent understanding of the options available for referral of Native Veterans for specialty care.

As is currently the case, the result is duplicative care for Native Veteran and duplicative costs for the Federal Government. NIHB has heard that some Native Veterans prefer to simply hand carry their EHR records from their IHS provider to their VHA provider to avoid having to receive the same care twice. In short, lack of written policy perpetuates this burdensome, pointless, and complicated process that only serves to frustrate patients, worsen administrative red tape, and increase expenditures.

For numerous Tribes, and especially for the Veterans themselves, it is an undue barrier to constantly have to refer patients back and forth to the VA that ultimately wastes time and delays access to care. The GAO identified that IHS and VA lack sufficient measures for quantifiable assessments of progress toward MOU goals and objectives. Although the VHA and IHS have created 15 performance measures, no specific targets or indicators have been established that allow Tribes to measure progress toward achieving the goals and objectives of the MOU.

3. Tribes and NIHB have strongly recommended that the VHA consult with Tribes and work through their MOU with IHS to create and publish a living list of available Veterans Liaisons/Tribal Veterans Representatives across all IHS and VHA regions

The VHA must do more outreach and education with Native Veterans to improve care coordination. Tribes and NIHB have consistently stressed the need for VHA to create toolkits and guides to assist Native Veterans in navigating care access. The paucity of currently available newsletters, outreach workers and liaisons such as Tribal Veteran Service Officers (TVSOs), and online resources specifically for Native

Veterans also sends the message that care for Native Veterans is not a priority. But despite repeated Tribal demands, the agency has yet to implement this request.

A closely related issue is the fact that Native Veterans are still charged copays and deductibles when receiving services under the VHA. The Federal Government's trust responsibility for health services extends to all Native Veterans. In recognition of this, AI/ANs do not have copays or deductibles for services received at an I/T/U facility. Additionally, the ACA further affirmed the trust responsibility when it included language at Section 1402 to exempt all AI/ANs under 300 percent of the Federal poverty level from co-pays and deductibles on plans purchased on the health insurance Marketplace.

4. Congress should pass legislation exempting Native Veterans from copays and deductibles

Section 222 of IHCIA prohibits cost sharing of AI/ANs in cases where an AI/AN receives a referral from the from an IHS or THP under the PRC program. Like IHS and the Marketplace, the VHA is another means by which the Federal Government must uphold its trust responsibility to AI/ANs. As such, it is imperative that Congress enact legislation that requires the VHA to similarly exempt AI/AN Veterans from copays and deductibles in the VA system in recognition of the Federal trust responsibility. Importantly, copay costs should not be shifted to IHS or Tribes. The VHA must absorb these costs on behalf of AI/AN Veterans in recognition of their Trust and Treaty obligations to AI/AN Peoples.

5. Congress should pass the bipartisan H.R. 2791 - Department of Veterans Affair Tribal Advisory Committee Act of 2019

Tribal Nations and NIHB have also strongly advocated for the seating of a Tribal Advisory Committee (TAC) within the Office of the Secretary at the VA. Establishing a Veteran TAC is essential for strengthening the government-to-government relationship, and improving VA accountability to Native Veteran health needs. Through the seating of a TAC, top VA officials would have the ability to hear directly from Tribal leaders about the unique health priorities and challenges that impact Native Veterans. In addition, it would help prevent the development of new rules or policies that would adversely affect care for Native Veterans. As such, Tribes and NIHB strongly support the bipartisan H.R. 2791, introduced by Representative Deb Haaland, and urges the House VA Committee to vote to pass this significant legislation.

EHR Interoperability and Health Information Technology (IT) Modernization

1. Congress must ensure parity between the VA and IHS in appropriations and technical assistance for health IT modernization

The Resource and Patient Management System (RPMS)-which is the primary health IT system used across the Indian health system-was developed in close partnership with the VHA and has become partially dependent on the VHA health IT system, known as the Veterans Information Systems and Technology Architecture (VistA). The RPMS is an early adoption of VistA for outpatient use, and the legacy system was designed with the decision to keep the same underlying code infrastructure as VistA. IHS began developing different clinical applications for their outpatient services, and the VHA adopted code from RPMS to provide this functionality for VistA.

RPMS eventually began to use additional VistA code as the need for inpatient functionality increased. This type of enhancement and support for both the IHS and VHA was made possible because VistA's software components were designed as an Open Source solution. The RPMS suite is able to run on mid-range personal computer hardware platforms, while applications can operate individually or as an integrated suite with some availability to interface with commercial-off-the-shelf (COTS) software products.

Currently, the RPMS manages clinical, financial, and administrative information throughout the I/T/U, although, it is deployed at various levels across the service delivery types. However, in recent years, many Tribes and even several Urban Indian Health Programs (UIHPs) have elected to purchase their own COTS systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and are significantly more navigable and modern systems to use. As a result, there exists a growing patchwork of EHR platforms across the Indian health system.

When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), concentrated efforts to re-evaluate the Indian Health IT system accel-

erated, and arose significant concerns as to how VHA and I/T/U EHR interoperability would continue. In 2018, IHS launched a Health IT Modernization Project to evaluate the current I/T/U health IT framework, and to, through Tribal consultation, key informant interviews, and national surveys, develop a series of next steps and recommendations toward modernizing health IT in Indian Country.

Difficulties in achieving IT interoperability among VA, IHS, and THP facilities pose significant problems for Native Veterans' care coordination. Unfortunately, the VHA and IHS have yet to identify a systemic solution toward increasing EHR interoperability between I/T/U and VHA hospitals, clinics, and health stations. A resulting scenario includes situations where a THP provider-having treated a Veteran and referred them to the VHA for specialty care-would not receive the Veteran's follow up records as quickly as if they had streamlined access to each other's systems.

Now that the VHA is transitioning to the Cerner system, it has worsened concerns around care coordination and sharing of EHRs between I/T/U and VHA systems. The fact is, Native Veterans are suffering today from the lack of health IT interoperability. **It is shameful that Native Veterans are put in a position where they have to find their own solutions to streamline EHR sharing, most shockingly exemplified by anecdotes of AI/AN Veterans hand carrying their health records between their IHS and VHA provider**.

Congress must ensure that the Indian health system is fully integrated across the development and implementation of the VHA's transition to Cerner; however, thus far it has failed to do so. By the most current estimates, the transition to Cerner will take up to 10 years to fully implement, with a current price tag of roughly $16 billion. None of the existing estimates include calculations of how much it will cost to include IHS in this transition; however, through its Health IT Modernization Project, IHS is attempting to arrive at an estimated dollar figure for this cost.

Tribes and NIHB were pleased to see that the Fiscal Year 2020 President's Budget included a request for a new $20 million line item in the IHS budget to assist with health IT modernization, and that this request was included in the House-passed Fiscal Year 2020 Interior Appropriations package. But in comparison, the Fiscal Year 2020 House Military Construction Appropriations bill budgeted $1.6 billion to assist VHA in its transition. Ensuring EHR interoperability between I/T/U and VHA health systems will be impossible if Congress fails to establish parity in appropriations for VHA and IHS health IT modernization.

Conclusion

The Federal Government has a dual responsibility to Native Veterans that continues to be ignored. As the only national Tribal organization dedicated exclusively to advocating for the fulfillment of the Federal trust responsibility for health, NIHB is committed to ensuring the highest health status and outcomes for Native Veterans. We applaud the House VA Subcommittee for Health for holding this important hearing, and stand ready to work with Congress in a bipartisan manner to enact legislation that strengthens the government-government relationship, improves access to care for Native Veterans, and raises health outcomes.

PREPARED STATEMENT OF KEVIN J. ALLIS

On behalf of the National Congress of American Indians (NCAI), thank you for the opportunity to provide testimony on the topic of American Indian and Alaska Native (AI/AN) veterans' access to healthcare. I serve as the Chief Executive Officer of NCAI, and I look forward to working with members of this Subcommittee and other Members of Congress to better fulfill the Federal Government's commitment to provide for the well-being of AI/AN veterans when they return home.

Founded in 1944, NCAI is the oldest and largest national organization composed of tribal nations and their citizens. Tribal leaders created NCAI in 1944 in response to termination and assimilation policies that threatened the existence of tribal nations. Since then, NCAI has fought to preserve the treaty and sovereign rights of tribal nations, advance the government-to-government relationship between tribal nations and the Federal Government, and remove historic structural impediments to tribal self-determination.

AI/ANs have a long history of distinguished service to this country. Per capita, AI/ANs serve at a higher rate in the Armed Forces than any other group of Americans and have served in all the Nation's wars since the Revolutionary War. In fact, AI/AN veterans served in several wars before they were even recognized as U.S. citizens. Despite this esteemed service, AI/AN veterans have lower personal incomes, higher unemployment rates, and are more likely to lack health insurance than other veterans.

The United States must honor its commitments to AI/AN veterans. The Federal Government's responsibility to provide quality healthcare to AI/AN veterans comes both from their service to this country and the Federal Government's treaty and trust obligations to AI/AN people. NCAI calls on Congress and the Administration to ensure that Federal policy addresses the unique needs and circumstances of AI/AN veterans and that Federal agencies coordinate closely to deliver the best possible services to AI/AN veterans, regardless of whether they are living on rural reservation lands or in major urban areas.

Cultural Competency at the Department of Veterans Affairs

NCAI's Veterans Committee provides a forum for discussing issues that impact AI/AN veterans and helps develop NCAI policy priorities to improve the lives of veterans across Indian Country. Participants in the NCAI Veterans Committee continue to highlight cultural competency issues across the Department of Veterans Affairs (VA) system. This directly impacts the provision of healthcare and can affect how veterans' claims are processed and whether they are approved. For example, the VA's generic Post Traumatic Stress Disorder (PTSD) Disability Benefits Questionnaire does not address cultural issues. This lack of consideration leads to many AI/AN veterans being denied benefits or receiving benefits that are insufficient given the severity of their conditions. Additionally, aging veterans and those with certain types of traumatic brain injuries affecting language that have reverted to their traditional languages face a lack of translation services.

Given the importance of cultural competency, the NCAI Veterans Committee has expressed the need to increase access to Tribal Veterans Service Organizations (TVSOs) to assist AI/AN veterans with benefits claims and accessing other VA services. Unfortunately, the current regulations require that for a tribal nation to have representatives trained and accredited through the VA, it must establish and fund an organization that has the primary purpose of assisting veterans and survivors with their claims. Requiring a tribal nation to establish and fund a separate organization fails to recognize tribal sovereign decisionmaking and creates unnecessary regulatory burdens. This burdensome regulatory structure is the reason only a handful of tribally affiliated groups have applied for accreditation-and why even fewer have received accreditation. We urge members of this Subcommittee to examine ways to ensure tribal nations are able to establish TVSOs to better assist AI/AN veterans with the preparation, presentation, and prosecution of benefits claims.

VA-IHS Memorandum of Understanding and GAO–19–291

In 2010, the VA and the Indian Health Service (IHS) signed a Memorandum of Understanding (2010 MOU) "to establish coordination, collaboration, and resources-sharing between the [VA and IHS] to improve the health status of [AI/AN] Veterans."[1] The MOU includes five goals:

- Increase access to and improve quality of healthcare and services to the mutual benefit of both agencies. Effectively leverage the strengths of the VA and IHS at the national and local levels to afford the delivery of optimal clinical care.
- Promote patient-centered collaboration and facilitate communication among VA, IHS, AI/AN veterans, tribal facilities, and Urban Indian clinics.
- In consultation with tribal nations at the regional and local levels, establish effective partnerships and sharing agreements among VA headquarters and facilities, IHS headquarters and facilities, tribal facilities, and Urban Indian Health Programs in support of AI/AN veterans.
- Ensure that appropriate resources are identified and available to support programs for AI/AN veterans.
- Improve health promotion and disease prevention services to AI/AN veterans to address community-based wellness.[2]

In furtherance of the 2010 MOU, VA enters reimbursement agreements with IHS and tribal health program facilities. These agreements allow AI/AN veterans to receive VA-eligible healthcare services at IHS and tribal facilities without prior VA approval. There is a single national reimbursement agreement between VA and IHS, which was extended in June 2018 through June 30, 2022. VA negotiates individual reimbursement agreements with tribal facilities.

In March 2019, the U.S. Government Accountability Office (GAO) published a report to provide updated information on implementation of the 2010 MOU. GAO

[1] U.S. Gov't Accountability Office, GAO–19–291, Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans (2019).
[2] Id.

found that since its last report on this issue, reimbursements by VA for healthcare services have increased, particularly at tribal health facilities. It also noted an increase in the number of VA-tribal health facility reimbursement agreements and the number of veterans served under reimbursement agreements.

GAO also identified challenges that continue to hinder full implementation of the 2010 MOU. Specifically, the report found that performance measures established by the agencies do not include targets to track progress and there is no national policy or guidance on referring AI/AN veterans from IHS and tribal facilities to VA for services, potentially causing duplicative tests and services.

GAO made the following recommendations: (1) "[a]s VA and IHS revise the MOU and related performance measures, the Secretary of Veterans Affairs should ensure these measures are consistent with the key attributes of successful performance measures, including having measurable targets"; (2) "[t]he Secretary of Veterans Affairs should, in consultation with IHS and tribes, establish and distribute a written policy or guidance on how referrals from IHS and THP facilities to VA facilities for specialty care can be managed"; and (3) "[a]s VA and IHS revise the MOU and related performance measures, the Director of IHS should ensure these measures are consistent with the key attributes of successful performance measures, including having measurable targets."[3]

VA and IHS are in the process of re-negotiating the 2010 MOU. In addition to calling on VA and IHS to ensure tribal stakeholders are at the table for those negotiations, NCAI would like to highlight several issues raised in the GAO report that continue to be tribal priorities for inclusion in the VA-IHS MOU.

Currently, VA does not reimburse for services provided by external providers paid for by IHS or tribal health facilities through the Purchase/Referred Care program. Instead, AI/AN veterans must be referred by VA facilities to be eligible to receive reimbursable specialty care. This is overly burdensome, results in duplicative processes that limit access to care for AI/AN veterans, and wastes Federal resources. VA reimbursement of Purchased/Referred Care must be included in the re-negotiated MOU.

A specific focus of the 2010 MOU is the interoperability of the VA and IHS systems "to facilitate sharing of information on common patients and populations." Nine years later, there still is not interoperability between VA and IHS electronic health information technology systems. NCAI urges VA and IHS to ensure interoperability of their health information as they evaluate and implement new electronic health record systems.

Finally, AI/ANs do not have cost-sharing for services received through IHS. However, AI/AN veterans are subject to the same copayments as other veterans when they receive care at the VA. In Fiscal Year 2017, approximately 30 percent of AI/AN veterans were charged co-payments, averaging approximately $281.56 per veteran.[4] This represents a significant barrier to care for AI/AN veterans. Accordingly, NCAI calls on Congress and the Administration to honor the treaty and trust obligations to provide healthcare to AI/ANs by eliminating VA co-payments for AI/AN veterans.

Pass the Department of Veterans Affairs Tribal Advisory Committee Act of 2019

AI/AN veterans, tribal leaders, and GAO have expressed the need for VA to engage with tribal stakeholders when assessing, developing, and implementing policy affecting AI/AN veterans. Establishing a VA Tribal Advisory Committee (VATAC) will help achieve this goal. Specifically, the VATAC would advise the Secretary on how to improve programs and services for AI/AN veterans, identify timely issues related to VA programs, propose solutions to identified issues, provide a forum for discussion, and help facilitate getting useful feedback from Indian Country. Building a strong relationship between the VA and tribal nations will increase awareness and understanding across the VA of the unique issues affecting AI/AN veterans in tribal communities. This awareness paired with more direct interaction with tribal leaders who regularly hear from AI/AN veteran constituents will ultimately produce faster solutions and better services for AI/AN veterans.

Legislation has been introduced in the House (H.R. 2791) and the Senate (S. 524) to create a VATAC that would provide vital opportunities for collaboration, communication, and coordination between the VA and tribal nations to help AI/AN veterans access the services they earned through their service to this country. NCAI supports this legislation via Resolution #REN–19–033, "Supporting the Department

[3] Id.
[4] Id.

of Veterans Affairs Tribal Advisory Committee Act." Accordingly, NCAI urges Congress to act swiftly to enact legislation establishing a VATAC.

Authorize IHS and BIA Advance Appropriations to Provide Certainty for AI/AN Veterans

Congress must uphold its solemn obligations to tribal nations by protecting programs serving Indian Country—especially those serving AI/AN veterans—from uncertainty in the Federal budget process.

Following the 2019 government shutdown, NCAI adopted Resolution #ECWS–19–001, which calls on Congress to pass legislation authorizing advance appropriations for IHS and the Bureau of Indian Affairs (BIA). This resolution expands on NCAI Resolution#ANC–14–007, which calls for advance appropriations for IHS.

Preventing Federal budget impasses from jeopardizing the health, safety, and well-being of AI/AN veterans and all those living in tribal communities is a major priority for Indian Country. Although the Veterans Health Administration receives advance appropriations to prevent Federal budget impasses from affecting or interrupting healthcare for veterans, IHS does not receive the same treatment—even though IHS is often the primary agency responsible for providing critical healthcare services to AI/AN veterans. Additionally, services provided through the BIA impact AI/AN veterans' access to health care both at IHS and VA facilities. For instance, BIA is responsible for construction and maintenance of roads across Indian Country, and lapses in related funding can prevent AI/AN veterans from traveling to healthcare appointments at the VA or Indian health system facilities. Authorizing advance appropriations for IHS and BIA will ensure that medical attention and resources that AI/AN veterans earned through their military service are available when the Administration and Congress cannot agree on spending priorities.

There are currently two bills pending in the U.S. House of Representatives that provide advance appropriations for tribal programs. H.R. 1128, the Indian Programs Advanced Appropriations Act was introduced by Representative Betty McCollum and authorizes advance appropriations for several accounts at IHS and BIA. This legislation has a Senate companion bill, S. 229, and nearly 40 bipartisan co-sponsors. H.R. 1135, the Indian Health Service Advance Appropriations Act, was introduced by Representative Don Young and authorizes advance appropriations for several accounts at IHS. This legislation has a Senate companion bill, S. 2541, and nearly 30 bipartisan co-sponsors.

NCAI supports H.R. 1128 and H.R. 1135, and NCAI strongly urges every member of this Subcommittee and the entire House of Representatives to join in supporting advance appropriations for Indian Country.

Pass the Health Care Access for Urban Native Veterans Act

Urban Indian Organizations (UIOs) are an important part of the Indian healthcare delivery system. Given that a majority of AI/ANs live off reservation, many of our AI/AN veterans utilize the UIO system. AI/AN veterans often prefer to use Indian healthcare providers, including UIOs, for reasons such as cultural competency, community and familial relations, and VA wait times.

Although the 2010 MOU recognizes that VA and IHS must meet the needs of Urban Indian health programs, UIOs are currently ineligible to be reimbursed for the services they provide to AI/AN veterans. Allowing reimbursement for UIO services would not only help alleviate broader issues with wait times at VA facilities, but also would provide AI/AN veterans the opportunity to seek culturally competent care when living away from their own tribal communities, which will help reduce overall health disparities in Indian Country.

NCAI strongly supports addressing this gap in the IHS-VA MOU. Legislation has been introduced in the House (H.R. 4153) and the Senate (S. 2365) to amend the Indian Health Care Improvement Act to provide Native veterans coverage by the VA for services at urban Indian health centers. NCAI's membership passed Resolution #REN–19–034, which calls on Congress to pass this important legislation.

Address Data Collection on Suicide among AI/AN Veterans

AI/ANs experience high rates of depression and psychological distress, which contributes to Native people having one of the highest suicide rates of any group in the United States. While the VA acknowledges suicide as a national health crisis that affects all Americans and publishes reports each year on suicide data, it continues to omit data specific to AI/AN veterans. When VA does disaggregate suicide data by race/ethnicity, AI/AN veterans fall under the category of "other." Capturing data specific to AI/AN veteran suicide is essential for developing effective policy and initiatives to generate improved outcomes. Therefore, NCAI urges Congress and the Administration to work to develop policies and procedures that ensure the collection

of AI/AN veteran suicide data so that Federal and tribal policymakers have the necessary information to address the suicide crisis among AI/AN veterans.

Invest in Tribal Infrastructure, Road Systems, and Tribal Transit Systems

Although outside this Committee's jurisdiction, supporting a strong surface transportation reauthorization bill for Indian Country also would help address some of the issues AI/AN veterans face when trying to access VA services. NCAI urges Congress to provide significant increases for the Tribal Transportation Program, the Tribal Transit Program, the BIA Road Maintenance Program, and other programs that will improve road conditions and promote road safety in Indian Country. Increased investment in these programs will enhance the ability of AI/AN veterans to travel to VA services.

Conclusion

Thank you for the opportunity to testify regarding AI/AN veterans' access to quality, culturally appropriate healthcare. We greatly appreciate the work of this Committee to address the many challenges and barriers faced by AI/AN veterans. We loforward to working with this Subcommittee on a bipartisan basis to advance Federal policies that support those who have served our country.

PREPARED STATEMENT OF SONYA TETNOWSKI

My name is Sonya Tetnowski, I am a member of the Makah tribe, a U.S. Army Paratrooper Veteran, and the Chief Executive Officer of the Indian Health Center of Santa Clara Valley in California. I'm also the Vice President of the National Council of Urban Indian Health (NCUIH), which represents 41 Title V Urban Indian Health Organizations (UIOs) across the Nation, as well as the President of the California Consortium for Urban Indian Health (CCUIH). UIOs provide high-quality, culturally competent care to urban Indian populations, which constitute more than 78 percent of all American Indians and Alaska Natives (AIANs). I would like to thank Chairwoman Brownley, Ranking Member Dunn, and other distinguished members of the subcommittee for holding this important hearing. It is my pleasure to testify today regarding H.R. 4153, the Health Care Access for Urban Native Veterans Act.

H.R. 4153 is a necessary and critical piece of legislation, one that will make a real meaningful difference in the funding for health care services provided by UIOs across the United States. Just last month, I came to Washington D.C. to advocate and give in person testimony on this very issue before the House Indigenous Peoples of the United States Subcommittee Legislative Hearing on held on September 25, 2019 and to voice my support of H.R. 4153.

I cannot express more urgently, that the single most important thing the Department of Veterans Affairs (VA) can do to improve healthcare to AI/AN Veterans, is to fully implement the VA and Indian Health Services' Memorandum of Understanding (VA-IHS MOU) and Reimbursement Agreement for Direct Health Care Services. This would allow UIOs to be reimbursed for providing culturally competent care to AI/AN Veterans residing in urban areas. Despite an embattled history between tribal people and the U.S. Government, and as an inherited responsibility to safeguard the lands of their ancestors, AI/ANs serve this country at a higher rate than any other group in the Nation. A significant number of these Veterans live in urban areas and seek out the high-quality, culturally competent care at their local UIO.

UIOs were formally recognized by Congress following the end of the Termination Era in 1976 under the Indian Health Care Improvement Act to fulfill the Federal Government's health care-related trust responsibility to Indians who live off the reservations. Each UIO is led by a Board of Directors that must be majority Indian. They are collectively represented by the National Council of Urban Indian Health (NCUIH), which is a 501(c)(3), member-based organization devoted to the development of quality, accessible, and culturally sensitive healthcare programs for AIANs living in urban communities. UIOs are a critical part of the Indian Health Service (IHS), which uses a three-prong approach to provide health care: Indian Health Services, Tribal Programs, and Urban Indian Organizations commonly referred to as the I/T/U.

VA-IHS MOU Historical Background

In February 2003, the VA and IHS signed a Memorandum of Understanding (MOU) and updated this MOU in October 2010. The very first paragraph of the MOU states:

" the intent of this MOU (is) to facilitate collaboration between IHS and VA, and **not limit initiatives, projects, or interactions between the agencies in any way**. The MOU recognizes the importance of a coordinated and cohesive effort on a national scope, while also acknowledging that the implementation of such efforts requires local adaptation to meet the needs of individual tribes, villages, islands, and communities, as well as local VA, IHS, Tribal, and **Urban Indian health programs**."

In December 2012, the two agencies signed a reimbursement agreement allowing the VA to financially compensate IHS for health care provided to AIANs that are part of the VA's system of patient enrollment. While this MOU has been implemented for IHS and Tribal providers, it has not been implemented for UIOs, despite the fact that UIOs are explicitly mentioned in the original language of the 2010 MOU, and provide healthcare within IHS's own I/T/U system. Leaving out UIOs is a violation of the MOU since the agencies agreed to "not limit initiatives, projects, or interactions between the agencies in any way." Not reimbursing UIOs for services provided to Native Veterans is limiting this vulnerable, underserved population from the healthcare they need and deserve. NCUIH and UIO leaders have been testifying before Congress for years that the MOU is not being recognized for UIOs. Members have said this is an "easy fix," and "an oversight," so we are happy to see that there is now a bill to address this issue once and for all. We maintain that as part of the I/T/U, the VA already has the authority to reimburse title V UIOs, but we are happy Congress is taking the next step to address this important issue.

Between 2012 and 2015, the VA reimbursed over $16.1 million for direct services provided by IHS and Tribal Health Programs covering 5,000 eligible Veterans under the IHS-VA MOU. In spite of the Federal trust responsibility to AIANs, the VA had decided to deem UIOs ineligible to enter into the reimbursement agreement under the IHS-VA MOU. For context, UIOs are already extremely underfunded and receive less than $400 per patient from IHS, versus national health expenditure rates of almost $10,000 per patient. In 2018, UIOs received a total of $51.3 million to support 41 programs, and that is before IHS's administrative costs are removed. UIOs only receive one line-item appropriation in the IHS budget-the urban Indian health line item. UIOs don't receive purchase and referred care dollars, Federal Tort Claims Act coverage, 100 percent FMAP, or facilities funding. In fact, a few UIOs temporary closed during the shutdown due to the lack of parity within the IHS system. VA reimbursement, even half of the $16.1 million, would drastically help our facilities. It is time to fix this issue for good.

The VA's position is that UIOs are not identified in 25 U.S.C. § 1645(c) as one of the organizations it may reimburse. However, it is important to note that **two UIOs are covered under the IHS-VA MOU because VA officials report that those programs function as a service unit as defined in 25 U.S.C. § 1603(20)**.

There have been several Government Accountability Office (GAO) reports conducted on the VA-IHS MOU—two reports on VA and IHS implementation and oversight of the MOU were released in 2013 and 2014. In March 2019, the GAO released a study entitled "*VA AND INDIAN HEALTH SERVICE Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans*". The GAO was asked to provide updated information related to the agencies' MOU oversight. This report examines **(1)** VA and IHS oversight of MOU implementation since 2014, **(2)** the use of reimbursement agreements to pay for AI/AN veterans' care since 2014, and **(3)** key issues identified by selected VA, IHS, and tribal health program facilities related to coordinating AI/AN veterans' care. In this report the GAO report makes the recommendation to both the VA Secretary and IHS Director to ensure measureable targets to track and measure performance, and has jump started efforts by VA to conduct consultation and confer. The VA is currently working with IHS to revise the MOU, stating their goals for this revision: **increase access** and quality of care for AI/AN veterans, improve health promotion and disease prevention, encourage patient centered collaboration and communication, consult with Tribes at the regional and local levels, ensure appropriate resources for services for AI/AN Veterans. Furthermore, the VA in a 2018 report to Congress stated themselves that UIOs under IHCIA are "eligible, capable, and are entitled to receive reimbursement for healthcare services they provide to AI/AN veterans from any payer" as part of the IHS I/T/U system. They also acknowledge that they have no current legal authority to allow for expanding existing reimbursement agreements to include UIOs. If the goal is to **increase access** to care for AI/AN veterans, then now is the time for the VA to finally recognize that UIOs are a critical part of the Indian Health Service (IHS), acknowledge the needs of the significant amounts of AI/AN veterans who live in urban areas and expand the reimbursement agreement to include UIOs.

Both the legislative and executive branches **strongly** support efforts to increase timely access of healthcare for Veterans. Recognition of the MOU for UIOs and urban Indian Veterans would be highly consistent with those efforts. NCUIH has worked closely with the National Congress of American Indians who recently passed a resolution in support of our efforts to ensure parity for UIOs. This resolution is being submitted as a part of my testimony today.

In Conclusion

We strongly recommend that the VA reimburses UIOs for services rendered to Native Veterans. These reimbursements must be companied by outreach and advocacy resources to ensure that Native Vets are aware of all the health care options available to them in their communities. The VA is known for its challenging wait times, yet we all agree access to care for Veterans is a priority. UIOs can provide excellent, culturally competent primary care, dental, and behavioral health services to Veterans, while reducing the burden on the VA and allowing it to focus on the specialty services it provides best.

Our national interest of serving Veterans will be best carried out when we extend the collaborative arrangements already agreed to by the VA and IHS to include the bulk of our Nation's Native American Veterans—who either are or could be served by a UIO.

NCUIH strongly recommends, pursuant to **Section 405(c) of the Indian Health Care Improvement Act**, that the VA-IHS MOU be expanded to include reimbursement for care provided by the UIOs. Thank you for holding this hearing today and for the Committee's support of urban Indian healthcare issues. We strongly support H.R. 4153 and look forward to working with Congress to serve as an expert resource regarding this legislation.

PREPARED STATEMENT OF WILLIAM F. SMITH

The Alaska Native Health Board (ANHB) thanks Chairwoman Brownley, Ranking Member Dunn, and Distinguished Members of the House Committee on Veterans' Affairs Subcommittee on Health for the opportunity to provide this written statement to augment Chief William F. Smith's oral testimony. The ANHB was established in 1968 and serves as the statewide voice of the Alaska Tribal Health System (ATHS) on Alaska Native health issues. ANHB represents 229 federally recognized Alaska Tribes that provide health services to over 177,000 Alaska Native people and thousands of veterans (Native and non-Native alike) spread across the greater than 660,000 square miles that Alaska encompasses. Please accept this statement providing background and context and a listing of our issues and priorities pertinent to this hearing.

Honoring Our Veterans

Alaska Natives and American Indians are the highest represented population in the armed forces per capita. Tribal leadership stands beside them and by their Non-Native brothers and sisters who have served in the military and believe they should be encouraged and enabled to utilize the benefits promised them by the Federal Government. Tribal sharing agreements and engagement with the Tribal health system provides a method for the Federal Government and agencies to meet those promises. These individuals have sacrificed for our security and our freedom and are to be lifted and celebrated. However, sadly many veterans do not have faith and trust in the VA after past experiences with delays in enrollment, denial of care or lack of access to VA services. The Alaska VA is to be commended for the strides it has taken in partnership with tribes to remedy these barriers. Its partnership with tribes is a key component in its success.

Background:

Trust Responsibility

Established in numerous Treaties and the Constitution, the Trust Responsibility forms a unique government-to-government relationship between the Federal Government and American Indian and Alaska Native (AI/AN) people. These actions form the legal basis by which the United States has committed to protecting the health and well-being of America's first citizens in perpetuity. Alaska Tribes have taken over our programs and services through a contracting and compacting process and now carry out nearly all of the functions previously administered by the IHS. Collectively, the Alaska Tribal Health System forms an integrated statewide health network, providing health care services at village clinics, regional hubs and the Alaska Native Medical Center. In taking on this responsibility, Alaska Tribes oper-

ate on the principle of self-determination and intertribal cooperation, and in doing so have achieved remarkable advances in strengthening the health and well-being of our people.

The Alaska Tribal Health System

The Alaska Tribal Health System (ATHS) is a truly comprehensive statewide system of health care. It is a voluntary affiliation of over 30 Alaskan tribes and tribal organizations providing health services to over 177,000 Alaska Natives/American Indians. Each tribe or tribal health organization is autonomous and serves a specific geographical area; and, many are the only health provider in their respective community. This fact makes the ATHS an integral part of the Alaska Public Health System. It is a finely tuned network that provides services through:

- 180 small community primary care centers
- 25 sub regional mid-level care centers
- 4 multi-physician health centers
- 6 regional hospitals
- Alaska Native Medical Center tertiary care
- Referrals to private medical providers and other states for complex care

The infrastructure of the ATHS, including facilities and staffing, make the ATHS a critical partner for the VA. And in most rural locations the ATHS is the only health care provider available, making the ATHS a necessary partner in providing veterans living in rural Alaska the care they have earned through service.

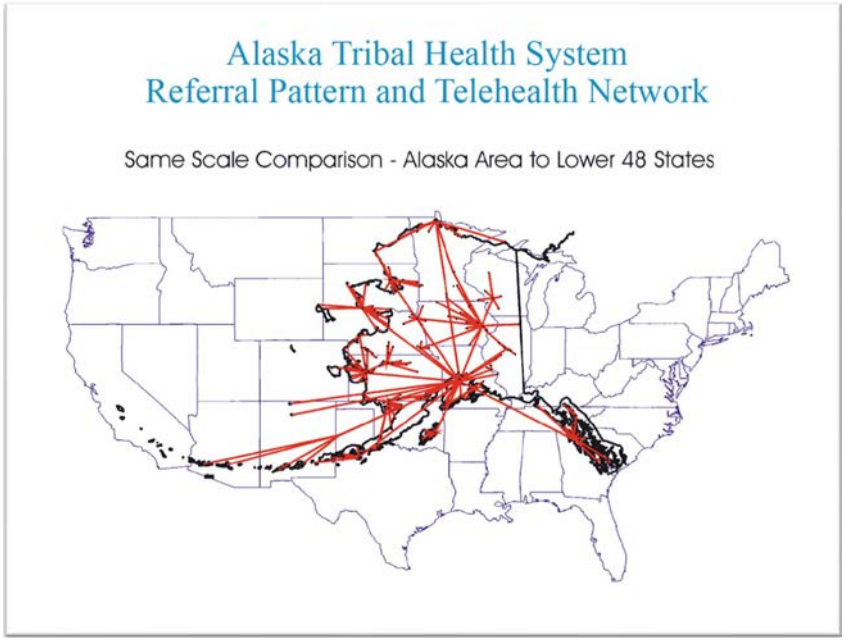


Figure 1 Scaled map of Alaska with ATHS referral patterns imposed over the contiguous US.

Alaska Tribal Sharing Agreements

The Alaska Tribal Sharing Agreements were established in 12 as a part of an initiative known as "Care Closer to Home." As a result, Alaska veterans were found to not have to endure the same wait-times as their compatriots in the contiguous United States. Furthermore, prior to the establishment of the Tribal Sharing Agreements, Alaska's veterans, especially in rural Alaska, had limited or no access to health care services supported by the VA. Alaska has the highest per capita representation of veterans in the Nation; the ATHS is an essential partner in the VA's mission to "care for him who shall have borne the battle and his widow and orphan." The Alaska model has unequivocally expanded access to care to veterans, who have benefited immensely in the years subsequent to the agreements as a result of the partnership between Tribal Health Programs (THPs) and the VA. The

tribal sharing agreements also support an integral partnership for enrollment and outreach to Alaska veterans. In Alaska, prior to this partnership between the Alaska VA and the ATHS, the VA had six access points of care to Alaska veterans. Since 2012, the VA's footprint now matches that shown in Figure 1. Protecting and renewing these agreements are of utmost importance to our partnership with the VA.

The Issues:

Support for H.R. 2791 and S. 524

Department of Veterans' Affairs Advisory Committee Act of 2019

ANHB encourages the full Committee to support H.R. 2791, the Department of Veterans' Affairs Advisory Committee Act of 2019, introduced by Congresswoman Debra Haaland of New Mexico. The companion bill, S. 524, was introduced in the Senate by Senator Dan Sullivan of Alaska, and is cosponsored by Senator Lisa Murkowski, also of Alaska. Creating a VA Tribal Advisory Committee (TAC) would reflect the government-to-government relationship and improve communications with tribal partners. Alaska Tribes note that a VA TAC would augment (not supplant) the consultative process. The creation of the VA TAC could coincide with and support an update to the VA's Tribal Consultation Policy and Process which would allow tribes to provide input on a tribal consultation policy that better reflects the government-to-government relationship they have with the VA. The VA TAC would play an important role for the VA to provide regular feedback to tribes and THPs about what actions have been taken based on tribal consultations.

Tribal Representation on the IHS VA Leadership Team on the MOU

Tribal and THP representatives need to be included in the Indian Health Service (IHS)-VA Memorandum of Understanding (MOU) Leadership Team and in any oversight committees which monitor its implementation in order to honor the government-to-government relationship between the Tribes and the Federal Government. The services provided under this MOU are predicated on the Federal Trust Responsibility. And in consideration of the Government Accountability Office (GAO) report (GAO–19–291) assessing the MOU and the planning to update the agreement, it is important to include tribal voices upfront, in the design, which will have definite impacts on their programs. This will also benefit the VA in seeking how to followup and implement recommendations brought forward from tribal consultations. We ask that Congress encourage the VA and IHS to include tribes and THPs IHS-VA MOU Leadership Team in order to address challenges and to reflect the government-to-government relationship in which collaboration has already mutually benefited the VA and Tribes and THPs. On these principles we also ask that tribes and THPs serve an active role in reviewing, revising and evaluating the 15 performance measures identified by the two agencies and in setting associated targets for the selected and revised measures.

Tribal Consultation

The current Department of Veterans Affairs' Tribal Consultation Policy was signed in 2011, ANHB recommends that the VA as a practice work with Tribes to update this policy on a regular basis. The Policy as it stands offers on page 5 subparagraph 7.d., provides "through reviewing proposed plans, policies, rules, or other pending and proposed programmatic actions, recognizes the need to assess whether such actions may impact Indian Tribes and/or American Indian and Alaska Native Tribes. Consultation should take place prior to any actions that may have the potential to significantly affect tribal resources, rights, or land. VA strives to notify appropriate Tribal Officials about such actions in an effort to provide Tribal Officials the opportunity to pursue and/or engage in the consultation process." There are many areas where the VA can benefit from consulting with Tribes, from implementing the VA Mission Act of 2018 to the renewal of the VA memorandum of understanding (MOU) with the Indian Health Service (IHS).

Issues where the VA TAC, IHS VA MOU Leadership Team, and/or tribal consultation would benefit Native veterans include:

- Ensure that Tribes and THPs are, and for as long as they choose, exempt from the establishment and consolidation of the community care networks;
- Implement Section 405(c) of the Indian Health Care Improvement Act and that the VA provide reimbursement for specialty care provided through referrals from IHS and THPs;
- Increase resource sharing between the IHS and VA, e.g. telehealth services (including robust infrastructure development);
- Collaborate and provide support for and access to Behavioral Health services to get the 22 suicides a day to zero;
- Support medical training received in the military be applied to certification programs after leaving the military;
- Allow for innovative culturally-based approaches to treatment, such as traditional healing assessments that allow culturally competent providers to assess the cultural identity of a patient;
- Rebuild trust, use/expand/support Alaska's Tribal Veteran Representative model;
- Allow for longer Tribal Sharing Agreement periods/support step up and step down of capacity building and support continuity of care over time.

Build Parity Between the VA and IHS

Congress must give the IHS and its tribal partners parity with the VA. For example, in Fiscal Year 17, VA spending per user was $7,600 [1], whereas for the same year, IHS spending per user was $3,332.[2] The IHS spends half what the VA spends per user. When Native veterans are treated in IHS and THPs, that means that they are accessing a system that is funded at half the rate of direct care VHA facilities. The IHS is also subject to government shutdowns because it lacks the advance appropriations authority given to the VHA. This causes instability in care for Native veterans who receive their care in tribal facilities. It is vital that we achieve parity with the VA to ensure our heroes receive the care they deserve.

VA Copayments and Deductibles

The IHS and THPs do not charge co-payments or deductibles to AN/AI beneficiaries as part of the Federal Trust Responsibility to provide healthcare to AN/AIs. The same Trust Responsibility extends to Native veterans who receive their care through the VHA. In recognition of the Federal Trust Responsibility, the VA should eliminate all deductibles and co-pays for Native veterans. Congress should clarify in statute that the Trust Responsibility does not end at the IHS' doors but extends to VA programs for Native veterans as well.

Alaska's Tribal Veteran Representative Model

There are many barriers to seeking care for Native veterans, including stigmas around care; prior denials of application; distance to care; and lack of awareness of benefits and services they are entitled to receive. The Tribal Veterans Representative (TVR) program was developed to reach Native veterans in their communities through trusted community members. TVRs are volunteers, who are veterans and tribal community members who reach out to unenrolled Native veterans, provide them with information on VA health care services and benefits, and assist them with the enrollment process. The program has proved very successful, and Congress should continue to support this important program.

In Conclusion:

Many veterans have broken faith in the VA system, some having not accessed care in decades. Tribes in Alaska and across the Nation are working with the VA to help restore that faith. The issues we have raised in this testimony can continue the work of restoring trust in the VA for veterans, Native and non-Native alike. Our collaborative relationship with the VA can be strengthened through further con-

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[1] Golding, H. "Potential Spending on Veterans' Health Care: 18–28", Congressional Budget Office. Slide 7. Accessed: (https://www.cbo.gov/system/files/2018–11/54690-presentation_0.pdf)

[2] "The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2020 Budget", National Indian Health Board. Page 3. Accessed: (https://www.nihb.org/docs/03012018/TBFWG%20FY%202020%20Recommendations%20Brief.pdf)

sultation and policy development that eases access to care for all veterans through Indian health programs.

As Congress continues its review of health care access for veterans, we should build on programs and institutional supports which are proven. An important step would be to allow for longer Tribal Sharing Agreement periods, where the agreements support step up and step down of capacity building and support continuity of care over time. Allowing for tribal representation and consultation are effective methods for ensuring that policies and programs do not leave Native veterans behind. Supporting access for veterans through culturally engaged methods has demonstrated time and again through increased Native veteran participation the importance that this approach provides. Finally, building parity between the VA and IHS lifts up veterans, especially Native and rural/remote veterans, who seek care through tribal facilities.

ANHB thanks the subcommittee and looks forward to further supporting the members in their work on veterans' health care issues, and ANHB welcomes questions at anhb@anhb.org.

PREPARED STATEMENT OF MARILYNN MALERBA

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee,

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), it is an honor to submit the following formal written testimony on the unique barriers that Native veterans face when seeking access to quality, culturally competent care. Established in 1996, the TSGAC provides information, education advocacy, and policy guidance for the implementation of Self-Governance within the IHS.

Native Veterans have a uniquely special status with the United States. Our American Indian and Alaska Natives have fought alongside the colonial government beginning with the Battle of Bunker Hill, and they have subsequently fought for the United States armed forces in every war and conflict, at higher rates per capita than any other group in the United States.

Treaties between our native governments and the United States included health care for our people. Our Native veterans, as warriors on behalf of this Nation are deserving of the best health care we can provide. All veterans, Native and non-Native, alike have sacrificed much for this country and are owed the best health care that we can provide.

The United States Commission on Civil Rights notes in the report titled "Broken Promises: Continuing Federal Funding Shortfall for Native Americans" "the United States expects all nations to live up to their treaty obligations and it should live up to its own." It specifically recommends that the Federal Government should provide steady, equitable and **non-discretionary** funding directly to Tribal nations to support the public safety, health care, education, housing, and economic development of Native Tribes and people.

One way to enhance the funding for the health of our Native veterans was implemented with the Memorandum of Understanding (MOU) between the U.S. Department of Veterans Affairs (VA) and the U.S. Department of Health and Human Services' (HHS) Indian Health Service (IHS). In fact, given the inequity of funding for our Native people within the Federal system, the ability to access VA funding for services provided to our Native veterans provides better care for our veterans and provides some relief for a very economically challenged Indian health care system. In 2017, the funding per person per year for an American Indian was $3,332 while the Veterans Health Administration funding per person was $8,759.

The TSGAC would specifically like to comment on the effectiveness of this MOU and provide solutions to overcome the systematic health inequities experienced by Native veterans as a means to improve Native veterans' health status and well-being.

As reported by the U.S. Government Accountability Office (GAO) in 2019, Federal Indian policy has promoted Tribal self-government—the practical exercise of Indian tribes and nations' inherent sovereign authority—for more than four decades The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, authorizes federally recognized tribes to assume the administration of a variety of Federal programs—or portions thereof—that were previously managed by the Indian Health Service. In effect, the Tribes are fulfilling the trust and treaty obligations of the United States through contractual arrangements with the Federal Government.

Since enactment of ISDEAA, Tribal nations have demonstrated and proven that a government-to-government relationship based on respect of sovereignty and the inherent right of Tribes to self-govern is an effective and successful approach for both the delivery of services to Tribal communities and to uphold the United States' trust responsibility to Tribal Nations and their citizens.

The VA reports there are 145,000 Native Veterans living in the United States. The VA also reported that Native Veterans have an average life expectancy 4 years shorter than that of the general U.S. population and are more likely than Veterans of other ethnicities to experience social and economic difficulties that may impact their health or wellness, such as lower income, lower education levels and higher unemployment. Native veterans are eligible to receive health care services from the VA, IHS, and Tribal nations and Tribal organizations that operate under a Self-Governance agreement (referred to as Tribal Health Providers or THPs).

Tribal Nations that elect to administer health programs and services under a Self-Governance agreement to their citizens and communities are effective, in part, because Tribal Nations know the needs of their communities and are in the best position to provide culturally appropriate solutions tailored to address those local needs. Many THPs have significant experience serving veterans in their communities and have entered into reimbursement agreements with the VA, pursuant to Section 405(c) of the Indian Health Care Improvement Act (IHCIA).[1]

As Native veterans return home and seek to access the benefits they are entitled to, healthcare services often fall short to meet their needs. Factors, such as, residing in remote rural communities, poverty, mental health conditions, historical mistrust and a limited number of culturally competent healthcare providers create barriers to care and lead to Native veterans experiencing greater health disparities compared to other veterans. Other social determinants of health impact the overall health of our Native veterans including lack of running water, lack of indoor plumbing, overcrowded housing and in some cases lack of fully functioning kitchen facilities for nutrition.

Further, regulatory barriers exacerbate Native veterans' ability to access care. Restrictions on specialty care, assessment of co-pays, duplicative processes, overly burdensome administrative requirements and lack of coordination of care delay access to care and have caused irreparable harm to veterans.

Native Veterans reside in rural areas in greater proportions when compared to Veterans of other races—with nearly 40 percent of Native veterans residing in rural areas, often on geographically dispersed reservations or Tribal lands which are often remote, isolated and considered highly rural. THPs are often one of few, if any, health providers in rural areas. As such, THPs are a critical partner for increasing access to quality healthcare to all veterans, both Native and non-Native. IHCIA Section 405(c) provides the authority for Tribes to receive reimbursement for services provided to non-Native veterans but THPs are limited from playing a greater role in providing increased access to healthcare because VA limits the services that IHS can provide to non-Native veterans.

In recent years, the VA and IHS made some progress overcoming these challenges to ensure eligible veterans can access efficient adequate health services in their own communities through THP's. However, the VA limits the types of care that can be provided at IHS and does not cover non-Native veterans who would otherwise routinely receive services through IHS, such as non-Native women pregnant with Native children; even in cases where the IHS or THP is the only facility in close proximity to the veteran. Limiting the services that IHS can provide in turn limits the services that Tribally administered healthcare programs can provide to their communities.

Coordination Between VA and IHS

In 2010, VA and IHS expanded upon a 2003 memorandum of understanding (MOU) to improve the health status of American Indian and Alaska Native veterans through coordination and resource sharing among VA, IHS, and Tribal Nations. This 2010 MOU outlined mutual goals for VA and IHS collaboration and coordination of resources and health care services provided to AI/AN veterans. For example, it included provisions for joint contracts and purchasing agreements, sharing staff, ensuring providers in VA and IHS could access the electronic health records of

[1] Section 405 (c) of the IHCIA provides that...the 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.

shared patients, and the development of reimbursement policies and mechanisms to support care delivered to AI/AN veterans eligible for care in both systems.

In December 2012, VA and IHS signed a reimbursement agreement that facilitates reimbursement from VA to IHS facilities for the direct care services they provide to eligible Native veterans. VA has established similar reimbursement agreements with individual Tribally administered healthcare programs. The VA and IHS are now in the process of updating the MOU. This process provides a tremendous opportunity for the VA, IHS, and Tribal governments to work collaboratively to identify activities that will help ensure Native Veterans are receiving the quality healthcare services they are owed.

The current MOU between VA and IHS includes the following five primary goals:

1. Increase access to care and services for American Indian and Alaska Native Veterans
2. Promote patient-centered collaboration and communication
3. Improve health-promotion and disease prevention
4. Consult with Tribes at the regional and local levels
5. Ensure appropriate resources are identified and available.

In accordance with these five goals, the MOU contains specific areas in which VA and IHS agreed to collaborate and coordinate on, including:

- Reimbursement: development of payment and reimbursement policies and mechanisms to support care delivered to dually eligible Native veterans.
- Sharing staff: sharing of specialty services, joint credentialing and privileging of health care staff, and arranging for temporary assignment of IHS Public Health Service commissioned officers to VA.
- Staff training: providing systematic training for VA, IHS, THP, and Urban Indian Health Program staff on VA and IHS eligibility requirements to assist them with appropriate referrals for services.
- Information Technology Interoperability: interoperability of systems to facilitate sharing of information on common patients, and establishment of standard mechanisms for VA, IHS, and THP providers to access records for patients receiving care in multiple systems.

We offer the following comments and recommendations that are related to several of the goals and/or areas of agreed collaboration and coordination:

Patient Referrals

As VA, IHS, and Tribal Nations work to build greater partnerships, we must address issues with regard to coordination of care. Failing to adequately coordinate care is magnified by VA's unwillingness to reimburse referral services. For example, if a Native veteran goes to an IHS or Tribal facility for service and needs a referral, the same patient must then be seen within the VA system before a referral can be secured. This is a not an efficient use of Federal funding as it is duplicative, fails to acknowledge similarly credentialed providers and makes care navigation difficult for Native veterans.

Recommendation: The VA should accept referrals made by IHS and THPs in order to provide the best services to our veterans.

Reimbursement of Purchased and Referred Care

Although the MOUs and agreements with VA have demonstrated success in facilitating patient care for veterans, neither the current national agreement nor the Tribal agreements include reimbursement for Purchased and Referred Care (PRC) at IHS or Tribal healthcare facilities. Consequently, veterans are forced to maneuver through a complex healthcare system and an elaborate administrative process.

Veterans often require additional services that are not available at IHS or THPs. In many instances eligible veterans are also eligible for PRC services. The PRC program authorizes Indian Healthcare facilities to purchase services from a network of private providers. IHS and THPs are the payors of last resort, which require that all other sources of obtaining health services must be exhausted prior to receiving care through the PRC program. These services may include primary or specialty care that is not available at an IHS and/or Tribal healthcare facility. Many THPs have existing provider networks to ensure veteran's complex healthcare needs are met.

The VA, however, will not reimburse THPs for their referrals but instead insist that the veteran in need of specialty care return to the VA health system for a VA

referral for care. In certain instances, this level of care may be directly available and provided under the current reimbursement agreements and reimbursed by the VA. However, because the mix of direct versus purchased care varies across the Indian health system, some IHS or Tribal health programs may purchase more care from outside providers, which currently is unreimbursed by VA.

This illogical and inconsistent management of care is inefficient, a waste of resources (both time and money) and fails to prioritize the healthcare needs of Native veterans. THPs work hard to provide a seamless health care experience. Lack of coordination of care for specialty care and other medically necessary care paid by PRC creates more barriers for our veterans. This creates misalignment with the VA's mission for care which strives for improved access to all types of care.

Recommendation: VA should include PRC in the IHS/THP reimbursement agreements to eliminate further rationing of health care provided by IHS and THPs to Native veterans and other eligible veterans and to ensure timely quality healthcare.

Native Veterans Co-Pays

Native veterans who seek health care services at a VA facility are assessed co-payments which is in direct opposition to the Federal trust obligation to provide health care for all American Indians and Alaska Natives. IHS and THPs are the payor of last resort (section 2901(b) of the ACA) whether or not there is a specific agreement in place for reimbursement. Therefore, neither the Native Veteran nor the IHS should be responsible for any co-payments.

Recommendation: The TSGAC recommends the discontinuation of the practice of collecting co-payments from Native Veterans.

Tribal Provider Credentialing

Although stated in the MOU, the VA does not accept provider credentialing from THPs. Tribes that administer their health programs through Self-Governance agreements have the right to choose and operate their own credentialing system or to leverage the credentialing system administered by IHS.

VA acceptance of IHS/THP-credentialed providers facilitates care coordination by allowing IHS/THP primary care providers to refer directly into the VA system for either continued care to be provided in a VA facility, or for care to be purchased through outside providers. This would eliminate the duplicative primary care visit and referral and ensures that the Veteran continues with their primary care provider of choice who coordinates their care and receives all reports and results from other providers. VA has attempted in some local areas to re-credential IHS/THP providers under the VA system, but the length of time required for a provider to proceed through the entire VA credentialing process is not practical or timely.

Recommendation: To ensure care coordination is effective and efficient, VA should accept provider credentialing from IHS/THPs, upon the provider releasing the credentialing package to VA.

Graduate Medical Education (Tribal Medical Residency Programs)

IHS and THPs have significant workforce challenges due, in part, to most facilities being located in rural and/or remote locations. The HHS Health Resources and Services Administration (HRSA) automatically designates IHS, Tribally operated and Urban Indian Health programs as Health Professionals Shortage Areas (HPSAs) and Medically Underserved Area and Medically Underserved Population (MUA/MUP) for these reasons. Several THPs currently have Tribal medical residency programs.

TSGAC was very encouraged to review the provisions of the recent VA Mission Act, specifically Section 403 which included a "Pilot Program on Graduate Medical Education and Residency." This new pilot includes facilities operated by Tribes, Tribal Organizations and IHS as "covered facilities" for purposes of the program and requires such facilities have a priority in placement of residents.

Recommendation: VA should include IHS and Tribes in the planning of the pilot program to ensure that any regulations or policies that may be developed in the future for the pilot work optimally in Indian Country.

Access to Consolidated Mail Order Pharmacy (CMOP)

Currently only those IHS and Tribal Health Programs that use the RPMS system have access to CMOP. This is an important means of improving compliance with prescriptions when those medicines are delivered directly to the Veteran's homes. This reduces barriers to effective disease management

Recommendation: Information Technology Systems experts from both VA and IHS need to ensure that all systems used by Tribal Health programs are compliant and compatible with the CMOP system.

Quality Measures

The TSGAC is supportive of quality measures that provide for tracking of meaningful outcomes. However, the TSGAC would be very disturbed at the prospect of developing either data reporting requirements that affect reimbursements to IHS/THPs, or that require new collection of data and reporting systems in addition to those already imposed on IHS/THPs. All IHS/THPs receiving reimbursement from VA are required to be accredited by a nationally recognized health accreditation agency, which assures quality standards are being maintained. The VA also conducts quality monitoring, and visits IHS/THP programs regularly for review, even though this is not a requirement of the statute. Finally, all IHS/THPs participating in Medicare and Medicaid must comply with all of their quality and performance programs and reporting, as applicable. The VA itself is not required to comply with this level of accountability to external agencies.

Recommendation: The IHS and VA should work together and consult with the Tribes to develop evaluation measures for assessing the progress toward MOU goals. Additionally, the VA should not impose any additional quality programs upon IHS/THPs, because it is very burdensome, costly, and unnecessary because there are sufficient quality requirements already in place.

Health Information Exchange

VA belongs to the eHealth Exchange—a national health information exchange—and it reported to GAO in March 2019 that IHS or THPs could join the exchange to access information about common veteran patients. However, IHS reported to GAO that although the agency explored connecting to the eHealth Exchange several years ago, testing and onboarding costs to participate were prohibitive. THPs that GAO spoke with reported being a part of other, more locally based health information exchanges, but noted that VA was not part of these exchanges.

Recommendation: Local VA health care facilities should work with their local THPs to ensure health information can be exchanged at the local levels through local health information exchanges rather than one national health information exchange.

Tribal Advisory Board

Tribal advisory committees provide an effective forum for Tribes and Federal agencies to work together as government-to-government partners to address policy, legislative, budget, program and service issues and formulate recommended actions. In response to GAO's March 2019 report, VA stated that it will establish a Tribal advisory group that will make recommendations related to care coordination guidance and policies. The VA set a target completion date for establishing this group is spring 2020.

Recommendation: The VA should work in coordination with Tribes to establish a Tribal Advisory Board. Tribal leaders have significant experience serving on Tribal advisory committees/boards at Federal agencies and can provide crucial input on key components and characteristics that make an effective advisory board.

GAO's Review of Coordination Between VA and IHS

The TSGAC fully supports the development of specific, measurable metrics by which to evaluate the progress being made under the MOU. Although there are a number of measures identified in annual reports issued by the IHS and VA, they are largely process measures which report on the number of veterans served, amount of reimbursements, number of trainings or events, etc.

In March 2019, GAO reported that the MOU signed by the VA and IHS lacks sufficient measures for assessing progress toward its goals. Specifically, GAO reported that the agencies established 15 performance measures, but they did not establish targets against which performance could be measured. For example, while the number of shared VA-IHS trainings and webinars is a performance measure, GAO noted that there is no target for the number of shared trainings VA and IHS plan to complete each year. Two of the three recommendations GAO made to the VA and IHS focus on the lack of performance measures and one focuses on the lack of written policy and guidance.

Recommendation: Federal agencies should focus their limited resources on actions that will directly improve the health and well-being of Native veterans and should ensure that measures they develop are focused on outcomes rather than

counting administrative activities that should already occur as part of routine operations. Additionally, these outcome measures should be developed and agreed upon jointly.

In closing, VA and IHS have made progress and have demonstrated a willingness to improve quality access to care for Native Veterans. But, as you see in my statements here, there are still significant opportunities for improvement. The TSGAC truly appreciates the opportunity to provide the Subcommittee with these written recommendations. Thank you.

PREPARED STATEMENT OF KAMERON MATTHEWS

Good morning, Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee. I appreciate the opportunity to discuss how care at the Department of Veterans Affairs (VA) and our partnership with Indian Health Service (IHS) positively impact our Native American Veterans. I am accompanied today by my colleagues Ms. Stephanie Birdwell, Director for the Department of Veterans Affairs' Office of Tribal Government Relations and Dr. Thomas Klobucar, Executive Director for Veterans Health Administration's (VHA) Office of Rural Health (ORH).

Introduction

As Secretary Wilkie has shared during his meetings with Native American Veterans and tribal leaders across the country, our goal at VA is to shorten the distance between people in need of Veterans services. VA is working to increase our reach into tribal communities through telehealth, visits from VA representatives, and closer cooperation between VA and IHS. VA is committed to ensuring our Native American Veterans, more specifically our American Indian and Alaska Native (AI/AN) Veterans, receive and find access to quality, culturally competent care from VA and tribal health systems.

Five Goals of the Memorandum of Understanding between VA and IHS

A Memorandum of Understanding (MOU), originally signed in 2003 and updated again in 2010, established that IHS and VA can coordinate, collaborate, and share resources between the Departments. Five mutual goals were agreed upon when the MOU was signed:

- Increase access to and improve quality of health care and services to the mutual benefit of both agencies by effectively leveraging the strengths of VA and IHS at the national and local levels to afford the delivery of optimal clinical care;
- Promote patient-centered collaboration and facilitate communication among VA, IHS, AI/AN Veterans, Tribal facilities, and Urban Indian Clinics;
- Establish effective partnerships and sharing agreements among VA headquarters and facilities, IHS headquarters, and IHS, Tribal, and Urban Indian health programs in support of AI/AN Veterans;
- Ensure that appropriate resources are identified and available to support programs for AI/AN Veterans; and
- Improve health-promotion and disease-prevention services to AI/AN to address community-based wellness.

To achieve these goals, VHA has piloted and subsequently adopted several programs. To address access to care, achieve effective partnerships, and ensure the availability of resources, in 2012 VA began to establish a national reimbursement template with IHS which led to over 112 Tribal Health Programs (THP) agreements.

In addition to these reimbursement agreements, local VA medical centers have established, where appropriate, several agreements with THPs and IHS facilities to deliver telemental health care to AI/AN Veterans. The program serves tribal communities in Alaska, Montana, Wyoming, and Oklahoma. ORH's Veterans Rural Health Resource Center, Salt Lake City (VRHRC SLC) has an active portfolio of innovations in AI/AN Veteran health care, including the creation of a Rural Veteran Tribal Navigator program that will connect AI/AN Veterans with the benefits and care they have earned.

In addition, VA Video Connect (VVC) is a pilot program currently being deployed nationwide. VVC will allow rural AI/AN Veterans to access VA health care in their homes or local communities via cellular and wireless capabilities. VRHRC SLC is currently working to tailor this program to AI/AN Veteran-communities, creating a model that will weave together the evidence-based Western medicine, traditional Native Healing, and rural Native communities' strengths through four main compo-

nents: mental health care, technology (access), care coordination, and a tailored implementation facilitation strategy. In addition to these programs, VRHRC SLC is piloting programs to establish Tribal-VHA Partnerships in Suicide Prevention and developing Native Veteran Content for the VA Community Provider Toolkit.

One of the great successes in achieving the 2010 MOU goals was the establishment of the VA/IHS Consolidated Mail Order Pharmacy Program (CMOP) that sends prescription medications to AI/AN Veterans' homes. In 2018 alone, CMOP processed 840,000 prescriptions for AI/AN Veterans, up 17 percent from the previous year. Since its inception, CMOP has processed more than 3.6 million prescriptions for AI/AN Veterans served by IHS and THP programs.

The March 2019 Government Accountability Office (GAO) report **"VA and Indian Health Services: Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans"** cites challenges in obtaining the MOU goals, specifically around establishing targets for outcome metrics to assess progress. Specifically, the inadequacies found in performance metrics could limit the agencies' ability to measure progress toward MOU goals and ultimately impact decisions about programs or activities.

In early Fiscal Year 2019, VHA and IHS MOU leadership agreed that the 2010 MOU was no longer meeting the agencies' needs and required modification to create the flexibility needed to move the interagency relationship forward to a new level. The leadership team drafted a new MOU and conducted a first listening session with tribal leaders on May 15, 2019. Tribal input from that session was incorporated into the draft VHA-IHS MOU and VA and IHS conducted a subsequent consultation session at the National Indian Health Board annual meeting on September 16, 2019. This additional input is now being considered for inclusion in the draft MOU. After the IHS and VA MOU leadership team reaches agreement on the draft MOU, it will enter formal clearance channels for approval by IHS and VA. The approved draft MOU document will be posted in the Federal Register and further tribal consultation for a period of no less than 60 days. Tribal input will be incorporated into the draft document and it will move forward for final approval and signature.

The challenges found in the 2010 MOU performance metrics may have limited the ability of VA and IHS managers to gauge progress and make decisions about whether to expand or modify programs or activities because the agencies did not have information on the effectiveness of the programs in supporting MOU goals. VA and IHS also acknowledge that the performance metrics contained weaknesses and that refining them is a top priority.

To address the shortcomings associated with the 2010 MOU metrics noted by GAO, VA and IHS have brought in metrics experts from each agency to the MOU development process. Once the draft is finalized, the process of creating new targets and metrics to meet the requirements outlined by GAO will take place as new programs and pilots are developed under the new instrument.

Reimbursement Agreements

Since the Summer of 2012, VA has signed individual reimbursement agreements with THPs to provide direct care services to eligible AI/AN Veterans closer to their homes in a culturally sensitive environment. In December 2012, VA signed a national reimbursement agreement with IHS. Today, the national reimbursement agreement with IHS covers 75 IHS sites. There are also 114 individual reimbursement agreements with THPs of which 26 are in Alaska and cover AI/AN Veterans and Non-Native Veterans.

From August 2012 through August 2019, VA has reimbursed IHS and THPs over $103 million covering approximately 10,645 AI/AN Unique Veterans. Of the $103 million, VA has reimbursed approximately $32.2 million to Alaska THPs for covering an estimated 1,513 AI/AN Unique Veterans. Additionally, VA has reimbursed Alaska THPs approximately $27.7 million for approximately 4,787 Unique Non-Native Veterans.

IHS and several THPs have requested that the agreements be expanded to cover reimbursements for purchased referred care (PRC) under which IHS and THPs can refer AI/AN Veterans to their contracted community care. They feel this will enhance care coordination. VA is also looking to enhance care coordination with IHS and THP facilities. However, VA has the primary responsibility for care provided to Veterans and related care coordination. If VA approves PRC for AI/AN Veterans under the reimbursement agreements, VA may lose track of that care provided to Veterans. As a result, VA is developing a standardized care coordination process that will enhance care coordination for AI/AN Veterans. Initial steps include establishing an Advisory Board for care coordination and inviting Tribal Officials to be members on the Board. The Board's main scope will be to implement the standard-

ized care coordination process and to improve care coordination between VA and IHS/THP sites for the benefit of Veterans.

Conclusion

The health and well-being of all our nations' Veterans is of the utmost importance. We strive to consistently provide high quality care to all Veterans and continue to make significant strides in enhancing the practice and culture of the Department to be more accessible to our Native American Veterans. Working with many diverse, sovereign tribes is essential to successfully achieve the goals of the MOU. VA is committed to ensuring that our goals align with IHS and that the needs of our Native American Veterans are met. I want to thank the Committee for hosting this hearing. This concludes my written testimony.

PREPARED STATEMENT OF BENJAMIN SMITH

Good morning, Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee. I am Benjamin Smith, Deputy Director for Intergovernmental Affairs, Indian Health Service (IHS). Thank you for the opportunity to testify on native veterans' access to 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 2.6 million American Indians and Alaska Natives from 573 federally recognized tribes in 37 states, through a network of over 605 health care facilities, including hospitals, clinics, health stations, and other facility types.

The American Indian and Alaska Native population experiences health and other disparities that disproportionally affect their quality of life. American Indians and Alaska Natives have an average life expectancy of 5 years shorter than that of the general U.S. population and 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, Department of Veterans Affairs (VA), and their tribal partners will continue to combine their expertise, resources, and efforts to help the nearly 145,000 American Indian and Alaska Native veterans living in the United States.[2] The IHS and VA's Veterans Health Administration (VHA) continue work to provide eligible American Indian and Alaska Native 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. Revising the IHS-VA Memorandum of Understanding (MOU) signed in 2010 will help accomplish this goal. Our plan to complete revisions to the MOU and its related performance measures by fall 2020 includes tribal consultation with tribal leaders and native veterans, and conferring with urban Indian organizations.

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, and tribal organizations and the VA.[4] The law also directs the VA to reimburse the IHS, Indian tribes, or tribal organizations for the services provided to eligible beneficiaries of either Department in the respective facility.

Since implementing this provision in 2012, VA has reimbursed over $103 million for direct care services provided by IHS and Tribal Health Programs (THP), covering approximately 10,645 unique American Indian and Alaska Native veterans. Currently, IHS and VA operate under a national reimbursement agreement, inclusive of 75 IHS Federal facilities. Likewise, the VA has entered into 114 individual reimbursement agreements with THP. We are aware of an additional 42 tribes working with VA's Office of Community Care to enter into a reimbursement agreement for direct care services.

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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).

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.

IHS-VA MOU

In 2003, IHS and VA entered into the initial MOU to improve access and health outcomes for American Indian and Alaska Native veterans. To maximize resources and deliver an integrated approach that supports the health and well-being of the American Indian and Alaska Native veterans living in the United States, the IHS and VA signed a revised MOU in 2010.[5] The updated MOU built upon a decade of successful collaboration and further established mutual goals to advance collaboration, coordination and resource-sharing between VA and IHS "to improve the health status of American Indian and Alaska Native Veterans." The IHCIA affirms the goals of the MOU.[6]

Together, the IHS and the VA Veterans Office of Tribal Government Relations and Office of Rural Health form a MOU leadership team. The leadership team meets quarterly and is responsible for review and oversight of the MOU collaboration on care coordination, reimbursement, workforce training, and cultural competency that align with the five overarching goals to:

1. Increase access to care and services for American Indian and Alaska Native veterans.
2. Promote patient-centered collaboration and communication.
3. Improve health-promotion and disease prevention.
4. Consult with tribes at the regional and local levels.
5. Ensure appropriate resources are identified and available.

In Fiscal Year (FY) 2018, the VA-IHS MOU leadership team conducted an in-depth revision of the existing MOU to reflect changes in law, as well as, the evolving health care and health information technology landscape. The VA-IHS MOU leadership team focused on areas concerning health and its social determinants for Native Veterans, including prescription services, transportation, housing services, workforce training and consultation with tribal communities. In addition, the team concentrated on revising the 2010 MOU to reflect progress made to date under the new Administration's leadership priorities. Our vision of a revised MOU contemplates a more comprehensive and flexible structure to support and adopt to the needs of both agencies and the veterans they serve well into the future.

The IHS-VA workgroups completed several MOU-related activities, which are now a routine part of each department's operations, including:

- Workforce Training: To better coordinate on training and recruitment efforts, VA and IHS opened their training resources to each organization's staff. In Fiscal Year 2018, they shared 256 online and in-person training events focused on mental health, clinical support, oral health, diabetes and more.
- Access to Care: Since their inception in Fiscal Year 2012, the VA-IHS and VA-THP reimbursement agreements provided $103 million to IHS and THP for care of approximately 10,645 unique American Indian and Alaska Native veterans. In Fiscal Year 2018 alone, VA paid IHS and THP $20 million for the care of nearly 5,300 enrolled American Indian and Alaska Native veterans.
- Access to Medication: The VA Consolidated Mail Outpatient Pharmacy Program (CMOP) processed 840,000 prescriptions, an increase of 17 percent from 2017. Since its inception in Fiscal Year 2010, CMOP processed more than 3.6 million prescriptions for VA-IHS patients.
- Housing Assistance: The Tribal Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH) program increased tribal engagement in Fiscal Year 2018 from 23 to 26 tribes that used the program to find homes for Veterans. As a result, the program found homes for 130 American Indian and Alaska Native veterans.

As part of the process for revising the MOU, the IHS and VA conducted an initial listening session to solicit tribal input for the MOU on May 15, 2019, as part of the

[5] IHS-VA Memorandum of Understanding, October 2010: https://www.ihs.gov/sites/vaihsmou/themes/responsive2017/display__objects/documents/VA__IHS__MOU__508c.pdf.

[6] See 25 U.S.C. § 1647(a)(2).

National Indian Health Board's 10th Annual National Public Health Summit. On September 4, 2019, IHS sent a letter to tribal and urban Indian organization leaders to initiate tribal consultation and urban confer on the MOU and related performance measures. The IHS and VHA held their first in-person session on

September 16, 2019 in Temecula, California in conjunction with the National Indian Health Board's Tribal Health Conference. 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.

The IHS remains firmly committed to improving quality and access to health care for American Indian and Alaska Native veterans. We appreciate all your efforts in helping us provide the best possible health care services to the veterans we serve. Thank you, and I am happy to answer any questions you may have.

Statements for the Record

STATEMENTS FOR THE RECORD

PREPARED STATEMENT OF THE UNITED SOUTH AND EASTERN TRIBES SOVEREIGNTY PROTECTION FUND

The United South and Eastern Tribes Sovereignty Protection Fund (USET SPF) is pleased to provide the House Committee on Veterans' Affairs Subcommittee on Health with the following statement for the record of the oversight hearing entitled, "Native Veterans' Access to Healthcare." USET SPF is appreciative of the Subcommittee's commitment to examining and addressing the unique barriers that American Indian and Alaska Native (AI/AN) veterans face when seeking the healthcare to which they are entitled. Whether delivered through IHS or the VA, AI/AN veterans have pre-paid for their healthcare, both through the cession of Tribal homelands and the defense of our Nation. We remind the Subcommittee of the unique Federal trust responsibility to Tribal Nations and urge the Subcommittee and Congress to improve access to quality and culturally competent healthcare for AI/AN veterans.

USET SPF is a non-profit, inter-tribal organization representing 27 federally recognized Tribal Nations from Texas across to Florida and up to Maine [1]. Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service, which contains 36 IHS and Tribal health care facilities. Our patients receive health care services both directly at IHS facilities, as well as in Tribally operated facilities under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93–638.

As the Subcommittee is likely aware, AI/AN veterans serve in the military at higher rates per capita than any other group in the Nation. In addition, the VA has found that AI/AN veterans are more likely to have a service-connected disability than non-Indian veterans. AI/AN veterans face significant disparities in care when compared to other veterans. In the USET SPF region, AI/AN veterans are often faced with access to only either the limited services provided by the chronically underfunded IHS and Tribally operated facilities or no services at all. As the Subcommittee seeks to help improve access to quality healthcare for AI/AN veterans, USET SPF requests the exercise of this body's oversight functions to ensure VA's actions reflect and uphold the Federal trust responsibility and obligations unique to our population. This includes working to institute programs that address historical trauma, provide culturally competent treatment, and provide greater access to behavioral health programs. We provide additional recommendations below to the Subcommittee on how to meet the Federal trust obligation to AI/AN veterans.

IHS-VA MOU

USET SPF is appreciative of the Subcommittee's efforts to bring together Tribal Nations as well as IHS and the VA to discuss the 2010 memorandum of understanding (MOU) between the VA and IHS. The intention of the MOU was to better facilitate patient care for AI/AN veterans across country within both agencies. How-

[1] USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME),Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

ever a report by the Government Accountability Office (GAO) in 2019, "Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans", found that more action is needed to strengthen oversight and coordination between IHS and the VA regarding implementation of the MOU.

Preservation of Existing Reimbursement Agreements

The existing reimbursement agreements within MOU have demonstrated success in facilitating patient care for AI/AN veterans. As both agencies seek to expand the existing MOU or establish new agreements, the VA must continue to uphold and preserve the existing agreements within the MOU which should serve as a template for the VA to enter into similar agreements within the Indian Healthcare System. Specifically, USET SPF underscores the importance of preserving the IHS All-Inclusive rate on reimbursements for outpatient services for AI/AN veterans delivered through IHS. Preservation of the All-Inclusive rate within the MOU will ensure critical dollars remain within the Indian Health System to be able to continue support the facilities and services provided to AI/AN veterans.

Reimbursement Agreements for PRC

IHS and Tribal health programs are not always able to directly provide AI/AN veterans with all necessary health care services. Like other AI/ANs, many of these veterans receive essential health services through the Purchased/Referred Care (PRC) program, which authorizes the purchase of services from a network of private providers when care is not available at IHS or Tribal facilities. PRC is an integral part of IHS and Tribal health care systems, as it facilitates access to care that the Federal Government has failed in providing the funding to deliver directly.

However, the VA does not currently reimburse IHS or Tribal programs for services provided using PRC funds. Instead, the VA requires that veterans in need of care return to the VA for a referral instead-an inefficient and time consuming process. USET SPF asserts that this policy fails to prioritize the healthcare necessities of AI/AN veterans by creating additional and unnecessary burdens. The continued lack of coordination of care between the VA and the Indian Healthcare System for the full complement of health care services will only continue to create additional barriers in access to care for our veterans.

This limitation is further contrary to the plain language of Section 405(c) of the Indian Health Care Improvement Act, 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 IHS, Tribal Nations, Tribal organizations, and UIOs are payers of last resort. Through these provisions, Congress clearly intended to shield IHS and Tribal PRC dollars from being used to pay for services when other sources of funding are available, including funding from VA. Accordingly, VA should reimburse for all services provided by or through Tribal health programs.

Ensuring UIOs are Eligible to Bill VA for AI/AN Veterans Care

Approximately 78 percent of AI/ANs do not live on Tribal reservations. However, the MOU does not include Urban Indian Organizations (UIOs) as eligible to for inclusion in the reimbursement agreements even though UIOs provide critical healthcare services to AI/AN veterans residing in urban areas. While the VA has successfully implemented the MOU for IHS and Tribal facilities, the VA has made a discretionary decision to deem UIOs ineligible for inclusion in the MOU, excluding UIOs from entering into reimbursement agreements. The Federal trust responsibility to provide healthcare to AI/ANs in perpetuity is not limited to where an AI/AN veteran resides. USET SPF encourages the Subcommittee to use its authority to address this discrepancy by ensuring the MOU, including eligibility for reimbursement agreements, is extended to UIOs. We remind the Subcommittee that Congress created the UIO system to honor a Federal trust obligation and assert that UIOs are well-positioned to play a vital role in closing the gap in service to AI/AN veterans.

Exempt AI/AN Veterans from VA Copays

USET SPF highlights that AI/AN veterans are currently subject to standard copays for services received within the VA. When healthcare is received through IHS or Tribally operated facilities, AI/AN veterans are not subject to any cost-sharing. However, AI/AN veterans are subject to certain copayments, such as for urgent

care services, when they are receiving care from VA facilities. Subjecting AI/AN veterans to any copayments as a condition of healthcare access is a violation of the Federal trust responsibility, which all Federal agencies share in equally. Further, AI/AN veterans may be discouraged from seeking critical and life-saving healthcare if they are subject to copays for certain VA services. We recommend the Subcommittee work with the VA to waive any and all copays for AI/AN veterans in a manner that upholds current law authorizing IHS as the agency of "payer of last resort."

Improved VA-IHS EHR Interoperability

Since 2018, the VA has been working to replace the agency's current electronic health record (EHR) system, VistA, to an off-the-shelf EHR known as Cerner Millennium. Since then, IHS has been considering either maintaining its current system, the Resource and Patient Management System, or implementing a new EHR system altogether-previously, IHS and the VA participated in cost sharing for necessary periodic updates. While the VA and IHS committed to facilitate the interoperability of health information data systems between both agencies to share information on common patients, the differences in EHR systems have led to challenges with regard to information technology interoperability. These challenges have made it difficult for healthcare providers to have access important patient information within one another's EHR systems. USET SPF underscores to the Subcommittee that interoperability between both EHR systems be prioritized as healthcare providers for AI/AN veterans must have access to real-time, life-saving data.

Conclusion

There is great potential in the MOU and care coordination between IHS and the VA. However, it is critical that VA do more to recognize its unique obligations to AI/AN veterans. Left unaddressed, AI/AN veterans will continue to face many ongoing challenges when it comes to accessing quality healthcare and resulting disparities. The Federal trust obligation to provide comprehensive healthcare to Tribal Nations and AI/AN veterans exists in perpetuity and is shared by all Federal entities including IHS, the VA, as well as the Subcommittee. It is incumbent upon the whole of the Federal Government to remove barriers in accessing healthcare for AI/AN veterans, and we encourage the Subcommittee to work to address these problems, as well as strengthen existing partnerships between the VA and the Indian Healthcare System.

PREPARED STATEMENT OF THE CALIFORNIA RURAL INDIAN HEALTH BOARD

My name is Mark LeBeau, CEO for the California Rural Indian Health Board, Inc. (CRIHB). CRIHB has a network of 19 Tribal Health Programs (THPs) that provide health care support and services to members of 59 Tribes in California (CA).

I would like to thank Chairwoman Brownley, Ranking Member Dr. Dunn, Representative Takano, and other distinguished members of the Veteran's Affairs Committee, Subcommittee on Health for holding this important hearing. It is my pleasure to submit a written statement regarding the Memorandum of Understanding (MOU) between the U.S. Department of Veteran's Affairs (VA) and the Indian Health Service (IHS).

The Federal Government's trust responsibility to provide health care to all American Indians/Alaska Natives (AI/AN) extends across all departments and agencies of the United States (U.S.) and includes the VA. And yet, although AI/ANs serve in the U.S. military at higher rates than any other population, 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 to have a disability, service-connected or otherwise, than Veterans of other races.

In 2003, a MOU was established between the IHS and the VA to improve the health status of AI/AN through the coordination and resource sharing among VA, IHS, and Tribes. The MOU was expanded in 2010 to outline mutual goals for VA and IHS collaboration and coordination of resources and health care services provided to AI/AN Veterans.[1]

The MOU is an ideal mechanism for the Federal Government to preserve and build on the existing excellent relationships that the VA has with IHS and THPs.

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[1] Government Accountability Office, Report 19–291 Action Needed to Strength Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans Page 1 (Washington, DC. March 2019) https://www.gao.gov/assets/700/697736.pdf

For Tribes in the CRIHB membership, it is particularly challenging, as CA has no IHS-funded hospitals and is designated as a Purchased/Referred Care (PRC) Dependent Area. Tribes in the CA service area must use their extremely limited PRC funding to cover the costs of placing patients in non-IHS/Tribal hospitals and/or buying other specialty care services. Before the PRC program provides payment, AI/AN patients must exhaust all payer of last resort health care resources.

According to a 2019 GAO Report, many THPs were denied reimbursement, as the VA noted, "there is no statutory requirement for them to include the PRC program in the reimbursement agreements."[2] Although CA has the largest population of AI/ANs compared to any other State, under the MOU, the reimbursement agreements are not grandfathered in.

Having said that, THPs have and continue to utilize their resources to establish reimbursement agreements with the VA for direct services to AI/AN veterans.

Many of the CA AI/AN Veterans live in rural areas and seek out the high-quality, culturally competent care at their THPs. As it currently states in the MOU between IHS and the VA, THPs cannot be reimbursed for providing services paid for with PRC funds. There are a few challenges in seeking treatment at a VA hospital that may pose several barriers for CA AI/AN Veterans.

- Access to Care: Transportation is extremely difficult, if available. Many Tribes are located great distances from VA facilities. Getting to and from appointments can take up 2 days and increases the patient's discomfort.
- Duplication of Services: Many AI/AN Veterans are referred to specialty care upon receiving initial assessment services by the physician at their local THP. Upon arriving to the VA hospital for that specialty care, the AI/AN Veterans are often required to have an additional assessment conducted by the VA physician, resulting in a duplication of services.
- Wait Times: The VA is known for its challenging wait times. This often requires the patients to spend extensive time waiting to be seen by a provider.
- Cultural barriers: AI/AN Veterans raise concerns regarding being misdiagnosed by practitioners who may not know the health history of the AI/AN Veteran.
- Registration: Several AI/AN Veterans do not register because of the complexity of the application process.
- War designation: The VA requires patients to specify if they are post-9/11 or non-post-9/11 Veterans. This is viewed as downplaying Veterans of other wars and they may be less apt to seek care.
- Behavioral Health: At times, the VA has not provided adequate Mental Health and Counseling Services for AI/AN Veterans.
- Lack of Coordination of Care: AI/AN Veterans cannot choose their specialist for specialty care services.

Our national interest of serving AI/AN Veterans will be best achieved when we extend the collaborative arrangements already agreed to by the inherent Federal trust responsibility. In order to improve care to AI/AN Veterans, CRIHB strongly recommends the VA support:

- The establishment of Reimbursement Agreements with THPs through the authority granted to Tribes under the Indian Self-Determination and Education Assistance Act, resulting in an increase to access to care.
- IHS and Tribal providers to be reimbursed for services provided under the PRC program.
- Exempting all AI/AN Veterans from copays and deductibles in accordance with the Federal trust responsibility.
- Legislation authorizing a Tribal Advisory Committee at the VA.
- THP reimbursement of non-AI/AN Veterans as referenced in the Indian Health Care Improvement Act Section 405 (c)[3]

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[2] Government Accountability Office, Report 19–291 Action Needed to Strength Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans Page 1 (Washington, DC. March 2019) https://www.gao.gov/assets/700/697736.pdf Pg 23.

[3] Indian Health Care Improvement Act (1976) https://legcounsel.house.gov/Comps/Indian%20Health%20Care%20Improvement%20Act.pdf

PREPARED STATEMENT OF THE CALIFORNIA CONSORTIUM FOR URBAN INDIAN HEALTH

CaliforniaConsortium**for**Urban**Indian**Health
1016 Lincoln Blvd. Suite 111 · San Francisco, CA 94129 · 415-345-1205
CCUIH 1900 Point West Way, Suite 111 · Sacramento CA, 95815 · ccuih.org · info@ccuih.org

The Honorable Julia Brownley
Chairwoman, Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Madam Chairwoman,

On behalf of the California Consortium for Urban Indian Health (CCUIH), we thank you for the opportunity to submit a statement for the record regarding the Committee on Veterans' Affairs oversight hearing entitled "Native Veterans' Access to Healthcare." CCUIH is an alliance of ten California Urban Indian Health Programs (UIHP), representing nearly 1/4 of all UIHP nationally. CCUIH supports health promotion and access for American Indian/Alaska Natives (AIAN), living in California cities. CCUIH provides centralized management of community health organizing, training and technical assistance, public education, civic engagement, policy support, and advocacy for UIHPs in California. According to the 2010 U.S. Census California has the largest population of AIAN, of which, 90% reside in urban areas.

American Indian/Alaska Natives (AIAN) serve in the military at higher rates than any other population. AIAN people have always felt a strong allegiance to our nation, regardless of the historic atrocities committed against our communities by federal, state, and local governments. Regrettably, AIAN veterans are disproportionately more likely to have service-related disabilities, experience sexual assault, and die by suicide. These deplorable outcomes need to be addressed with every available resource.

Since 2010, the Department of Veterans' Affairs (VA) and the Indian Health Service (IHS) have had a Memorandum of Understanding (MOU) created to improve the lives of AIAN Veterans through better healthcare services. The MOU allows the VA to reimburse IHS for services provided by the IHS Indian/Tribal/Urban (I/T/U) health care delivery system. However, the VA has refused to provide reimbursement to UIHPs, leaving millions of vulnerable AIAN veterans without the service they deserve. CCUIH is unclear about the rationale for disallowing reimbursement for UIHPs, but there is a clear historic record of various government bureaucracies disregarding legislative and executive authority when mandated to work with Tribes and AIAN serving organizations.

There is a persistent lack of understanding of the history of Urban Indian communities and the complexity of the Indian health delivery system. As a result, UIHPs have been consistently excluded from laws intended to benefit both AIAN served by the IHS delivery system. UIHPs are an integral part of the I/T/U but benefit from far fewer funding mechanisms than our Tribal program partners. Requiring the VA to reimburse UIHPs would allow AIANs veterans to receive culturally competent high-quality care in the neighborhoods where they live. Besides the wounds AIANs veterans received on the battlefield, AIAN veterans are more likely to suffer from historical trauma. These challenges are met head on by UIHP doctors and staff who are well equipped to deal with the issues faced by our community.

CCUIH thanks the Committee for holding this hearing to address these longstanding issues. We hope you will consider correcting this misinterpretation of the law and allow Native Veterans to receive care they need in the culturally competent high-quality care settings they deserve.

Respectfully,

Jyl Marden
Executive Director

PREPARED STATEMENT OF THE SAULT STE. MARIE TRIBE OF CHIPPEWA INDIANS

Dr. Aaron Payment, n'dizhnikaaz. Sault Ste. Marie Tribe of Chippewa Indians ndoo-debendaagoz. Kina Baawaa'ting Anishinaabek Omaa go nda Onji-kida. I am Dr. Aaron Payment. As the elected Chairman of the Sault Ste. Marie Tribe of Chippewa Indians, I am speaking on behalf of my Tribe. With over 45,000 members, my Tribe is the largest Tribe east of the Mississippi River. My testimony today will focus on the barriers American Indian and Alaska Native (AI/AN) veterans face when seeking access to quality, culturally competent care from the Veterans Administration (VA) and from Tribal health systems. It will also recommend solutions.

It is important to begin this testimony with the statement about Tribal sovereignty and treaty obligations. Tribes are governments, pre-dating the United States. The U.S. Constitution recognizes Tribes as "distinct governments," along with foreign nations and the several States. The U.S. Supreme Court has described their status as "domestic dependent nations" in which Tribal governments have retained nation status and inherent powers of self-government, but are subservient to U.S. Federal Government powers. The United States entered into more than 370 treaties with the Tribes. Within these treaties, Tribal governments retained their sovereignty rights, and ceded millions of acres of land and natural resources to the Federal Government in exchange for peace. The specifics of each treaty are unique, but for purposes of this testimony, it is important to recognize that they all contained health and general welfare provisions.

It is also important to begin with a statement regarding the Federal trust responsibility. As noted by the Department of Interior, the Federal trust responsibility is a legal obligation under which the United States "has charged itself with moral obligations of the highest responsibility and trust" toward Indian Tribes (Seminole Nation v. United States, 1942). This obligation was first discussed by Chief Justice John Marshall in Cherokee Nation v. Georgia (1831). Over the years, the trust doctrine has been at the center of numerous other Supreme Court cases, thus making it one of the most important principles in Federal Indian law. The Federal Indian trust responsibility is also a legally enforceable fiduciary obligation on the part of the United States to protect tribal treaty rights, lands, assets, and resources, as well as a duty to carry out the mandates of Federal law with respect to American Indian and Alaska Native tribes and villages.

American Indian and Alaska Native Veterans:

American Indians and Alaska Natives serve in the United States Armed Forces at higher rates than any other ethnicity. Despite this, they are significantly underrepresented among Veterans who access the services and benefits they have earned. Often, this is due to barriers created by distance, poverty, mental health symptoms, historical mistrust, and a lack of culturally competent providers.[1] Native Veterans are also less likely than Veterans of other races to have health insurance and more likely to have a disability.

To combat these problems, the VA has entered into memoranda with the Department of Health and Human Services (HHS), Indian Health Service (IHS) and Tribal health organizations. Overall, the use of Memorandum of Understanding (MOUs) and Agreement (MOAs) between the IHS and Tribal providers have been an excellent method of ensuring health care delivery to AI/AN Veterans. These memoranda created scaffolding that enable Veteran health care services reach American Indian and Alaska Native Veterans that have earned them. Today, however, there is a need to improve upon existing memoranda.

Barriers and Recommendations:

- **All Native Veterans should be exempted from copays and deductibles at the VA in accordance with the Federal trust responsibility.**

The health and general welfare provisions within the Treaties, as well as the Federal trust responsibility to the Tribes, obligate the Federal Government to provide health care treatment to Tribal members. This is why American Indians and Alaska Natives do not owe copays or deductibles for services received at Indian health facilities. Similarly, it is the reason the Patient Protection and Affordable Care Act exempts AI/ANs from various cost-share requirements. [2] The Federal trust responsibility and the US Treaty obligations apply to all aspects of the Federal Government, including the VA. For this reason, my Tribe recommends Native Veterans be exempted from copays and deductibles at the Veterans Administration.

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[1] National Indian Health Board. 2019.
[2] 42 U.S. Code 18071(d).

- **Allow IHS and Tribal providers to be reimbursed by the VA for services provided under the purchased/referred care program.**

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, this is what typically happens to Native Veterans seeking treatment in the First District of Michigan: If a Native Veteran goes to a Tribal Health Services facility in Sault Ste. Marie or Manistique for service and needs a referral, the same patient must be seen within the VA system before a referral can be secured. This means that the patient will need to go to the Veterans Health Administration medical center service this area, located in Iron Mountain, which involves 3-5 hours of travel. Thus, the VA is paying for the same services twice, first for those primary care services provided to the veteran in the Tribal health program facilities (same, if the Native Veteran started at an IHS facility) 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 veteran's need, many Tribal Health Programs 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 recommend that the IHS and Tribal providers should be exempted from any value-based reimbursement scheme for other VA providers.

- **The VA should reimburse Urban Indian Health Programs.**

The 2010 reimbursement MOU has been extended and been implemented for IHS and Tribal Providers, however it has not been implemented for Urban Indian Health Programs.[3] This needs to be addressed. My Tribe strongly recommends utilizing Urban Indian Health Programs within the parameters of the MOU. AI/AN Veterans often prefer Native health care providers for reasons related to performance, cultural competency, and/or the availability of non-health care-related services, and as a result, are more likely to receive care from these institutions. Urban Indian Health Programs provide these services, off Tribal lands and within urban settings. AI/veterans can obtain their health care in culturally appropriate ways and Urban Indian Health Programs can assist the Department of Veterans Affairs meet its demand for services.

- **Ensure Health IT and Telehealth upgrades at IHS are made in tandem with the VA, and ensure Tribal Health Programs have adequate access, as well.**

As both the Indian Health Service and the Veterans Administration are updating their Health Information Technology systems, my Tribe recommends Congress require the IHS and the VA work closely together to coordinate on upgrades for the Electronic Health Record systems at the respective agencies, and make upgrades in tandem.

The IHS, the VA, and the DoD should be encouraged to ensure that the IT systems continue to operate together. My Tribe recommends Congress do this, via adequate appropriations. We recommend the VA and the HIS prioritize interoperability between the IHS Health IT system and the VA.

My Tribe recommends that the IHS and the VA work to assist Tribal health programs in obtaining and adopting systems that are interoperable with the IHS/VA systems.

- **Create a Tribal Advisory Committee for the VA.**

AI/AN Veterans experience multiple barriers to receiving treatment from the VA. Creation of a Tribal Advisory Committee (TAC) for the VA will work to ensure that the VA fulfills its trust responsibility to AI/AN Veterans in a culturally competent manner.

Often, perhaps unknowingly, the VA acts in a manner that negatively impacts Native Veterans. A TAC can educate VA officials and work to ensure that policy changes do not adversely affect the Indian health care system. It can provide insight and assistance to maintaining and strengthening the implementation of the Memo-

[3] Fiscal Year 2021 Budget Recommendations. The National Tribal Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2021 Budget. April 2019. Page 29.

randum of Understanding Agreements between the VA, the IHS, and Tribal Health Programs. The TAC can provide critical assistance to the VA in improving its outreach and communication to Native Veterans. A fully functioning TAC can provide VA leadership with information and insight into Indian Country, the Federal trust responsibility, and Tribal sovereignty; assist in the identification and implementation of policies that meet the Federal Government's obligations to the Tribes, and improve the government-to-government relationship between the VA and the Tribal Nations.

The "Department of VA Tribal Advisory Committee Act of 2019" currently stands before the House Committee on Veterans' Affairs (HR 2791) and its Senate counterpart (S 524) is before the Senate Committee on Veterans Affairs. Designed to create a VA Tribal Advisory Committee, both bills have strong bi-partisan support. My Tribe strongly supports this legislation.

If you have any questions or need additional information, please do not hesitate to contact me or the Sault Ste. Marie Tribe of Chippewa Indians Legislative Director, Mike McCoy at MMcCoy@saulttribe.net.

PREPARED STATEMENT OF THE STANDING ROCK SIOUX TRIBE

Mike Faith
Chairman

TRIBAL COUNCIL
(AT LARGE)
Nola Taken Alive
Charles Walker
Avis Little Eagle
Kory McLaughlin
Warren Hawk
Jesse McLaughlin

Ira Taken Alive
Vice Chairman

Susan Agard
Secretary

John Pretty Bear
Cannonball District
Brandon Maual
Long Soldier District
Wayne Looking Back
Wakpala District
Delray Demery
Kenel District
Joe White Mountain Jr.
Bear Soldier District
Caroline Thompson
Rock Creek District
Verdell Bobtail Bear
Running Antelope District
Samuel B. Harrison
Porcupine District

28 October 2019

JULIA BROWNLEY, Chairwoman
Subcommittee on Health Committee on Veterans Affairs
B-234 Longworth House Office Building
Washington, DC 20515

Dear Congresswoman Brownley,

Attached are comments and concerns regarding Native Veterans obstacles and barriers (Brownley letter 7 October 2019) to obtaining health benefits earned while serving in the military.

The attached listing of barriers and obstacles are not listed in priorities they are listed as issues regarding obstructions to Veterans obtaining health care. These issues arise as individual Veterans obtain their scheduled appointments. In this highly rural area the weather plays an important factor in the ability to access health care, along with other obstacles and barriers that are listed. One cannot say for certain that a single obstacle or a group of particular obstacles and barriers are the most prevalent or create the greatest problems each situation is unique.

One thing that is obvious is the need for our Tribal Veteran Service Officers to be at the planning table during the development stages of programs designed to provide services to our Veterans on reservations and in highly rural areas.

For additional information and questions please contact:

Manaja Hill, Director/Veterans Service Officer
Phone: 701/854-8527 Fax: 701/854-8596
Email: mhill@standingrock.org

Respectfully submitted,

Mike Faith, Chairman
Standing Rock Sioux Tribe

Planning-

a. Native Veterans from reservations or highly rural areas are not represented at any table when planning is being done regarding services and program availability.
b. Planning, viewing results, gives very little regard to what Native Veterans have to say and how it is communicated. This is due to the lack of understand of culture and traditional customs of Native Veterans.
c. The lack of understanding or sensitivity by VA personnel to the cultures in which Native Veterans reside is evident by comments and actions. Planning activities should always take into consideration the diversity that accompany any session when Native Veterans are involved.

Rural-

a. Resources necessary to effectively implement programs and services in highly rural areas and reservations are not available.
b. Existing infrastructure will not permit particular services to be implemented on reservations or highly rural areas.
c. Distances required to travel to a VA appointment range from 75 miles to the nearest CBOC to 240 to the nearest VA Medical Facility. Veterans without transportation rely on tribal Veterans program to transport. Those Veterans that are on VA disability and qualify for travel pay have to wait for days, sometimes weeks to be reimbursed for their trip.
d. Whole health programs, services, and therapies are not available on reservation and in highly rural areas. The VA does not recruit vendors in these areas to an extent where vendors are located.
e. Physicians, therapist, and other professionals that can assist Veterans in the claims process (C&P exam) are not available thus requires another trip to an urban environment.
f. Family issues more often than not take priority over fund availability for Veterans medical needs.

Infrastructure-

a. Lack of supportive environments to assist in the growth of services and supports to Native Veterans on reservations and highly rural areas are most times not available.
b. Local substitutions for these environmental deficiencies are not considered primarily because Native Veterans who have this knowledge are not at the planning table i.e. traditional methods (therapy), Internet is not widely available on reservations and in highly rural areas.
c. Roads on reservations and in highly rural areas are most times gravel and impassible during rain or snow storms.
d. Telephone communication on reservations and in highly rural areas in difficult or impossible at times.
e. Food, clothing, and shelter are available on, at most times, a very limited basis. Some communities on the reservation DO NOT have a food or clothing store or anything that resembles one. There is a shortage of houses on the reservation.

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Additional Submissions for the Record

SUBMISSIONS FOR THE RECORD

TREATIES SUBMITTED BY THE HONORABLE RUBEN GALLEGO

Indians are exempt from paying copays under section 1402(d) of the ACA if they are

(d) SPECIAL RULES FOR INDIANS.— (1) INDIANS UNDER 300 PERCENT OF POVERTY.— If an individual enrolled in any qualified health plan in the individual

market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is

not more than 300 percent of the poverty line for a family of

the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any costsharing under the plan.

(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN

HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a

qualified health plan is furnished an item or service directly by

the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under

contract health services—

(A) no cost-sharing under the plan shall be imposed

under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment

to any such entity for such item or service by the amount

of any cost-sharing that would be due from the Indian but

for subparagraph (A).

(3) PAYMENT.—The Secretary shall pay to the issuer of a

qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this

subsection.

Article VI of the Constitution says

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

The Snyder Act of 1921 saw the appropriation of funds to Indians of the United States "For relief of distress and conservation of health" and "For the employment of inspectors, supervisors, superintendents, clerks, field matrons, farmers, physicians, Indian police, Indian judges, and other employees."

The Transfer Act of 1954

Indian Sanitation Facilities and Services Act of 1959

The Indian Self Determination and Education Assistance Act 1975

The Indian Alcohol and Substance Abuse prevention and Treatment Act of 1986

Indian Child Protection and Family Violence Prevention Act of 1990

Th ACA

Witness List

1. Indian Health Service
2. Veterans Health Administration- Dr. Stone
3. National Congress of American Indians- President Keel
4. National Indian Health Board- (Andy Joseph?)
5. National Council of Urban Indian Health
6. Alaska Native Health Board
7. Oglala Sioux- Julian Bear Runner
8. Three Affiliated Tribes- Mark Fox
9. Indian Health Service Self Governing- Chief Lynn Malerba
10. Choctaw Nation- Melanie Fourkiller

Hearing questions

"The Congress shall have the power to…regulate commerce with foreign nations, and among the several states, and with the Indian tribes."

- Article 1, Section 8, United States Constitution

"Indian Nations had always been considered as distinct, independent political communities, retaining their original natural rights, as the undisputed possessors of the soil… The very term "nation" so generally applied to them means 'a people distinct from others.'"

- Chief Justice Marshall, United States Supreme Court

From 1774 until about 1832, treaties between individual sovereign American Indian nations and the U.S. were negotiated to establish borders and prescribe conditions of behavior between the parties. The form of these agreements was nearly identical to the Treaty of Paris ending the Revolutionary War between the U.S. and Great Britain. The negotiations ended in a mutually signed pact which had to be approved by the U.S.Congress. Non-tribal citizens were required to have a passport to cross sovereign Indian lands.

From 1832 until 1871, American Indian nations were considered to be domestic, dependent tribes. Negotiated treaties between tribes and the U.S. had to be approved by the U.S. Congress.

In 1871, the House of Representatives ceased recognition of individual tribes within the U.S. as independent nations with whom the United States could contract by treaty, ending the nearly 100 year old practice of treaty-making between the U.S. and American Indian tribes.

https://www.nihb.org/docs/05202015/Foundations%20of%20Indian%20Health%20Care%20(March%202015).pdf

U.S. Department of Veterans Affairs
and
Indian Health Service
Memorandum of Understanding
Annual Report
Fiscal Year 2018

Prepared December 2018
by

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Rural Health

U.S. Department of Health and Human Services
Indian Health Service

U.S. Department of Veterans Affairs
Office of Tribal Government Relations

EXECUTIVE SUMMARY

On October 1, 2010, Indian Health Service (IHS), an agency of the U.S. Department of Health & Human Services (HHS), and the U.S. Department of Veterans Affairs (VA) signed a Memorandum of Understanding (MOU) "to improve the health status of American Indian and Alaska Native (AI/AN) Veterans," authorized by the Indian Health Care Improvement Act. (25 U.S.C. §§ 1645, 1647; 38 U.S.C. §§ 523(a), 6301-6307, 8153). The intent of the MOU is to advance collaboration, coordination and resource-sharing between VA and IHS to ensure equitable access to care and services to AI/AN Veterans. On December 5, 2012, VA Veterans Health Administration (VHA) and IHS entered into an agreement for reimbursement for direct health care services (Reimbursement Agreement), to enable VA to reimburse IHS and Tribal Health Programs (THP) for certain healthcare services provided to VHA enrolled AI/AN Veterans that are eligible to receive services at IHS or THP facilities. In June 2018, VA and IHS amended the Reimbursement Agreement to clarify pharmacy services and to extend the terms of the agreement through June 30, 2022. In fiscal year 2018, the VA/IHS leadership team focused on prescription services, transportation, housing services, workforce training and consultation with tribal communities. In addition, the leadership team concentrated on revising the 2010 MOU to account for progress made to date under the new Administration's leadership priorities. This report describes key outcomes of the MOU objectives, as well as VA-IHS inter-departmental activities not related to the MOU.

National Leadership

- Thomas F. Klobucar, Ph.D., Executive Director, VA Office of Rural Health
- P. Benjamin Smith, MBA, Deputy Director for Intergovernmental Affairs, IHS, HHS
- Stephanie E. Birdwell, MSW, Director, VA Office of Tribal Government Relations

The VA-IHS MOU leadership team met quarterly to oversee administration of the MOU, evaluate outcomes, and plan future inter-agency initiatives.

2018 VA/IHS Partnership Accomplishments

- The workgroups completed a number of MOU-related goals which are now a routine part of each department's operations. As a result, 2018 saw:
  - $20 million reimbursed to IHS and THP by VA for care of almost 5,300 enrolled AI/AN Veterans;
  - 840,109 prescriptions processed through the VA Consolidated Mail Out Pharmacy (CMOP) program for IHS Veteran patients enrolled in VA;
  - 256 in-person and online trainings shared between agencies; and
  - 130 AI/AN Veterans placed in housing through the Tribal Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH) program.

- Non-MOU related interagency collaboration at the local level created access programs that resulted in:
  - 23 tribal communities that received transportation support for Veterans through the Highly Rural Transportation Grant program;

- 47 consultations, "Dear Tribal Leader" letters, and trainings with tribal communities pertaining to Native Veteran issues;
- 16 tribal communities that received care through VA telehealth services in Montana, Wyoming and Oklahoma; and
- 5 IHS and THP clinics that participated in a VA led workforce training program.

The VA/IHS MOU leadership team met quarterly to review MOU objectives and discuss updates to the MOU document to remove outdated language and create a more comprehensive, flexible agreement that will serve both agencies well into the future.

PERFORMANCE METRICS

Section 102b of the Veterans Access, Choice and Accountability Act of 2014 required the establishment of VA and IHS MOU performance metrics to monitor progress. The table below captures 14 performance metrics developed by VA and IHS and their fiscal year 2018 outcomes.

Metric	Activity
1. Number of VA enrolled Veterans served by IHS and Tribal Operated Health Programs (THP) through the VA-IHS and VA-THP reimbursement agreements.	VA-IHS: 2,829 VA-THP: 2,531
2. Total disbursed dollar amount through the VA-IHS and VA-THP reimbursement agreements.	VA-IHS: $7,960,903 VA-THP: $12,068,644
3. Total prescriptions filled through VA Consolidated Mail Out Pharmacies (CMOP) for direct AI/AN Veteran care.	840,109
4. Completion of annual metrics review.	Completed Fiscal Year 2018
5. Total number of instances where VA and IHS or tribal operated health programs share space, equipment, services and/or personnel to provide health care for AI/AN Veterans.	16
6. Quality measures tracked specifically for enrolled Veterans served by IHS through the VA-IHS reimbursement agreement.	Data not available
7. Completion of annual metrics review.	Completed Fiscal Year 2018
8a. Number of shared VA-IHS trainings and webinars.	256
8b. Number of training attendees.	Data not available
9. Number of meetings between VA ORH and IHS leaders to coordinate MOU implementation activities.	12
10. Completion of annual metrics review.	Completed Fiscal Year 2018
11. Total reimbursement for suicide prevention, tobacco cessation and diabetes management services.	$1,920,287.75
12. Completion of annual metrics review.	Completed Fiscal Year 2018
13. Number of consultations, "Dear Tribal Leader" letters, and trainings with tribal communities pertaining to Native Veteran issues.	47
14. Completion of annual metrics review.	Completed Fiscal Year 2018

Source: *Internal VA and IHS reports*

ACCOMPLISHMENTS

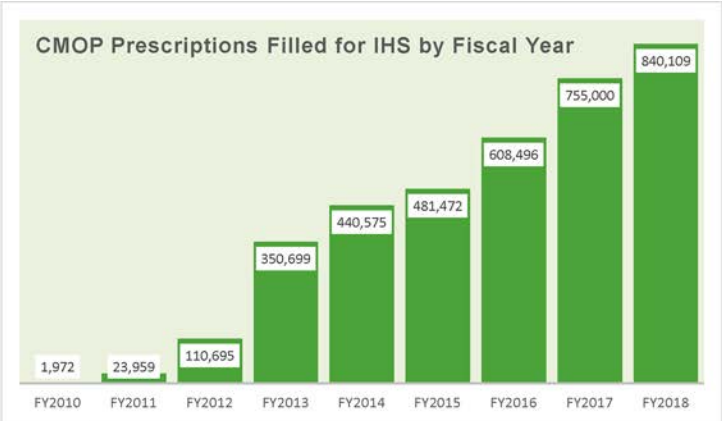
To support the MOU's goal to "improve the health status" of AI/AN Veterans, the MOU team focused on how to increase the number of care sites, bring care closer to home, reduce barriers to care (e.g., travel, geography, time, transportation), and train health care professionals. All of this was done in constant coordination with tribal communities. Note that some of the activities listed below began in MOU workgroups but is now a routine part of each agencies' operations. Similarly, some of the interagency collaborations began in the field, independent of the MOU. In both cases, the MOU leadership team monitors their activities, but does not oversee their operations.

Access to Care

- In 2012, VA and IHS entered into the VA-IHS Reimbursement Agreement that facilitates VA payment to IHS for care delivered to VA enrolled AI/AN Veterans at 77 IHS facilities without prior authorization. On June 29, 2018, agency leaders signed amendment three to the agreement, extending it to June 30, 2022. In addition, VA has 112 separate reimbursement agreements with THP. The VA Office of Community Care administers these agreements and is responsible for their execution.
    - Since inception in fiscal year 2012, the VA-IHS and VA-THP reimbursement agreements provided $84.2 million to IHS and THPs for care of 9,802 VHA enrolled AI/AN Veterans. In fiscal year 2018 alone, VA paid IHS and THPs $20 million for the care of almost 5,300 enrolled AI/AN Veterans.
- VA delivered care through eight tribal telemental health clinics for the Montana VA Health Care System. The program serves 16 tribal communities in Montana, Wyoming and Oklahoma. A ninth clinic in Rocky Boy, Montana, is scheduled to reopen in early 2019.

Access to Medication

- One of the most successful collaborations between VA and IHS is the VA CMOP program for enrolled AI/AN Veterans served at IHS clinics. On December 12, 2016, the VA and IHS entered into an Interagency Agreement that extended CMOP to THPs that meet necessary requirements. CMOP mails prescriptions to Veteran homes which can significantly reduce or eliminate travel to/from rural or remote communities to obtain medication. This collaboration continues to expand annually. In fiscal year 2018 CMOP processed 840,109 prescriptions, an increase of 11percent from fiscal year 2017. Since inception in fiscal year 2010, CMOP processed more than 3.6 million prescriptions for VA-IHS patients.



Source: *Internal VA data*

Workforce Training

- VA and IHS coordinated on training and recruitment efforts whenever possible. In fiscal year 2018, VA and IHS shared 256 training events, including online and in-person sessions focused on mental health, clinical support, oral health, diabetes and more.

- The Rural Interdisciplinary Team Training (RITT), part of the VA Geriatric Scholars Program, trains providers to address the unique needs of the geriatric Veteran population. This well-established program is included in both VA's and IHS' response to the National Alzheimer's Disease Plan. This year, VA provided five RITT training sessions at IHS and THP clinics in four of the 12 Indian Health Service Area regions.

Access to Transportation

- The VA Highly Rural Transportation Grant Program (HRTG) provides funds to Veteran Service Organizations and state Veterans' service agencies to transport Veterans who reside in highly rural areas to VA medical appointments. In fiscal year 2018, HRTG grantees served 23 tribal communities in Montana, Alaska, Nevada, North Dakota, South Dakota, Washington, and California.

Social Determinants of Health (Housing Assistance)

- VA and IHS recognize the impact housing, or the lack thereof, has on Veterans' health. To address this social determinant of health, the HUD-VASH program provides rental assistance for homeless or at-risk AI/AN Veterans.

- HUD-VASH increased tribal engagement in fiscal year 2018 from 23 to 26 tribes that used the program to find homes for Veterans. As a result, the program found homes for 130 new AI/AN Veterans. Additionally, the program grew 33 percent, from 264 to 350 Veterans served.

Tribal Consultations

- VA and IHS strive to consult regularly with tribal partners in order to more effectively serve AI/AN Veterans. Over the past year, the VA Office of Tribal Government Relations (OTGR) assisted the VA Historic Preservation Office with one tribal consultation, sent two "Dear Tribal Leader" letters, led one tribal Veteran representative training session, directed 9 Veteran training summits, and conducted two stand downs to gather tribal input and promote VA programs and resources. IHS participated in many of these events.

- The Veterans Benefits Administration and OTGR conducted a Presumptive Campaign Claims Clinic initiative, serving over 1,000 Veterans and spouses at 32 events involving 24 tribal governments. OTGR plans to publish an Executive Summary on this initiative.

FUTURE COLLABORATION

The VA/IHS partnership has yielded years of tangible outcomes that increased native Veterans' and Alaska Native Veterans' access to care. While the current VA/IHS MOU provided a good starting point for some of the innovations highlighted above, many of the most effective collaborative practices evolved at the local level as partnerships between local VA facility leadership and local IHS or THP leaders. In fiscal year 2018, the VA/IHS MOU leadership team conducted an in-depth revision of the existing document, with the goal of creating a new MOU that reflects the evolving health care and health information technology landscape to create a more comprehensive, flexible MOU structure that will support both agencies and the Veterans they serve well into the future.

DEPARTMENT OF VETERANS AFFAIRS TRIBAL CONSULTATION POLICY

Department of Veterans Affairs

Tribal Consultation Policy

1. **Introduction:**

   a. The U.S. Government has a unique relationship with American Indian and Alaska Native Tribal Governments as set forth in the Constitution of the United States, treaties, statutes, court decisions, executive orders, and memoranda. The United States recognizes the right of federally-recognized Indian Tribes to self-government. Indian Tribes exercise inherent sovereign powers over their members and territory. The United States Department of Veterans Affairs (VA) establishes this policy in order to enhance the relationship of cooperation, coordination, open communication, good will; to work in good faith to amicably and fairly resolve issues/differences; and to continue to pursue mutually agreeable objectives successfully.

   b. Thus, in accordance with Executive Order 13175, "Consultation and Coordination with Indian Tribal Governments," and guidance promulgated during the White House Tribal Nations Conference, November 5, 2009, wherein the President reaffirmed the Federal Government's commitment to meaningful consultation with Indian Tribes, by directing that each Federal Agency adopt a "detailed plan of action" to implement Executive Order 13175 (November 9, 2000), 65 Fed. Reg. 67249-67252, VA establishes this Tribal Consultation Policy.

2. **Purpose:** Through this Policy, VA will seek to enhance positive government-to-government relations between VA and all federally recognized Indian Tribes, and to establish meaningful consultation procedures to develop, improve, or maintain partnerships with American Indian and Alaska Native Tribes. Thereby, VA will meet the intent of Executive Order 13175 and the President's directive to establish meaningful consultation procedures with American Indian and Alaska Native Tribes.

3. **Definitions:**

   a. Indian Tribe means an American Indian or Alaskan Native tribe, band, nation, pueblo, village, or community that the Secretary of Interior acknowledges to exist as an Indian Tribe pursuant to the Federally-Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a.

   b. Indian Organizations means those organizations, predominantly operated by Indian Tribes that represent or provide services to all American Indians or Alaskan Natives living on and/or off tribal lands and/or in urban areas.

   c. Tribal Government means the governing structure of a sovereign, federally-recognized government of an Indian Tribe.

d. Tribal Officials are the elected or duly appointed officials of Indian Tribes or authorized intertribal organizations.

e. Government-to-Government describes the relationship between VA and the American Indian and Alaska Native Tribal Governments.

f. Work Groups means task forces established through a joint effort by VA and individual Indian Tribes. Work Groups can be established to address or develop more technical aspects of policies or programs separate or in conjunction with the formal consultation process. Work Groups shall, to the extent possible, consist of members from VA and participating Indian Tribe(s).

g. Participation describes an ongoing activity that allows interested parties to engage one another through negotiation, compromise and problem solving to reach a desired outcome.

h. Communication means verbal, electronic or written exchange of information between duly appointed officials of VA and Indian Tribes.

4. Principles:

a. Confidentiality: VA will continue to protect and exhibit a high degree of respect and sensitivity regarding confidential information provided by Tribal Governments and staff, and ensure confidentiality to the extent provided by applicable Federal law.

b. Recognize and Respect Sovereignty: VA, as a representative of the United States Government, recognizes that the various American Indian and Alaska Native Tribes are sovereign governments. The recognition and respect of sovereignty is the basis for government-to-government relations and this Policy. Sovereignty must continue to be respected and recognized in government-to-government consultation and collaboration between VA and American Indian and Alaska Native Tribes.

c. Government-to-Government Relations: VA recognizes the importance of collaboration, communication and cooperation with American Indian and Alaska Native Tribes. VA further recognizes that VA policies, programs and/or services may directly or indirectly affect these Tribes. Accordingly, VA recognizes the value of dialogue with the American Indian and Alaska Native Tribes on specific policies, programs, and/or services.

d. Efficiently addressing Tribal Issues and Concerns: VA recognizes the value of the American Indian and Alaska Native Tribes' input regarding VA policies, programs and/or services. Thus, it is important that the Tribes' interests are continuously reviewed and considered by VA in its policy, program and/or services development processes.

e. Collaboration and Mutual Resolution: VA recognizes that good faith, mutual respect, and trust are fundamental to meaningful collaboration and communication policies. As concerns arise, VA shall continue to strive to address and mutually resolve them with impacted American Indian and Alaska Native Tribes.

f. Communication and Positive Relations: VA shall strive to enhance positive government-to-government relations with the American Indian and Alaska Native Tribes by: (1) continuing to interact with the Tribes in a spirit of mutual respect; (2) seeking to understand the varying Tribes' perspectives; (3) enhancing communication, understanding and appropriate dispute resolution with the Tribes; and (4) continuing to work through the government-to-government process towards a shared vision in areas of mutual interest.

g. Informal Communication: VA recognizes that formal consultation may not be appropriate in all situations or interactions. VA may seek to communicate with and/or respond to the Tribes outside the consultation process. These informal communications do not negate the authority or the importance of VA and the Tribes pursuing formal consultation.

5. Protocol:

a. When working with Indian Tribes and/or tribal governments, it is important to understand the unique political relationship between American Indian and Alaska Native Tribal Governments and the United States Government. Under both Federal and common law, Indian Tribes are sovereign governments with recognized powers of self-government. The status of Indian Tribes as sovereigns means that Tribes possess the inherent right to develop their own forms of government, to determine their own citizenship and to make their own judicial systems. Thus, it is important not to assume that one tribe or one leader speaks for all.

b. VA recognizes the unique sovereign status of Indian Tribes. To promote effective communication and collaboration between VA and the Tribes relating to this Policy, VA shall continue to endeavor to understand the protocols for interacting with each American Indian and Alaska Native Tribe. Collaboration is a recursive process in which two parties work together to achieve a common set of goals. Collaboration may occasionally occur, between VA and the Tribes, their respective agencies or VA's, or their official designees. Collaboration is the timely communication and joint effort that lays the groundwork for mutually beneficial relations, including identifying issues and problems, generating improvements and solutions, and providing follow-up as needed.

c. Consensus serves as a decision making method for reaching agreement through a participatory process that: (1) involves VA and Indian Tribes through their official representatives; (2) actively solicits input and participation by VA

and the Tribes; and (3) encourages cooperation in reaching agreement on the best possible decision for those affected. VA shall continue to endeavor to conduct deliberations with Indian Tribes in good faith and in accordance with the processes outlined in this Policy. Within this process, it is understood that consensus, while a goal, may not always be achieved.

d. Consultation shall operate as an enhanced form of communication that emphasizes trust and respect. It is a shared responsibility that allows an open and free exchange of information and opinion among parties that, in turn, may lead to mutual understanding and comprehension. Consultation with American Indian and Alaska Native Tribes is a unique government-to-government process with two main goals: (1) to reach consensus in decision-making; and (2) whether or not consensus is reached, to afford any party the opportunity to issue a dissenting opinion for the record, and more importantly to have honored each other's sovereignty.

6. **General Provisions:**

a. The Role of Work Groups: VA, in consultation with recognized Tribal officials, may appoint a Tribal Work Group to develop recommendations and provide input on VA policies, programs and/or services as they might impact American Indian and Alaska Native Tribes. VA or the Work Group may develop procedures for the organization and implementation of Work Group functions.

b. Communication: VA recognizes that Tribal Officials may communicate with appropriate VA employees outside the consultation process to ensure that any policies will not adversely impact tribal interests. While less formal mechanisms of communication may be more effective at times, this does not negate VA's or the Tribe's ability to pursue formal consultation on a particular issue or policy.

c. Informal Communication with Indian Organizations: The Federal-Tribal relationship is based on a government-to-government relationship. VA recognizes the existence of Indian organizations, such as those representing or providing services to urban and/or off-reservation American Indians and Alaskan Natives. Through this Policy, VA recognizes that it may continue to solicit recommendations or otherwise collaborate and communicate with these organizations and may do so through offices that VA established to serve those populations.

7. Consultation:

a. Authority: Consultation shall be between the Secretary of Veterans Affairs, or his/her designated representative and Tribal Officials or their delegated representatives, who possess authority to negotiate on their behalf. The Deputy Assistant Secretary for Intergovernmental Affairs is designated as VA's primary point-of-contact for implementation of this policy, and for coordinating VA's relationships with Tribal Governments and other tribal entities. The Deputy Assistant Secretary for Intergovernmental Affairs shall continue to represent the Secretary in interactions and will serve as the liaison on these matters between VA and the American Indian and Alaska Native Tribes.

b. Applicability: Tribal consultation is most effective and meaningful when conducted before taking actions that impact American Indians and Alaskan Natives. VA acknowledges that a best case scenario may not always exist, and that VA and the Tribes may not have sufficient time or resources to fully consult on a relevant issue; however, consultation should be initiated as soon as possible to discuss any relevant issues.

c. Focus: The principal focus for government-to-government consultation is with American Indian and Alaska Native Tribes through their duly appointed Tribal Officials. Nothing shall restrict or prohibit the ability or willingness of Tribal Officials and the Secretary to meet directly on matters that require direct consultation. VA recognizes that the principle of intergovernmental collaboration, communication, and cooperation is a first step in government-to-government consultation. VA shall continue to determine when direct leader-leader meetings shall occur.

d. Areas of Consultation: VA, through reviewing proposed plans, policies, rules, or other pending and proposed programmatic actions, recognizes the need to assess whether such actions may impact Indian Tribes and/or American Indian and Alaska Native Tribes. Consultation should take place prior to any actions that may have the potential to significantly affect tribal resources, rights, or land. VA strives to notify appropriate Tribal Officials about such actions in an effort to provide Tribal Officials the opportunity to pursue and/or engage in the consultation process.

e. Initiation: Written notification requesting consultation by VA or an Indian Tribe shall serve to initiate the consultation process. Written notification, at the very least, should:

(1) Identify the proposed action to be consulted upon.

(2) Identify personnel who are authorized to consult on behalf of VA or the Tribe.

f. Process: VA, in order to engage in consultation, may utilize duly-appointed Work Groups, or the Deputy Assistant Secretary for Intergovernmental Affairs, or appointed representatives to meet directly with Tribal Officials, or set forth other means of consulting with affected Tribes as the situation warrants.

(1) Consultation will be between the Secretary of Veterans Affairs and Tribal Officials or their delegated representatives with authority to negotiate on their behalf.

(2) VA will make a good faith effort to invite for consultation all affected Tribes.

8. **Limits on Consultation:**

a. This policy will not diminish any administrative or legal rights and remedies otherwise available by law to VA or American Indian or Alaska Native Tribes.

b. The Policy does not prevent VA or the Tribes from entering into Memoranda of Understanding, Intergovernmental Agreements, Joint Powers Agreements, professional service contracts, or other established administrative procedures and practices mandated by Federal law or Tribal laws or regulations.

c. VA retains final decision making authority with respect to actions undertaken by VA and within Federal jurisdiction. In no way should this Policy impede VA's ability to manage its operations.

d. This Policy is not intended to create any right, benefit, or trust responsibility, substantive or procedural, enforceable law by a party against the United States, VA, or any person.

9. **Dissemination of Policy:** Upon adoption of this Policy, VA will ensure the Policy is disseminated to all employees and to the various Indian Tribes.

10. **Amendments and Review of Policy:** This Policy is a working document and may be revised as needed.

11. **Effective Date:** This Policy shall become effective upon the date signed by the Secretary, Department of Veterans Affairs.

12. **Sovereign Immunity:** The Policy shall not be construed to waive the sovereign immunity of the United States or any of its Agencies, or any Tribe, or to create a right of action by or against the United States or a Tribe, or any official of either, for failing to comply with this Policy.

The United States Department of Veterans Affairs hereby adopts this Federal – Tribal Consultation Policy.



2/4/11
Date

MEMORANDUM OF UNDERSTANDING BETWEEN THE DEPARTMENT OF VETERANS AFFAIRS (VA) AND INDIAN HEALTH SERVICE (IHS)

Memorandum of Understanding
Between the
Department of Veterans Affairs (VA)
and
Indian Health Service (IHS)

I. Purpose: The purpose of this Memorandum of Understanding (MOU) is to establish coordination, collaboration, and resource-sharing between the Department of Veterans Affairs (VA) and Indian Health Service (IHS) to improve the health status of American Indian and Alaska Native Veterans. The goal of the MOU is to foster an environment that brings together the strengths and expertise of each organization to actively improve the care and services provided by both. The MOU establishes mutual goals and objectives for ongoing collaboration between VA and IHS in support of their respective missions and to establish a common mission of serving our nation's American Indian (AI) and Alaska Native (AN) Veteran. The MOU is intended to provide authority for a broad range of collaboration between the agencies that facilitate development of additional agreements around specific activities. It is the intent of this MOU to facilitate collaboration between IHS and VA, and not limit initiatives, projects, or interactions between the agencies in any way. The MOU recognizes the importance of a coordinated and cohesive effort on a national scope, while also acknowledging that the implementation of such efforts requires local adaptation to meet the needs of individual tribes, villages, islands, and communities, as well as local VA, IHS, Tribal, and Urban Indian health programs.

II. Authority: The Indian Health Care Improvement Act, 25 U.S.C. Sections 1645, 1647; 38 U.S.C. Sections 523(a), 6301-6307, 8153

III. Background: The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social and spiritual health to the highest level. The goal of IHS is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all American Indian and Alaska Native people. The foundation of IHS is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

The mission of the Department of Veterans Affairs is to "care for him who shall have borne the battle and his widow and orphan." Those words were spoken by Abraham Lincoln during his second inaugural address and reflect the philosophy and principles that guide VA in everything it does.

IHS and VA enter into this MOU to further their respective missions. This MOU builds upon decades of successful collaboration, as well as the 2003 MOU signed between IHS and VA. This MOU also conforms to the most current legislation. It is the intent of this MOU that, through appropriate coordination, collaboration, and resource sharing, both organizations will achieve greater success in reaching their organizational goals and in more effectively serving as stewards of public resources.

IV. Actions:

A. This MOU sets forth 5 mutual goals:

1. Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Effectively leverage the strengths of the VA and IHS at the national and local levels to afford the delivery of optimal clinical care.
2. Promote patient-centered collaboration and facilitate communication among VA, IHS, American Indian and Alaska Native Veterans, Tribal facilities, and Urban Indian Clinics.
3. In consultation with tribes at the regional and local levels, establish effective partnerships and sharing agreements among VA headquarters and facilities, IHS headquarters and IHS, Tribal, and Urban Indian health programs in support of American Indian and Alaska Native Veterans.
4. Ensure that appropriate resources are identified and available to support programs for American Indian and Alaska Native Veterans.
5. Improve health-promotion and disease-prevention services to American Indians and Alaska Natives to address community-based wellness.

B. To further the goals of this MOU, VA and IHS agree to actively collaborate and coordinate:

1. To **increase access** to services and benefits of IHS and VA (including the Veterans Benefits Administration (VBA)) for AI/AN Veterans, by:
    a. Expanding the highly successful Tribal Veterans Representative (TVR) program into the Indian health system, through integration into existing infrastructure.
    b. Providing systematic training for Benefits Coordinators at IHS, Tribal, and Urban programs in eligibility requirements for VBA benefits and priority designations for VA services and tools to assist them with appropriate referrals for benefits and services.
    c. Providing systematic training for appropriate VA staff on IHS services and IHS Contract Health Services (CHS) eligibility and tools to assist them with appropriate referrals for services.

2. To **improve coordination of care**, including co-management, for AI/AN Veterans served by both IHS, Tribal, or Urban Indian health programs and VA by:
    a. Developing and testing of innovative approaches to improve coordination of care and dissemination of best practices.
    b. Establishing standardized mechanisms for access by providers in one system to the electronic health records in the other system for patients receiving care in both systems.

3. To **improve care** through the development of health information technology, including the following:
    a. Sharing of technology
        i. Joint development of applications and technologies.
        ii. Adaptation of applications and technologies developed by one agency to permit use by the other.
        iii. Mechanisms for the exchange of funds to support this adaptation and sharing.
    b. Interoperability of systems to facilitate sharing of information on common patients and populations

c. The VA and IHS will develop processes to share information regarding planned development of applications and technologies to facilitate this collaboration.
d. The VA and IHS will develop standard, pre-approved language for inclusion in sharing agreements to support this collaboration.

4. To **enhance access** through the development and implementation of new models of care using new technologies, including:
    a. Tele-health services such as tele-psychiatry and tele-pharmacy.
    b. Services using mobile communication technologies.
    c. Enhanced telecommunications infrastructure to support collaboration in remote areas.
    d. Sharing of training programs and materials supporting these models of care.
    e. Sharing of knowledge gained from testing of new models of care.

5. To **improve efficiency and effectiveness** of both the VA and IHS at a system level through:
    a. Sharing of contracts and purchasing agreements that may be advantageous to both IHS and VA, supported by the development of:
        i. Standard, pre-approved language for inclusion of one party into contracts and sharing agreements developed by the other.
        ii. Processes to share information at an early stage of strategic planning to facilitate inclusion of one party into contracts and sharing agreements developed by the other.
    b. Development of pre-approved templates for agreements to facilitate local, regional, and national collaborations.
    c. Development of standard policies for use when IHS and VA facilities are co-located.

6. To **increase availability of services, in accordance with law,** by the development of payment and reimbursement policies and mechanisms to:
    a. Support care delivered to eligible AI/AN Veterans served at VA and IHS.
    b. Facilitate the sharing and coordination of services, training, contracts, and sharing agreements, sharing of staff, and development of health information technology and improved coordination of care as specified elsewhere in this agreement.

7. To **improve the delivery of care** through active sharing of care process, programs, and services with benefit to those served by both IHS and VA.
    a. Examples of important collaborations currently underway include: the Consolidated Mail Outpatient Pharmacy, Post-Traumatic Stress Disorder, Home-Based Primary Care, and dementia care, but many additional opportunities exist and should be jointly pursued under this agreement. Especially valuable may be services where one party has unique expertise to share with the other, e.g. VA expertise in PTSD treatment and IHS expertise in diabetes management.

b. To facilitate this sharing, IHS and VA will, in consultation with the Tribes, develop a strategic investment plan to identify high priority services and programs for collaboration and for possible joint investment of resources.

8. To **increase cultural awareness and culturally competent care** for VA and IHS beneficiaries. Recognizing that many cultures are represented in the populations served by IHS, Tribal and Urban Indian health programs and by VA, this will require:
    a. Attention to cultural issues of importance in caring for American Indians and Alaska Native Veterans in the unique systems of care represented by VA and by IHS, Tribal, and Urban Indian health programs.
    b. Attention to cultural issues of importance for the local Tribes and communities served.

9. To **increase capability and improve quality** though training and workforce development, including:
    a. Sharing of educational and training opportunities and the development of joint training initiatives.
    b. Provision of continuing education units (CEUs) and continuing medical education (CMEs) activities at VA training to Indian health staff and at Indian health training to VA staff.
    c. Education of residents, students, preceptors, and staff in IHS, Tribal, Urban and VA settings.
    d. Sharing and exchange of staff for training opportunities.
    e. Sharing of existing on-line and satellite training resources.
    f. Collaboration on development of training opportunities.
    g. Development of processes to share information regarding planned or projected training opportunities to facilitate this collaboration.

10. To **increase access to care** through sharing of staff and enhanced recruitment and retention of professional staff, including:
    a. Sharing of specialty services.
    b. Joint credentialing and privileging of staff.
    c. Joint training initiatives.
    d. Sharing materials and training in the use of Title 38 wage and benefits system.
    e. Joint facility/service planning.
    f. Facilitation of the temporary assignment of Commissioned Officers to the VA
        i. For short-term training and projects.
        ii. For long-term training and service delivery
        iii. For deployment through existing rapid deployment force (RDF) programs and other Public Health Service emergency staffing systems to meet the needs of the VA in responding to public health crises of a regional and national nature.

11. To **address emergency, disaster, and pandemic preparedness and response**, including:
    a. Sharing of contingency planning and preparedness efforts, especially with regard to rural and vulnerable populations.
    b. Joint development of materials targeting AI/AN Veterans and their families and communities.

c. Joint exercises and coordination of emergency response.

12. To **accomplish the broad and ambitious goals of this agreement** through the development of a joint Implementation Task Force to identify the strategies and plans for accomplishing the tasks and aims of this agreement, including:
    a. Development of joint workgroups for both short-term and ongoing work necessary to accomplish the aims of this agreement.
    b. Regular meeting of IHS and VA leadership at multiple levels in the organizations to review progress and set priorities.
    c. An annual report of activities accomplished under the auspices of this agreement.

V. Other Considerations:

A. VA and IHS will comply with all applicable Federal laws and regulations, including those regarding the confidentiality of health information and the release of information to the public. For example, Medical records of IHS and VA patients are Federal records and are subject to some or all of the following laws: the Privacy Act, 5 U.S.C. 552a; the Freedom of Information Act, 5 U.S.C. 552; the Drug Abuse Prevention, Treatment, and Rehabilitation Act, 21 U.S.C. 1101, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, 42 U.S.C. 4541, the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1301, VA's Confidentiality of Certain Medical Records, 38 U.S.C. 7332; Confidential Nature of Claims, 38 U.S.C. 5701; Medical Quality Assurance Records Confidentiality, 38 U.S.C. 5705, and Federal regulations promulgated to implement those acts.

B. Care rendered under this MOU will not be part of a study, research grant, or other test without the written approval of both IHS and VA , subject to all appropriate IHS and VA research protocols.

C. VA and IHS agree to cooperate fully with each other in any investigations, negotiations, settlements or defense in the event of a notice of claim, complaint, or suit relating to care rendered under this MOU.

D. No services under this MOU will result in any reduction in the range of services, quality of care or established priorities for care provided to the Veteran population or IHS service population. Rather the intent of this MOU is to increase the efficiency of services rendered by VA and IHS.

E. VA will provide IHS employees with access to VA automated patient records maintained on VA computer systems to the extent permitted by applicable Federal confidentiality and security laws and policies. Additionally, IHS will likewise provide VA employees access to Veteran IHS records to the same extent permitted by applicable Federal confidentiality and security laws and policies.

F. Both parties to this MOU are Federal agencies and their employees are covered by the Federal Tort Claims Act, 28 U.S.C §§1346(b), 2671-2680, in the event of an allegation of negligence. It is agreed that any and all claims of negligence attributable to actions taken pursuant to this MOU will be submitted to legal counsel for both parties for investigation and resolution.

G. This MOU replaces and supersedes the MOU signed by the Department of Veterans Affairs and the Department of Health and Human Services on February 25, 2003.

VI. Termination: This MOU can be terminated by either party upon issuance of written notice to the other party not less than 30 days before the proposed termination date. The 30 days notice may be waived by mutual written consent of both parties involved in the MOU.

VII. Effective Period: VA and IHS will review the MOU annually to determine whether terms and provisions are appropriate and current.

VIII. Severability: If any term or condition of this MOU becomes invalid or unenforceable, such term or provision shall in no way affect the validity or enforceability of any other term or provision contained herein.

FOR THE DEPARTMENT OF
VETERANS AFFAIRS

Robert A. Petzel

ROBERT A. PETZEL
UNDER SECRETARY FOR HEALTH

OCT 01 2010

Date

FOR THE DEPARTMENT OF
AND HEALTH AND HUMAN SERVICES

Yvette Roubideaux

YVETTE ROUBIDEAUX
INDIAN HEALTH SERVICE DIRECTOR

10/1/10

Date

VHA Office of Community Care, Performance Improvement & Reporting
Informatics and Data Analytics (10D1E3)

Transactions through: 6/30/2019
Last Updated: 6/12/2019
Compiled by: John Hansen

The purpose of the report to is to present the total amount disbursed, total unique Veterans and total number of claims processed using the **Central Fee Filers & Fee Basis Claims System (FBCS)** for the Indian Health Service/Tribal Health Program.

Indian Health Service/Tribal Health Program

National Data

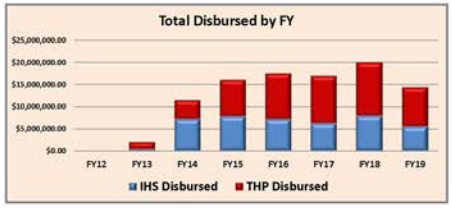
Total Disbursement for IHS/THP Program Agreement Date to FYTD	Total Disbursement by Program - Agreement Date to FYTD		Total Unique Veterans for IHS/THP Program Agreement Date to FYTD
	Program	Total Disbursed	Total Unique Veterans
$99,926,810.12	IHS	$42,878,039.20	5,981
	THP	$57,048,770.92	4,878	10,516

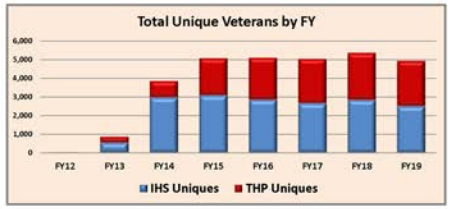
Total Disbursement - Out of System Retropayments (only)	Total Disbursement of Out of System Retropayments (only) - *Included in National Data*		*payments* Total Unique Veterans - Out of System Retropayments (only)
	Program	Total Disbursed	Total Unique Veterans
$38,427.00	IHS	$22,021.00	972
	THP	$16,406.00	410	1,382

Please note: data for unique Veterans cannot be added across fiscal years - individual Veterans may receive care during multiple fiscal years. Adding across fiscal years will result in double-counting of these Veterans.

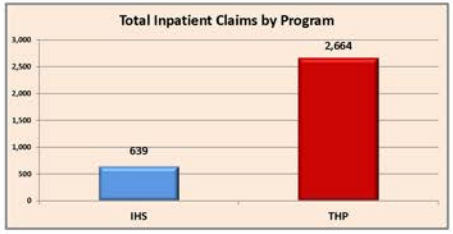
Total Disbursed by FY

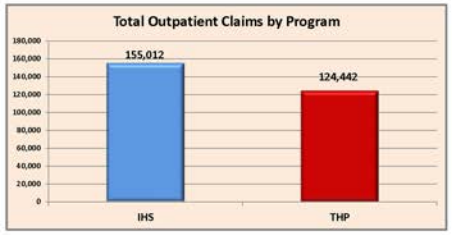
FY	Total Disbursed	Total Uniques	IHS Disbursed	IHS Uniques	THP Disbursed	THP Uniques
FY12	$4,517.30	17	$0.00	0	$4,517.30	17
FY13	$1,989,615.05	855	$402,085.41	537	$1,587,529.64	318
FY14	$11,497,556.17	3,839	$7,203,217.76	2,965	$4,294,338.41	885
FY15	$16,109,354.23	5,032	$7,834,172.94	3,082	$8,275,181.29	1,989
FY16	$17,537,773.33	5,031	$7,153,927.87	2,844	$10,383,845.46	2,254
FY17	$17,016,435.36	4,984	$6,247,807.75	2,654	$10,768,627.61	2,387
FY18	$20,029,546.72	5,296	$7,960,902.90	2,829	$12,068,643.82	2,531
FY19	$14,416,037.45	4,871	$5,499,709.02	2,498	$8,916,328.43	2,438



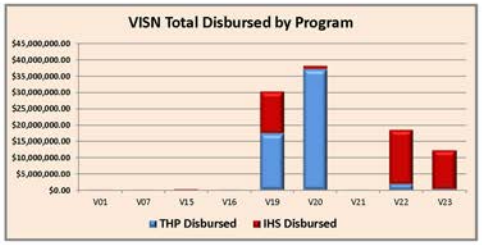


	Total Claims	Inpatient	Outpatient
IHS	155,651	639	155,012
THP	127,106	2,664	124,442
Total	282,757	3,303	279,454



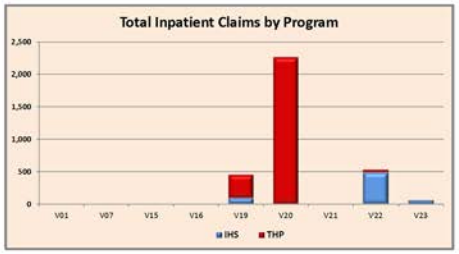


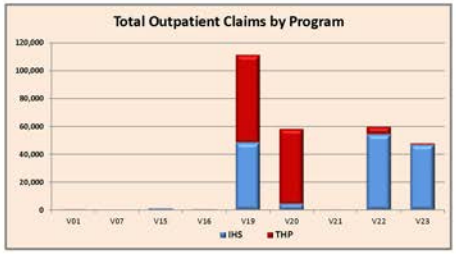
Total Disbursed by VISN by Program							Out of System Retropayments	
VISN	Total Disbursed	Total Unique Veterans	THP Disbursed	THP Unique Veterans	IHS Disbursed	IHS Unique Veterans	Total Disbursed	Unique Veterans
V01	$89,745.15	24	$30,985.15	9	$58,748.00	15	$12.00	1
V02	$0.00	0	$0.00	0	$0.00	0	$0.00	0
V06	$60,732.11	27	$60,732.11	27	$0.00	0	$0.00	0
V07	$17,189.70	8	$0.00	0	$17,144.70	8	$45.00	2
V10	$64,871.18	10	$64,871.18	10	$0.00	0	$0.00	0
V12	$81,204.07	39	$81,204.07	39	$0.00	0	$0.00	0
V15	$268,154.70	63	$28,158.54	4	$239,951.16	59	$45.00	3
V16	$148,067.81	33	$142,715.81	33	$0.00	0	$5,352.00	227
V19	$30,275,232.43	4,007	$17,369,083.11	2,505	$12,904,631.32	1,671	$1,518.00	66
V20	$38,118,729.12	1,795	$37,117,789.65	1,618	$996,238.47	181	$4,701.00	94
V21	$82,731.00	24	$82,731.00	24	$0.00	0	$0.00	0
V22	$18,505,792.27	2,954	$1,794,600.62	527	$16,711,155.65	2,561	$36.00	2
V23	$12,231,163.58	1,588	$275,899.68	92	$11,950,169.90	1,510	$5,094.00	204





Total Claims by VISN by Program by Patient Type						
	IHS			THP		
VISN	Total Claims	Inpatient	Outpatient	Total Claims	Inpatient	Outpatient
V01	172	0	172	184	0	184
V02	0	0	0	0	0	0
V06	0	0	0	151	0	151
V07	66	0	66	0	0	0
V10	0	0	0	163	0	163
V12	0	0	0	217	0	217
V15	953	0	953	69	0	69
V16	0	0	0	373	0	373
V19	48,448	92	48,356	63,205	359	62,846
V20	4,298	0	4,298	56,156	2,265	53,891
V21	0	0	0	216	0	216
V22	54,751	489	54,262	5,499	39	5,460
V23	47,011	58	46,953	900	1	899





Disclosure of Data
Data presented under the National Central Fee Roll-Up consists of data from the Central Fee post payment files.
Data reflects payments under the Inpatient, Outpatient, Inpatient Ancillary and Pharmacy file sources
Data reflects payments made under obligations - **FY12:** range C01033 - C28057, C91176, C91323; **FY13:** B39000, B39001, C31401, C31406, C31412, **FY14:** B40195, B40196; **FY15:** B50195, B50196; **FY16:** Y61176, Y61177, **FY17:** Y70177, Y71076, **FY18:** Y81176, Y81177, **FY19:** Y91176, Y91177
Data presented under the FBCS Roll-Up consists of data from the Fee Basis Claims System (FBCS) received in V20 Claims Processing Center.
Data reflects all claims received under all care categories Inpatient, Outpatient, Inpatient Ancillary and Pharmacy
Data reflected for FBCS uniques make up the number of unique patients in reference to the total number of claims

U.S. Department of Veterans Affairs
Veterans Health Administration
Chief Business Office Purchased Care
Informatics

Should you have any questions regarding this report, please contact
VHA OCC Informatics Leadership (VHAOCCInformaticsLeadership@va.gov)

VHA Office of Community Care, Program Oversight and Informatics
Informatics and Data Analytics (10D1E3)

				Agreement Date to FYTD	
				Disbursed	Unique Vets
VISN	STATION	NAME	Agreement Number	$99,926,810.12	10,516
1	402	Maliseet Health and Wellness Center (Houlton Band of Maliseet Indians)	VA241-15-H-0033	$12,317.00	5
1	402	Micmac Health Services	VA-402-IHS-0019	$57,408.00	14
1	402	Passamaquoddy Health Center	VA241-15-H-0032	$18,668.15	4
1	402	Pleasant Point Health Center (Passamaquoddy Tribe)	36C24118H0009	$0.00	0
1	650	Mashpee Wampanoag Tribal Health (Mashpee Wampanoag)	VA-650-IHS-0020	$1,340.00	1
2	528	St. Regis Mohawk Health Services	VA-528-15-H-0031	$0.00	0
2	528	Oneida Indian Nation Health Services	36C24219D0054	$0.00	0
6	637	Cherokee Indian Hospital (Eastern Band of Cherokee)	VA246-15-A-0073	$60,732.11	27
7	544	Catawba Service Unit	VA-534-IHS-0018	$17,144.70	8
10	515	Gun Lake Tribal Health (Match-E-Be-Nash-She-Wish Band of Potawatomi Indians)	36C25018H0125	$0.00	0
10	515	Pokagon Band Department of Health Services (Pokagon Band of Potawatomi)	VA250-17-H-0118	$64,871.18	10
10	655	Little Traverse Bay Band Health Department (Little Traverse Bay Band (LTBB) of Odawa Indians)	VA25116H0034	$0.00	0
12	585	Hannahville Potawatomi Indian Community Department of Health and Human Services	VA69O-15-G-0006	$0.00	0
12	585	Lac Vieux Desert Health Clinic and Pharmacy (Lac Vieux Desert (LVD) Band of Lake Superior Chippewa Indians)	VA69O-14-A-0002	$0.00	0
12	585	Peter Christensen Health Center (Lac Du Flambeau)	VA69O-17-G-0076	$14,991.47	7
12	585	Sault Ste. Marie Tribal Health Center (Sault Ste.Marie Tribe of Chippewa Indians)	VA69O-16-G-0081	$46,705.60	23
12	676	Ho-Chunk Health Care Center (Ho-Chunk Nation)	VA69O-15-G0036	$11,844.00	7
12	695	Stockbridge-Munsee Health and Wellness Center (Stockbridge Munsee)	VA69O-15-G-0007	$7,663.00	2
15	589A5	Haskell Indian Health Center	VA-589A5-IHS-0044	$239,951.16	59
15	589A5	Prairie Band Potawatomi Health Center (Prairie Band Potawatomi)	VA255-14-A-0030	$0.00	0
15	589A5	White Cloud Health Center	VA-589-IHS-0118	$0.00	0
15	589A6	Kickapoo Tribe in Kansas Health Center (Kickapoo Tribe)	VA255-16-A-0016	$28,158.54	4
16	586	Choctaw Health Center (Mississippi Band of Choctaw)	VA25615H0001	$139,923.60	32
16	629	Chitimacha Health Clinic (Chitimacha Tribe of Louisiana)	VA256-15-H-0114	$2,792.21	1
19	436	Browning PHS Indian Hospital (Blackfeet Service Unit)	VA-436-IHS-0001	$1,696,903.48	181
19	436	Crow/Northern Cheyenne Hospital	VA-436-IHS-0073	$561,096.97	87
19	436	CSKT Tribal Health Department (Confederated Salish and Kootenai Tribes)	VA259-15-H-0145	$614,986.98	134
19	436	Fort Belknap Hospital	VA-436-IHS-0074	$330,922.71	48
19	436	Fort Peck Service Unit	VA-436-IHS-0075	$774,222.29	114
19	436	Lame Deer Health Center	VA-666-IHS-0076	$465,682.64	53
19	436	Rocky Boy Health Center (Chippewa Cree Tribe in Montana)	VA 259-14-H-0150	$144,078.77	49
19	575	Southern Ute Indian Tribe Health Center	VA259-14-H-0135	$0.00	0
19	575	Utah Navajo Health System, Inc.	VA259-14-H-0148	$65,110.77	29
19	575	Ute Mountain Ute Health Center (Towoac)	VA-575-IHS-0056	$82,455.06	13
19	623	Wyandotte Bearskin Health Center	VA256-15H-009	$0.00	0
19	623	Choctaw Nation Health Care Center (Choctaw Nation)	VA256-13-H-0287	$5,308,784.60	565
19	623	Claremore Indian Hospital	VA-623-IHS-0040	$2,744,623.86	429
19	623	Muscogee (Creek) Nation Health System (Muscogee (Creek) Nation of Oklahoma)	VA256-13-H-0286	$3,060,181.41	358
19	623	Health Centers & Hospitals of Cherokee Nation	VA256-14-H-0005	$4,743,739.76	866
19	623	Indian Health Care Resource Center (IHCRC) of Tulsa	VA-623-IHS-0116	$117,123.10	55
19	623	Northeastern Tribal Health System (NTHS)	VA256-14-H-0003	$710,383.19	85
19	623	Pawhuska Indian Health Service	VA-623-IHS-0045	$165,842.40	27
19	623	Pawnee Indian Health Service (Pawnee Service Unit)	VA-623-IHS-0009	$1,373,089.36	116
19	623	Wah-Zha-Zhi Health Center	VA256-16-H-0151	$0.00	0
19	635	Absentee Shawnee Tribal Health Authority, Inc. (Absentee Shawnee Tribe)	VA256-14-H-0007	$43,114.08	18
19	635	Anadarko Indian Health Center	VA-635-IHS-0038	$449,496.16	77
19	635	Black Hawk Health Center (Sac and Fox Nation)	VA256-15-H-0002	$424,409.19	42
19	635	Carnegie Indian Health Center	VA-635-IHS-0039	$30,366.76	18
19	635	Chickasaw Nation Division of Health	VA256-14-H-0001	$1,840,235.35	345
19	635	Citizen Potawatomi Nation Health Clinic (Citizen Potawatomi Nation)	VA256-16-H-0013	$100,498.43	17
19	635	Clinton Indian Health Center	VA-635-IHS-0041	$309,689.25	48
19	635	El Reno Indian Health Center	VA-635-IHS-0042	$257,804.34	40
19	635	Kanza Health Center (Kaw Nation)	VA256-14-H-0006	$0.00	0

19	635	Kickapoo Health Center (Kickapoo Tribe of Oklahoma (KTO))	VA256-16-H-0152	$0.00	0
19	635	Lawton Indian Hospital	VA-635-IHS-0037	$1,462,598.61	201
19	635	Oklahoma City Indian Health Clinic	VA-635-IHS-0117	$163,459.18	51
19	635	Perkins Family Clinic (Iowa Tribe of Oklahoma)	VA25616H0023	$1,519.00	2
19	635	Watonga Indian Health Center	VA-635-IHS-0043	$12,730.43	13
19	635	Wewoka Indian Health Service	VA-635-IHS-0046	$402,071.90	59
19	635	White Eagle Health Center (White Eagle - Ponca Tribe of Oklahoma)	VA256-14-H-0002	$126,699.03	36
19	660	Fort Duchesne Health Center	VA-660-IHS-0033	$58,304.57	22
19	660	Fort Hall Indian Health Service (Not-Tsoo Gah-nee Indian Health Center)	VA-660-IHS-0017	$405,967.72	70
19	660	Newe Medical Clinic (Ely Shoshone)	VA259-14-H-0149	$0.00	0
19	660	Southern Bands Health Center (Elko)	VA-660-IHS-0034	$422,553.92	38
19	666	Wind River Family and Community Health Care (Northern Arapahoe Tribe)	VA259-16H-0153	$185,342.55	37
19	666	Wind River Health Center	VA-666-IHS-0077	$617,626.61	86
20	463	Alaska Native Tribal Med Ctr	VA260-12-A-0052	$28,337,762.85	929
20	463	Aleutian Pribilof Islands Association	VA260-12-A-0085	$10,364.78	4
20	463	Annette Island Service Unit (Metlakatla)	VA260-12-A-0084	$541.00	1
20	463	Arctic Slope Native Association Limited	VA260-12-A-0049	$204,731.45	19
20	463	Bristol Bay Area Health Corporation	VA260-12-A-0074	$349,325.38	40
20	463	Chickaloon Village Traditional Council	VA260-12-A-0054	$0.00	0
20	463	Chief Andrew Isacc Health Center (Native Village of Tanana)	VA260-12-A-0066	$0.00	0
20	463	Eastern Aleutian Tribes, Inc.	VA260-12-A-0053	$3,862.00	5
20	463	Native Village of Eklutna	VA260-12-A-0043	$0.00	0
20	463	Gulkana and Gakona Clinics (Copper River Native Association -Ahtna T'aene Nene')	VA260-12-A-0048	$51,518.48	6
20	463	Ilanka Community Health Center (Native Village of Eyak)	VA260-12-A-0073	$44,053.52	19
20	463	Kodiak Area Native Association Medical Clinic	VA260-12-A-0051	$564,217.55	91
20	463	Kenaitze Wellness Center (Kenaitze Indian Tribe)	VA260-12-A-0046	$341,736.36	40
20	463	Ketchikan Indian Community Tribal Health	VA260-12-A-0044	$562,672.29	44
20	463	Maniilaq Health Center	VA260-12-A-0071	$176,732.52	28
20	463	Mentasta Lake and Chistochina Clinics (Mount Sandford Tribal Consortium)	VA260-12-A-0093	$0.00	0
20	463	Ninilchik Community Clinic	VA260-13-A-0020	$0.00	0
20	463	Chugachmuit	VA260-12-A-0045	$3,915.95	3
20	463	Norton Sound Health Corporation	VA260-12-A-0072	$219,151.61	28
20	463	Southcentral Foundation	VA260-12-A-0055	$724,986.13	207
20	463	Southeast Alaska Regional Health Consortium	VA260-12-A-0050	$801,445.92	182
20	463	Seldovia Village Tribe	VA260-12-A-0075	$168,059.52	16
20	463	Tanana Chiefs Conference (Dena ' Nena ' Henash)	VA260-12-A-0047	$3,448,234.15	202
20	463	Yakutat Tlingit Tribe	VA260-12-A-0086	$21,131.00	3
20	463	Athabascan Tribal Government	VA260-12-A-0077	$66,909.46	12
20	463	Yukon-Kuskokwim Health Corporation	VA260-12-A-0041	$478,561.51	76
20	531	Owyhee Community Health Facility (Shoshone-Paiute Tribe)	VA260-15-A-0041	$8,091.18	4
20	648	Chemawa Indian Health Center	VA-648-IHS-0013	$147,918.62	28
20	648	Confederated Tribes of Grand Ronde Health and Wellness Center	VA260-13-A-0060	$153,968.64	38
20	648	Cowlitz Family Health (Cowlitz Tribe)	36C260-18-A-0012	$2,646.00	2
20	648	Siletz Community Health Clinic (Confederated Tribes of Siletz Indians)	VA260-15-A-0040	$19,857.66	11
20	648	Warm Springs Service Unit	VA-648-IHS-0005	$72,159.40	46
20	653	Cow Creek Health and Wellness Center (Cow Creek Band of Umpqua Tribe of Indians)	VA260-14-A-0097	$0.00	0
20	663	Lummi Tribal Health Center	VA26015A0090	$6,132.00	2
20	663	Nooksack Indian Tribe	VA260-16-A-0029	$14,876.00	1
20	663	Port Gamble S'Klallam Health Center	VA26016A0031	$0.00	0
20	663	Sophie Trettevick Indian Health Center (Makah Tribe)	VA260-15A-0039	$0.00	0
20	668	Benewah Medical Wellness Center (Coeur d' Alene)	VA260-13-A-0053	$0.00	0
20	668	Omak Tribal Health Clinic	VA-668-IHS-0016	$200,009.63	21
20	668	Colville Health Center	VA-668-IHS-0011	$362,998.35	45
20	668	David C. Wynecoop (Wellpinit) Health Center	VA-668-IHS-0012	$40,117.12	17
20	668	Lake Roosevelt Community Health Centers (Colville)	VA26015A0043	$11,871.18	7
20	687	Nimiipuu Health (Nez Perce Tribe)	VA260-14-A-0027	$187,984.90	24
20	687	White Swan Dental Clinic	VA-687-IHS-0015	$0.00	0
20	687	Yakama Indian Health Center	VA-687-IHS-0014	$173,035.35	38
20	687	Yellowhawk Tribal Health Center	VA260-13-A-0059	$132,448.68	46
21	570	Central Valley Indian Health, Inc.	VA261-14-S-0080	$0.00	0
21	612	Greenville Clinic Red Bluff Clinic	VA261-15-S-0030	$0.00	0
21	612	Karuk Tribal Health and Human Service Program	VA261-14-S-0210	$0.00	0
21	612	Pit River Health Service	VA261-15-S-0029	$2,012.00	1
21	654	Yerington Paiute Tribal Health Clinic	VA261-15-S-0070	$0.00	0

21	662	Consolidated Tribal Health Project	VA261-15-S-0031	$0.00	0
21	662	Kimaw Medical Center (Hoopa Valley Tribe)	VA261-14-S-0081	$0.00	0
21	662	Lake County Tribal Health Consortium	VA261-14-S-0127	$17,526.00	2
21	662	Sonoma County Indian Health Project (SCIHP)	VA261-14-S-0138	$0.00	0
21	662	United Indian Health Services, Inc./PHV-MED	VA261-14-S-0039	$63,193.00	21
22	501	Acoma-Canoncito-Laguna Indian Hospital (ACL)	VA-501-IHS-0052	$517,785.16	99
22	501	Albuquerque Indian Health Center	VA-501-IHS-0069	$216,454.91	67
22	501	Canoncito Band of Navajos Health Center, Inc.	36C25818A0006	$2,711.80	7
22	501	Canoncito Health Center	VA-501-IHS-0053	$42,747.19	13
22	501	Cochiti Health Center	VA-501-IHS-0079	$29,654.03	6
22	501	Crownpoint Service Unit	VA-501-IHS-0021	$1,255,150.48	223
22	501	Shiprock Service Unit (Northern Navajo)	VA-501-IHS-0022	$1,799,687.08	414
22	501	Dulce Health Center (Jicarilla)	VA-501-IHS-0060	$115,944.54	22
22	501	Gallup Service Unit	VA-501-IHS-0031	$3,558,829.71	559
22	501	Isleta Health Center	VA258-15-A-0034	$21,468.62	9
22	501	Jemez Health Center (Pueblo of Jemez)	VA258-14-A-0054	$135,230.88	44
22	501	Laguna Health Center	VA-501-IHS-0054	$120.88	1
22	501	Mescalero Indian Health Service	VA-501-IHS-0063	$47,036.97	6
22	501	San Felipe Health Center	VA-501-IHS-0081	$6,311.43	3
22	501	Santa Ana Health Center	VA-501-IHS-0071	$4,622.95	2
22	501	Santa Clara Health Center	VA-501-IHS-0080	$89,577.93	17
22	501	Santa Fe Indian Hospital	VA-501-IHS-0078	$146,440.61	38
22	501	Santo Domingo Health Center (Kewa Pueblo Health Corp)	VA258-15-A-0046	$48,021.88	30
22	501	Taos/Picuris Health Center	VA-501-IHS-0055	$291,155.41	35
22	501	Fort Defiance Indian Hospital Board, Inc.	VA-258-15-A-0058	$42,128.39	12
22	501	Zia Health Center	VA-501-IHS-0070	$19,186.72	10
22	501	Zuni Indian Health Service	VA-501-IHS-0057	$1,293,815.48	79
22	593	Irene Benn Medical Center (Moapa)	VA-593-IHS-0059	$48,166.30	3
22	605	Riverside-San Bernardino County Indian Health, Inc.	VA262-16-S-0052	$1,179.00	1
22	605	Toiyabe Indian Health Clinic	VA262-14-A-0025	$312.00	1
22	644	Phoenix Indian Medical Center	VA-644-IHS-0036	$2,719,478.30	432
22	644	San Carlos Indian Hospital	VA-644-IHS-0025	$215,060.11	51
22	644	Wassaja Memorial Health Center (Fort McDowell Yavapai Nation)	VA258-15-A-0010	$0.00	0
22	644	Whiteriver Indian Hospital	VA-644-IHS-0032	$177,123.18	21
22	649	Chinle Service Unit	VA-649-IHS-0008	$1,904,529.11	388
22	649	Hopi Health Care Center	VA-649-IHS-0026	$1,087,343.06	142
22	649	Kayenta Health Center	VA-649-IHS-0035	$78,130.49	32
22	649	Native American Cardiology Program	VA-649-IHS-0072	$10,237.90	21
22	649	Parker Indian Hospital	VA-649-IHS-0023	$484,692.74	61
22	649	Peach Springs Health Center	VA-649-IHS-0024	$136,967.39	21
22	649	Tuba City Regional Health Corporation (Navajo Nation)	VA649-THP-0018	$435,054.79	140
22	649	Winslow Indian Health Care Center (WIHCC)	VA258-14-A-0030	$438,943.26	135
22	664	Indian Health Council, Inc.	VA262-14-A-0003	$170,225.63	32
22	664	Southern Indian Health Council, Inc.	VA262-14-A-0002	$5,847.00	4
22	664	Sycuan Medical & Dental Center (Sycuan Band of the Kumeyaay Nation)	36C2621850001	$0.00	0
22	678	Fort Yuma Indian Health Center	VA-678-IHS-0027	$67,360.90	11
22	678	San Carlos Apache Rural Healthcare Center (San Carlos Apache Tribe)	VA258-16-A-0048	$319,939.89	67
22	678	San Xavier Health Center	VA-678-IHS-0029	$81,750.27	19
22	678	Santa Rosa Health Center	VA-678-IHS-0030	$21,314.71	7
22	678	Sells Service Unit	VA-678-IHS-0010	$219,481.74	48
22	678	Tohono O'odham Nation	36C25818A005	$173,537.48	51
22	678	San Simon Health Center	VA-678-IHS-0028	$24,997.97	14
22	691	Santa Ynez Tribal Health Clinic	VA262-14-A-0127	$0.00	0
23	437	Cass Lake Hospital	VA-437-IHS-0058	$1,196,148.33	171
23	437	Quentin N. Burdick Memorial Health Care Facility (Belcourt/ Turtle Mountain Band)	VA-437-IHS-0050	$1,140,764.47	115
23	437	Red Lake Hospital	VA-437-IHS-0051	$1,029,992.82	56
23	437	Spirit Lake Health Center	36C26318M0002	$45,003.17	21
23	437	Spirit Lake Health Center (Ft. Totten)	VA-437-IHS-0048	$236,432.59	33
23	437	White Earth Health Center	VA-437-IHS-0003	$324,126.69	83
23	437	Woodrow Wilson Keeble Memorial Health Care Center (Sisseton Wahpeton Oyate)	VA-437-IHS-0002	$825,831.85	100
23	438	Flandreau Santee Sioux Tribe (FSST)	VA263-14-X-0152	$51,593.72	9
23	438	Fort Thompson IHS Health Center	VA-438-IHS-0061	$196,618.67	25
23	438	Lower Brule IHS Health Center	VA-438-IHS-0047	$234,824.44	34
23	438	Wagner Healthcare Center – IHS (Yankton-Wagner Service Unit)	VA-438-IHS-0004	$457,482.12	71

23	568	Eagle Butte PHS Indian Hospital (Cheyenne River Service Unit)	VA-568-IHS-0007	$1,702,026.96	185
23	568	Fort Yates IHS Hospital	VA-568-IHS-0062	$340,909.53	121
23	568	Kyle Health Center	VA-568A4-IHS-0066	$236,657.99	45
23	568	McLaughlin Health Center	VA-568-IHS-0068	$568,660.82	75
23	568	Pine Ridge Indian Health Service	VA-568A4-IHS-0064	$1,467,278.60	203
23	568	Rapid City IHS Hospital (Rapid City Service Unit)	VA-568-IHS-0006	$524,556.53	118
23	568	Rosebud IHS Hospital	VA-568A4-IHS-0067	$1,186,985.45	177
23	568	Wanblee Indian Health Service Center	VA-568A4-IHS-0065	$179,935.58	34
23	618	Fond du Lac Reservation	VA263-14-X-0002	$34,642.15	18
23	618	Lac Courte Oreilles	VA263-14-X-0165	$38,198.00	17
23	618	Red Cliff Community Health Center (Red Cliff)	VA26315X0040	$23,904.00	5
23	636	Carl T Curtis Health Ed Center (Omaha Tribe of Nebraska)	36C2318M003	$0.00	0
23	636	Ponca of Nebraska	VA263-14-X-0007	$0.00	0
23	636	Santee Health and Wellness Center (Santee Sioux Nation)	VA263-17-S-0138	$824.00	2
23	636	Winnebago IHS Hospital	VA-636-IHS-0049	$80,936.46	38
23	636A8	Meskwaki Tribal Health (Sac and Fox Tribe of the Mississippi in Iowa)	VA263-14-H-0191	$79,942.64	18
23	656	Bois Forte Band of Chippewa	36C26319H0001	$1,792.00	2

				FY19	
VISN	STATION	NAME	Agreement Number	Total Disbursed	Unique Vets
1	402	Maliseet Health and Wellness Center (Houlton Band of Maliseet Indians)	VA241-15-H-0033	$0.00	0
1	402	Micmac Health Services	VA-402-IHS-0019	$3,723.00	4
1	402	Passamaquoddy Health Center	VA241-15-H-0032	$2,738.21	3
1	402	Pleasant Point Health Center (Passamaquoddy Tribe)	36C2418H0009	$0.00	0
1	650	Mashpee Wampanoag Tribal Health (Mashpee Wampanoag)	VA-650-IHS-0020	$0.00	0
2	528	St. Regis Mohawk Health Services	VA-528-15-H-0031	$0.00	0
2	528	Oneida Indian Nation Health Services	36C2421H00054	$0.00	0
6	637	Cherokee Indian Hospital (Eastern Band of Cherokee)	VA246-15-A-0073	$22,844.38	18
7	544	Catawba Service Unit	VA-534-IHS-0018	$0.00	0
10	515	Gun Lake Tribal Health (Match-E-Be-Nash-She-Wish Band of Potawatomi Indians)	36C2501BH0125	$0.00	0
10	515	Pokagon Band Department of Health Services (Pokagon Band of Potawatomi)	VA250-17-H-0118	$37,697.18	10
10	655	Little Traverse Bay Band Health Department (Little Traverse Bay Band (LTBB) of Odawa Indians)	VA25116H0034	$0.00	0
12	585	Hannahville Potawatomi Indian Community Department of Health and Human Services	VA69D-15-G-0006	$0.00	0
12	585	Lac Vieux Desert Health Clinic and Pharmacy (Lac Vieux Desert (LVD) Band of Lake Superior Chippewa Indians)	VA69D-14-A-0002	$0.00	0
12	585	Peter Christensen Health Center (Lac Du Flambeau)	VA69D-17-G-0076	$7,987.47	6
12	585	Sault Ste. Marie Tribal Health Center (Sault Ste.Marie Tribe of Chippewa Indians)	VA69D-16-G-0081	$46,705.60	23
12	676	Ho-Chunk Health Care Center (Ho-Chunk Nation)	VA69D-15-G0036	$9,462.00	4
12	695	Stockbridge-Munsee Health and Wellness Center (Stockbridge Munsee)	VA69D-15-G-0007	$0.00	0
15	589A5	Haskell Indian Health Center	VA-589A5-IHS-0044	$28,655.30	12
15	589A5	Prairie Band Potawatomi Health Center (Prairie Band Potawatomi)	VA255-14-A-0030	$0.00	0
15	589A5	White Cloud Health Center	VA-589-IHS-0118	$0.00	0
15	589A6	Kickapoo Tribe in Kansas Health Center (Kickapoo Tribe)	VA255-16-A-0016	$7,826.00	3
16	586	Choctaw Health Center (Mississippi Band of Choctaw)	VA25615H0001	$34,808.66	10
16	629	Chitimacha Health Clinic (Chitimacha Tribe of Louisiana)	VA256-15-H-0114	$824.00	1
19	436	Browning PHS Indian Hospital (Blackfeet Service Unit)	VA-436-IHS-0001	$133,024.85	82
19	436	Crow/Northern Cheyenne Hospital	VA-436-IHS-0073	$11,034.27	40
19	436	CSKT Tribal Health Department (Confederated Salish and Kootenai Tribes)	VA259-15-H-0145	$14,742.00	12
19	436	Fort Belknap Hospital	VA-436-IHS-0074	$31,362.66	25
19	436	Fort Peck Service Unit	VA-436-IHS-0075	$66,349.17	60
19	436	Lame Deer Health Center	VA-666-IHS-0076	$2,080.78	11
19	436	Rocky Boy Health Center (Chippewa Cree Tribe in Montana)	VA 259-14-H-0150	$0.00	0
19	575	Southern Ute Indian Tribe Health Center	VA259-14-H-0135	$0.00	0
19	575	Utah Navajo Health System, Inc.	VA259-14-H-0148	$4,326.00	9
19	575	Ute Mountain Ute Health Center (Towoac)	VA-575-IHS-0056	$42,957.61	9
19	623	Wyandotte Bearskin Health Center	VA256-15H-009	$0.00	0
19	623	Choctaw Nation Health Care Center (Choctaw Nation)	VA256-13-H-0287	$1,035,632.44	344
19	623	Claremore Indian Hospital	VA-623-IHS-0040	$442,709.18	212
19	623	Muscogee (Creek) Nation Health System (Muscogee (Creek) Nation of Oklahoma)	VA256-13-H-0286	$525,656.67	183
19	623	Health Centers & Hospitals of Cherokee Nation	VA256-14-H-0005	$818,481.26	454
19	623	Indian Health Care Resource Center (IHCRC) of Tulsa	VA-623-IHS-0116	$11,003.82	20
19	623	Northeastern Tribal Health System (NTHS)	VA256-14-H-0003	$198,682.93	59
19	623	Pawhuska Indian Health Service	VA-623-IHS-0045	$0.00	0
19	623	Pawnee Indian Health Service (Pawnee Service Unit)	VA-623-IHS-0009	$198,208.45	46
19	623	Wah-Zha-Zhi Health Center	VA256-16-H-0151	$0.00	0

19	635	Absentee Shawnee Tribal Health Authority, Inc. (Absentee Shawnee Tribe)	VA256-14-H-0007	$3,659.34	4
19	635	Anadarko Indian Health Center	VA-635-IHS-0038	$90,292.72	38
19	635	Black Hawk Health Center (Sac and Fox Nation)	VA256-15-H-0002	$67,475.35	20
19	635	Carnegie Indian Health Center	VA-635-IHS-0039	$4,339.81	5
19	635	Chickasaw Nation Division of Health	VA256-14-H-0001	$329,269.53	132
19	635	Citizen Potawatomi Nation Health Clinic (Citizen Potawatomi Nation)	VA256-16-H-0013	$14,172.02	9
19	635	Clinton Indian Health Center	VA-635-IHS-0041	$37,701.71	21
19	635	El Reno Indian Health Center	VA-635-IHS-0042	$53,459.67	23
19	635	Kanza Health Center (Kaw Nation)	VA256-14-H-0006	$0.00	0
19	635	Kickapoo Health Center (Kickapoo Tribe of Oklahoma (KTO))	VA256-16-H-0152	$0.00	0
19	635	Lawton Indian Hospital	VA-635-IHS-0037	$311,368.02	84
19	635	Oklahoma City Indian Health Clinic	VA-635-IHS-0117	$28,781.00	20
19	635	Perkins Family Clinic (Iowa Tribe of Oklahoma)	VA2516H0023	$0.00	0
19	635	Watonga Indian Health Center	VA-635-IHS-0043	$3,111.73	4
19	635	Wewoka Indian Health Service	VA-635-IHS-0046	$44,236.83	29
19	635	White Eagle Health Center (White Eagle - Ponca Tribe of Oklahoma)	VA256-14-H-0002	$41,137.19	19
19	660	Fort Duchesne Health Center	VA-660-IHS-0033	$12,539.40	15
19	660	Fort Hall Indian Health Service (Not-Tsoo Gah-nee Indian Health Center)	VA-660-IHS-0017	$39,543.46	17
19	660	Newe Medical Clinic (Ely Shoshone)	VA259-14-H-0149	$0.00	0
19	660	Southern Bands Health Center (Elko)	VA-660-IHS-0034	$51,362.54	28
19	666	Wind River Family and Community Health Care (Northern Arapahoe Tribe)	VA259-16H-0153	$28,061.68	25
19	666	Wind River Health Center	VA-666-IHS-0077	$17,618.00	32
20	463	Alaska Native Tribal Med Ctr	VA260-12-A-0052	$4,091,596.60	498
20	463	Aleutian Pribilof Islands Association	VA260-12-A-0085	$0.00	0
20	463	Annette Island Service Unit (Metlakatla)	VA260-12-A-0084	$0.00	0
20	463	Arctic Slope Native Association Limited	VA260-12-A-0049	$14,424.00	4
20	463	Bristol Bay Area Health Corporation	VA260-12-A-0074	$150,991.26	25
20	463	Chickaloon Village Traditional Council	VA260-12-A-0054	$0.00	0
20	463	Chief Andrew Isaac Health Center (Native Village of Tanana)	VA260-12-A-0066	$0.00	0
20	463	Eastern Aleutian Tribes, Inc.	VA260-12-A-0053	$0.00	0
20	463	Native Village of Eklutna	VA260-12-A-0043	$0.00	0
20	463	Gulkana and Gakona Clinics (Copper River Native Association -Ahtna T'aene Nene')	VA260-12-A-0048	$12,067.13	2
20	463	Ilanka Community Health Center (Native Village of Eyak)	VA260-12-A-0073	$0.00	0
20	463	Kodiak Area Native Association Medical Clinic	VA260-12-A-0051	$66,753.48	20
20	463	Kenaitze Wellness Center (Kenaitze Indian Tribe)	VA260-12-A-0046	$68,168.67	18
20	463	Ketchikan Indian Community Tribal Health	VA260-12-A-0044	$68,228.10	18
20	463	Manilaq Health Center	VA260-12-A-0071	$9,652.96	6
20	463	Mentasta Lake and Chistochina Clinics (Mount Sandford Tribal Consortium)	VA260-12-A-0093	$0.00	0
20	463	Ninilchik Community Clinic	VA260-13-A-0020	$0.00	0
20	463	Chugachmiut	VA260-12-A-0045	$2,604.00	3
20	463	Norton Sound Health Corporation	VA260-12-A-0072	$41,306.28	7
20	463	Southcentral Foundation	VA260-12-A-0055	$94,340.00	47
20	463	Southeast Alaska Regional Health Consortium	VA260-12-A-0050	$207,157.36	52
20	463	Seldovia Village Tribe	VA260-12-A-0075	$48,321.00	6
20	463	Tanana Chiefs Conference (Dena ' Nena ' Henash)	VA260-12-A-0047	$617,885.19	109
20	463	Yakutat Tlingit Tribe	VA260-12-A-0086	$3,381.00	2
20	463	Athabascan Tribal Government	VA260-12-A-0077	$16,637.56	7
20	463	Yukon-Kuskokwim Health Corporation	VA260-12-A-0041	$66,676.56	21
20	531	Owyhee Community Health Facility (Shoshone-Paiute Tribe)	VA260-15-A-0041	$3,835.00	2
20	648	Chemawa Indian Health Center	VA-648-IHS-0013	$20,638.62	11
20	648	Confederated Tribes of Grand Ronde Health and Wellness Center	VA260-13-A-0060	$27,342.00	14
20	648	Cowlitz Family Health (Cowlitz Tribe)	36C260-18-A-0012	$1,365.00	1
20	648	Siletz Community Health Clinic (Confederated Tribes of Siletz Indians)	VA260-15-A-0040	$2,487.55	4
20	648	Warm Springs Service Unit	VA-648-IHS-0005	$1,763.68	5
20	653	Cow Creek Health and Wellness Center (Cow Creek Band of Umpqua Tribe of Indians)	VA260-14-A-0097	$0.00	0
20	663	Lummi Tribal Health Center	VA2615A0090	$6,132.00	2
20	663	Nooksack Indian Tribe	VA260-16-A-0029	$2,163.00	1
20	663	Port Gamble S'Klallam Health Center	VA2616A0031	$0.00	0
20	663	Sophie Trettevick Indian Health Center (Makah Tribe)	VA260-15A-0039	$0.00	0
20	668	Benewah Medical Wellness Center (Coeur d' Alene)	VA260-13-A-0053	$0.00	0
20	668	Omak Tribal Health Clinic	VA-668-IHS-0016	$44,482.69	13
20	668	Colville Health Center	VA-668-IHS-0011	$73,968.91	25
20	668	David C. Wynecoop (Wellpinit) Health Center	VA-668-IHS-0012	$3,147.91	4
20	668	Lake Roosevelt Community Health Centers (Colville)	VA2615A0043	$0.00	0

20	687	Nimiipuu Health (Nez Perce Tribe)	VA260-14-A-0027	$26,953.97	10
20	687	White Swan Dental Clinic	VA-687-IHS-0015	$0.00	0
20	687	Yakama Indian Health Center	VA-687-IHS-0014	$13,091.48	9
20	687	Yellowhawk Tribal Health Center	VA260-13-A-0059	$35,063.65	26
21	570	Central Valley Indian Health, Inc.	VA261-14-S-0080	$0.00	0
21	612	Greenville Clinic Red Bluff Clinic	VA261-15-S-0030	$0.00	0
21	612	Karuk Tribal Health and Human Service Program	VA261-14-S-0210	$0.00	0
21	612	Pit River Health Service	VA261-15-S-0029	$2,012.00	1
21	654	Yerington Paiute Tribal Health Clinic	VA261-15-S-0070	$0.00	0
21	662	Consolidated Tribal Health Project	VA261-15-S-0031	$0.00	0
21	662	Kimaw Medical Center (Hoopa Valley Tribe)	VA261-14-S-0081	$0.00	0
21	662	Lake County Tribal Health Consortium	VA261-14-S-0127	$0.00	0
21	662	Sonoma County Indian Health Project (SCIHP)	VA261-14-S-0138	$0.00	0
21	662	United Indian Health Services, Inc./PHV-MED	VA261-14-S-0039	$17,798.00	14
22	501	Acoma-Canoncito-Laguna Indian Hospital (ACL)	VA-501-IHS-0052	$66,058.72	26
22	501	Albuquerque Indian Health Center	VA-501-IHS-0069	$50,007.03	29
22	501	Canoncito Band of Navajos Health Center, Inc.	36C25818A0006	$2,633.51	7
22	501	Canoncito Health Center	VA-501-IHS-0053	$0.00	0
22	501	Cochiti Health Center	VA-501-IHS-0079	$715.78	1
22	501	Crownpoint Service Unit	VA-501-IHS-0021	$129,064.13	81
22	501	Shiprock Service Unit (Northern Navajo)	VA-501-IHS-0022	$344,374.87	203
22	501	Dulce Health Center (Jicarilla)	VA-501-IHS-0060	$15,180.00	9
22	501	Gallup Service Unit	VA-501-IHS-0031	$544,205.07	243
22	501	Isleta Health Center	VA258-15-A-0034	$5,056.00	5
22	501	Jemez Health Center (Pueblo of Jemez)	VA258-14-A-0054	$27,612.62	19
22	501	Laguna Health Center	VA-501-IHS-0054	$0.00	0
22	501	Mescalero Indian Health Service	VA-501-IHS-0063	$4,382.00	3
22	501	San Felipe Health Center	VA-501-IHS-0081	$1,648.00	2
22	501	Santa Ana Health Center	VA-501-IHS-0071	$1,758.85	1
22	501	Santa Clara Health Center	VA-501-IHS-0080	$15,854.04	7
22	501	Santa Fe Indian Hospital	VA-501-IHS-0078	$20,977.94	11
22	501	Santo Domingo Health Center (Kewa Pueblo Health Corp)	VA258-15-A-0046	$26,855.88	24
22	501	Taos/Picuris Health Center	VA-501-IHS-0055	$37,675.20	17
22	501	Fort Defiance Indian Hospital Board, Inc.	VA-258-15-A-0058	$42,128.39	12
22	501	Zia Health Center	VA-501-IHS-0070	$2,236.25	3
22	501	Zuni Indian Health Service	VA-501-IHS-0057	$352,809.56	44
22	593	Irene Benn Medical Center (Moapa)	VA-593-IHS-0059	$11,102.16	2
22	605	Riverside-San Bernardino County Indian Health, Inc.	VA262-16-S-0052	$0.00	0
22	605	Toiyabe Indian Health Clinic	VA262-14-A-0025	$0.00	0
22	644	Phoenix Indian Medical Center	VA-644-IHS-0036	$520,423.23	160
22	644	Wassaja Memorial Health Center (Fort McDowell Yavapai Nation)	VA258-15-A-0010	$0.00	0
22	644	Whiteriver Indian Hospital	VA-644-IHS-0032	$36,958.87	17
22	649	Chinle Service Unit	VA-649-IHS-0008	$312,869.97	164
22	649	Hopi Health Care Center	VA-649-IHS-0026	$130,811.41	62
22	649	Kayenta Health Center	VA-649-IHS-0035	$4,331.27	7
22	649	Native American Cardiology Program	VA-649-IHS-0072	$412.00	1
22	649	Parker Indian Hospital	VA-649-IHS-0023	$47,805.28	23
22	649	Peach Springs Health Center	VA-649-IHS-0024	$30,525.69	12
22	649	Tuba City Regional Health Corporation (Navajo Nation)	VA649-THP-0018	$2,590.00	3
22	649	Winslow Indian Health Care Center (WIHCC)	VA258-14-A-0030	$118,833.62	87
22	664	Indian Health Council, Inc.	VA262-14-A-0003	$26,399.34	16
22	664	Southern Indian Health Council, Inc.	VA262-14-A-0002	$0.00	0
22	664	Sycuan Medical & Dental Center (Sycuan Band of the Kumeyaay Nation)	36C2621850001	$0.00	0
22	678	Fort Yuma Indian Health Center	VA-678-IHS-0027	$4,524.65	8
22	678	San Carlos Apache Rural Healthcare Center (San Carlos Apache Tribe)	VA258-16-A-0048	$200,763.88	49
22	678	Sells Indian Hospital San Xavier Health Center San Simon Health Center Santa Rosa Clinic	VA-678-IHS-0010	$42.75	1
22	678	Tohono O'odham Nation	36C25818A005	$153,438.48	50
22	691	Santa Ynez Tribal Health Clinic	VA262-14-A-0127	$0.00	0
23	437	Cass Lake Hospital	VA-437-IHS-0058	$392,888.41	104
23	437	Quentin N. Burdick Memorial Health Care Facility (Belcourt/ Turtle Mountain Band)	VA-437-IHS-0050	$123,582.00	31
23	437	Red Lake Hospital	VA-437-IHS-0051	$152,859.02	30
23	437	Spirit Lake Health Center	36C26318M0002	$44,576.17	21
23	437	White Earth Health Center	VA-437-IHS-0003	$75,409.10	33
23	437	Woodrow Wilson Keeble Memorial Health Care Center (Sisseton Wahpeton Oyate)	VA-437-IHS-0002	$111,497.95	50

23	438	Flandreau Santee Sioux Tribe (FSST)	VA263-14-X-0152	$8,535.27	4
23	438	Fort Thompson IHS Health Center	VA-438-IHS-0061	$12,527.79	9
23	438	Lower Brule IHS Health Center	VA-438-IHS-0047	$33,224.29	20
23	438	Wagner Healthcare Center – IHS (Yankton-Wagner Service Unit)	VA-438-IHS-0004	$69,491.10	30
23	568	Eagle Butte PHS Indian Hospital (Cheyenne River Service Unit)	VA-568-IHS-0007	$284,094.04	84
23	568	Fort Yates IHS Hospital	VA-568-IHS-0062	$38,473.61	43
23	568	Kyle Health Center	VA-568A4-IHS-0066	$0.00	0
23	568	McLaughlin Health Center	VA-568-IHS-0068	$73,187.65	31
23	568	Pine Ridge Indian Health Service	VA-568A4-IHS-0064	$376.00	1
23	568	Rapid City IHS Hospital (Rapid City Service Unit)	VA-568-IHS-0006	$36,465.03	33
23	568	Rosebud IHS Hospital	VA-568A4-IHS-0067	$155,758.27	61
23	568	Wanblee Indian Health Service Center	VA-568A4-IHS-0065	$0.00	0
23	618	Fond du Lac Reservation	VA263-14-X-0002	$824.00	1
23	618	Lac Courte Oreilles	VA263-14-X-0165	$18,140.00	12
23	618	Red Cliff Community Health Center (Red Cliff)	VA26315X0040	$13,412.00	5
23	636	Carl T Curtis Health Ed Center (Omaha Tribe of Nebraska)	36C2318M003	$0.00	0
23	636	Ponca of Nebraska	VA263-14-X-0007	$0.00	0
23	636	Santee Health and Wellness Center (Santee Sioux Nation)	VA263-17-S-0138	$824.00	2
23	636	Winnebago IHS Hospital	VA-636-IHS-0049	$0.00	0
23	636A8	Meskwaki Tribal Health (Sac and Fox Tribe of the Mississippi in Iowa)	VA263-14-H-0191	$16,803.00	9
23	656	Bois Forte Band of Chippewa	36C26319H0001	$1,792.00	2
			Grand Total	**$15,740,697.64**	**4,871**

				FY18	
VISN	STATION	NAME	Agreement Number	Total Disbursed	Unique Vets
1	402	Maliseet Health and Wellness Center (Houlton Band of Maliseet Indians)	VA241-15-H-0033	$3,600.00	2
1	402	Micmac Health Services	VA-402-IHS-0019	$7,556.00	4
1	402	Passamaquoddy Health Center	VA241-15-H-0032	$9,024.61	4
1	402	Pleasant Point Health Center (Passamaquoddy Tribe)	36C2411BH0009	$0.00	0
1	650	Mashpee Wampanoag Tribal Health (Mashpee Wampanoag)	VA-650-IHS-0020	$0.00	0
2	528	St. Regis Mohawk Health Services	VA-528-15-H-0031	$0.00	0
6	637	Cherokee Indian Hospital (Eastern Band of Cherokee)	VA246-15-A-0073	$38,087.73	18
7	544	Catawba Service Unit	VA-534-IHS-0018	$145.76	1
10	515	Gun Lake Tribal Health (Match-E-Be-Nash-She-Wish Band of Potawatomi Indians)	36C25018H0125	$0.00	0
10	515	Pokagon Band Department of Health Services (Pokagon Band of Potawatomi)	VA250-17-H-0118	$27,174.00	6
10	655	Little Traverse Bay Band Health Department (Little Traverse Bay Band (LTBB) of Odawa Indians)	VA25116H0034	$0.00	0
12	585	Hannahville Potawatomi Indian Community Department of Health and Human Services	VA69D-15-G-0006	$0.00	0
12	585	Lac Vieux Desert Health Clinic and Pharmacy (Lac Vieux Desert (LVD) Band of Lake Superior Chippewa Indians)	VA69D-14-A-0002	$0.00	0
12	585	Peter Christensen Health Center (Lac Du Flambeau)	VA69D-17-G-0076	$7,004.00	3
12	585	Sault Ste. Marie Tribal Health Center (Sault Ste.Marie Tribe of Chippewa Indians)	VA69D-16-G-0081	$0.00	0
12	676	Ho-Chunk Health Care Center (Ho-Chunk Nation)	VA69D-15-G0036	$2,382.00	4
12	695	Stockbridge-Munsee Health and Wellness Center (Stockbridge Munsee)	VA69D-15-G-0007	$1,504.00	1
15	589A5	Haskell Indian Health Center	VA-589A5-IHS-0044	$56,249.68	17
15	589A5	Prairie Band Potawatomi Health Center (Prairie Band Potawatomi)	VA255-14-A-0030	$0.00	0
15	589A5	White Cloud Health Center	VA-589-IHS-0118	$0.00	0
15	589A6	Kickapoo Tribe in Kansas Health Center (Kickapoo Tribe)	VA255-16-A-0016	$20,332.54	4
16	586	Choctaw Health Center (Mississippi Band of Choctaw)	VA2561SH0001	$46,687.74	20
16	629	Chitimacha Health Clinic (Chitimacha Tribe of Louisiana)	VA256-15-H-0114	$1,592.21	1
19	436	Browning PHS Indian Hospital (BlackFeet Service Unit)	VA-436-IHS-0001	$248,564.33	107
19	436	Crow/Northern Cheyenne Hospital	VA-436-IHS-0073	$11,654.47	41
19	436	CSKT Tribal Health Department (Confederated Salish and Kootenai Tribes)	VA259-15-H-0145	$30,812.21	47
19	436	Fort Belknap Hospital	VA-436-IHS-0074	$40,045.42	20
19	436	Fort Peck Service Unit	VA-436-IHS-0075	$67,367.57	67
19	436	Lame Deer Health Center	VA-666-IHS-0076	$13,223.66	21
19	436	Rocky Boy Health Center (Chippewa Cree Tribe in Montana)	VA 259-14-H-0150	$20,310.13	20
19	575	Southern Ute Indian Tribe Health Center	VA259-14-H-0135	$0.00	0
19	575	Utah Navajo Health System, Inc.	VA259-14-H-0148	$9,939.77	13
19	575	Ute Mountain Ute Health Center (Towoac)	VA-575-IHS-0056	$15,437.52	7
19	623	Wyandotte Bearskin Health Center	VA256-15H-009	$0.00	0
19	623	Choctaw Nation Health Care Center (Choctaw Nation)	VA256-13-H-0287	$1,318,266.15	324
19	623	Claremore Indian Hospital	VA-623-IHS-0040	$660,998.40	180
19	623	Muscogee (Creek) Nation Health System (Muscogee (Creek) Nation of Oklahoma)	VA256-13-H-0286	$969,731.43	195
19	623	Health Centers & Hospitals of Cherokee Nation	VA256-14-H-0005	$725,491.50	462

19	623	Indian Health Care Resource Center (IHCRC) of Tulsa	VA-623-IHS-0116	$21,823.82	28
19	623	Northeastern Tribal Health System (NTHS)	VA256-14-H-0003	$247,193.41	58
19	623	Pawhuska Indian Health Service	VA-623-IHS-0045	$0.00	0
19	623	Pawnee Indian Health Service (Pawnee Service Unit)	VA-623-IHS-0009	$276,221.02	55
19	623	Wah-Zha-Zhi Health Center	VA256-16-H-0151	$0.00	0
19	635	Absentee Shawnee Tribal Health Authority, Inc. (Absentee Shawnee Tribe)	VA256-14-H-0007	$28,567.42	14
19	635	Anadarko Indian Health Center	VA-635-IHS-0038	$102,093.29	45
19	635	Black Hawk Health Center (Sac and Fox Nation)	VA256-15-H-0002	$93,059.20	28
19	635	Carnegie Indian Health Center	VA-635-IHS-0039	$7,754.23	5
19	635	Chickasaw Nation Division of Health	VA256-14-H-0001	$393,459.73	168
19	635	Citizen Potawatomi Nation Health Clinic (Citizen Potawatomi Nation)	VA256-16-H-0013	$34,557.41	13
19	635	Clinton Indian Health Center	VA-635-IHS-0041	$59,784.80	21
19	635	El Reno Indian Health Center	VA-635-IHS-0042	$76,340.01	20
19	635	Kanza Health Center (Kaw Nation)	VA256-14-H-0006	$0.00	0
19	635	Kickapoo Health Center (Kickapoo Tribe of Oklahoma (KTO))	VA256-16-H-0152	$0.00	0
19	635	Lawton Indian Hospital	VA-635-IHS-0037	$333,803.56	105
19	635	Oklahoma City Indian Health Clinic	VA-635-IHS-0117	$50,790.60	23
19	635	Perkins Family Clinic (Iowa Tribe of Oklahoma)	VA2561H0023	$1,519.00	2
19	635	Watonga Indian Health Center	VA-635-IHS-0043	$3,050.61	4
19	635	Wewoka Indian Health Service	VA-635-IHS-0046	$85,148.09	34
19	635	White Eagle Health Center (White Eagle - Ponca Tribe of Oklahoma)	VA256-14-H-0002	$24,577.12	12
19	660	Fort Duchesne Health Center	VA-660-IHS-0033	$18,948.76	13
19	660	Fort Hall Indian Health Service (Not-Tsoo Gah-nee Indian Health Center)	VA-660-IHS-0017	$30,228.16	17
19	660	Newe Medical Clinic (Ely Shoshone)	VA259-14-H-0149	$0.00	0
19	660	Southern Bands Health Center (Elko)	VA-660-IHS-0034	$70,500.52	23
19	666	Wind River Family and Community Health Care (Northern Arapahoe Tribe)	VA259-16H-0153	$30,212.06	16
19	666	Wind River Health Center	VA-666-IHS-0077	$51,628.66	40
20	463	Alaska Native Tribal Med Ctr	VA260-12-A-0052	$5,737,218.91	534
20	463	Aleutian Pribilof Islands Association	VA260-12-A-0085	$8,665.27	3
20	463	Annette Island Service Unit (Metlakatla)	VA260-12-A-0084	$0.00	0
20	463	Arctic Slope Native Association Limited	VA260-12-A-0049	$13,019.00	4
20	463	Bristol Bay Area Health Corporation	VA260-12-A-0074	$56,931.91	18
20	463	Chickaloon Village Traditional Council	VA260-12-A-0054	$0.00	0
20	463	Chief Andrew Isacc Health Center (Native Village of Tanana)	VA260-12-A-0066	$0.00	0
20	463	Eastern Aleutian Tribes, Inc.	VA260-12-A-0053	$616.00	1
20	463	Native Village of Eklutna	VA260-12-A-0043	$0.00	0
20	463	Gulkana and Gakona Clinics (Copper River Native Association -Ahtna T'aene Nene')	VA260-12-A-0048	$16,573.28	5
20	463	Ilanka Community Health Center (Native Village of Eyak)	VA260-12-A-0073	$1,222.85	1
20	463	Kodiak Area Native Association Medical Clinic	VA260-12-A-0051	$55,085.92	19
20	463	Kenaitze Wellness Center (Kenaitze Indian Tribe)	VA260-12-A-0046	$74,022.46	27
20	463	Ketchikan Indian Community Tribal Health	VA260-12-A-0044	$128,901.60	28
20	463	Manilaq Health Center	VA260-12-A-0071	$105,693.79	21
20	463	Mentasta Lake and Chistochina Clinics (Mount Sandford Tribal Consortium)	VA260-12-A-0093	$0.00	0
20	463	Ninilchik Community Clinic	VA260-13-A-0020	$0.00	0
20	463	Chugachmuit	VA260-12-A-0045	$1,311.95	2
20	463	Norton Sound Health Corporation	VA260-12-A-0072	$14,957.40	6
20	463	Southcentral Foundation	VA260-12-A-0055	$135,919.69	75
20	463	Southeast Alaska Regional Health Consortium	VA260-12-A-0050	$139,990.44	55
20	463	Seldovia Village Tribe	VA260-12-A-0075	$77,756.22	6
20	463	Tanana Chiefs Conference (Dena ' Nena ' Henash)	VA260-12-A-0047	$617,658.39	121
20	463	Yakutat Tlingit Tribe	VA260-12-A-0086	$16,127.00	2
20	463	Athabascan Tribal Government	VA260-12-A-0077	$11,387.42	6
20	463	Yukon-Kuskokwim Health Corporation	VA260-12-A-0041	$110,718.94	28
20	531	Owyhee Community Health Facility (Shoshone-Paiute Tribe)	VA260-15-A-0041	$2,347.16	3
20	648	Chemawa Indian Health Center	VA-648-IHS-0013	$21,758.15	12
20	648	Confederated Tribes of Grand Ronde Health and Wellness Center	VA260-13-A-0060	$38,102.65	22
20	648	Cowlitz Family Health (Cowlitz Tribe)	36C260-18-A-0012	$1,281.00	2
20	648	Siletz Community Health Clinic (Confederated Tribes of Siletz Indians)	VA260-15-A-0040	$5,505.19	5
20	648	Warm Springs Service Unit	VA-648-IHS-0005	$4,679.89	14
20	653	Cow Creek Health and Wellness Center (Cow Creek Band of Umpqua Tribe of Indians)	VA260-14-A-0097	$0.00	0
20	663	Lummi Tribal Health Center	VA2601SA0090	$0.00	0
20	663	Nooksack Indian Tribe	VA260-16-A-0029	$4,778.00	1
20	663	Port Gamble S'Klallam Health Center	VA2601GA0031	$0.00	0
20	663	Sophie Trettevick Indian Health Center (Makah Tribe)	VA260-15A-0039	$0.00	0

20	668	Benewah Medical Wellness Center (Coeur d' Alene)	VA260-13-A-0053	$0.00	0
20	668	Omak Tribal Health Clinic	VA-668-IHS-0016	$60,507.71	13
20	668	Colville Health Center	VA-668-IHS-0011	$87,347.04	27
20	668	David C. Wynecoop (Wellpinit) Health Center	VA-668-IHS-0012	$7,908.61	8
20	668	Lake Roosevelt Community Health Centers (Colville)	VA26015A0043	$11,871.18	7
20	687	Nimiipuu Health (Nez Perce Tribe)	VA260-14-A-0027	$82,138.33	13
20	687	White Swan Dental Clinic	VA-687-IHS-0015	$0.00	0
20	687	Yakama Indian Health Center	VA-687-IHS-0014	$31,006.48	10
20	687	Yellowhawk Tribal Health Center	VA260-13-A-0059	$42,960.48	37
21	570	Central Valley Indian Health, Inc.	VA261-14-S-0080	$0.00	0
21	612	Greenville Clinic Red Bluff Clinic	VA261-15-S-0030	$0.00	0
21	612	Karuk Tribal Health and Human Service Program	VA261-14-S-0210	$0.00	0
21	612	Pit River Health Service	VA261-15-S-0029	$0.00	0
21	654	Yerington Paiute Tribal Health Clinic	VA261-15-S-0070	$0.00	0
21	662	Consolidated Tribal Health Project	VA261-15-S-0031	$0.00	0
21	662	Kimaw Medical Center (Hoopa Valley Tribe)	VA261-14-S-0081	$0.00	0
21	662	Lake County Tribal Health Consortium	VA261-14-S-0127	$0.00	0
21	662	Sonoma County Indian Health Project (SCIHP)	VA261-14-S-0138	$0.00	0
21	662	United Indian Health Services, Inc./PHV-MED	VA261-14-S-0039	$15,721.17	13
22	501	Acoma-Canoncito-Laguna Indian Hospital (ACL)	VA-501-IHS-0052	$83,743.47	32
22	501	Albuquerque Indian Health Center	VA-501-IHS-0069	$48,857.10	30
22	501	Canoncito Band of Navajos Health Center, Inc.	36C25818A0006	$78.29	1
22	501	Canoncito Health Center	VA-501-IHS-0053	$0.00	0
22	501	Cochiti Health Center	VA-501-IHS-0079	$1,990.05	2
22	501	Crownpoint Service Unit	VA-501-IHS-0021	$181,012.81	115
22	501	Shiprock Service Unit (Northern Navajo)	VA-501-IHS-0022	$494,474.71	209
22	501	Dulce Health Center (Jicarilla)	VA-501-IHS-0060	$17,741.50	10
22	501	Gallup Service Unit	VA-501-IHS-0031	$673,972.43	261
22	501	Isleta Health Center	VA258-15-A-0034	$14,596.00	8
22	501	Jemez Health Center (Pueblo of Jemez)	VA258-14-A-0054	$31,388.11	22
22	501	Laguna Health Center	VA-501-IHS-0054	$0.00	0
22	501	Mescalero Indian Health Service	VA-501-IHS-0063	$3,736.64	3
22	501	San Felipe Health Center	VA-501-IHS-0081	$1,880.00	1
22	501	Santa Ana Health Center	VA-501-IHS-0071	$412.00	1
22	501	Santa Clara Health Center	VA-501-IHS-0080	$1,398.91	2
22	501	Santa Fe Indian Hospital	VA-501-IHS-0078	$23,299.97	11
22	501	Santo Domingo Health Center (Kewa Pueblo Health Corp)	VA258-15-A-0046	$15,971.00	15
22	501	Taos/Picuris Health Center	VA-501-IHS-0055	$78,301.31	14
22	501	Fort Defiance Indian Hospital Board, Inc.	VA-258-15-A-0058	$0.00	0
22	501	Zia Health Center	VA-501-IHS-0070	$10,619.47	6
22	501	Zuni Indian Health Service	VA-501-IHS-0057	$373,040.97	46
22	593	Irene Benn Medical Center (Moapa)	VA-593-IHS-0059	$18,383.21	2
22	605	Riverside-San Bernardino County Indian Health, Inc.	VA262-16-S-0052	$427.00	1
22	605	Toiyabe Indian Health Clinic	VA262-14-A-0025	$0.00	0
22	644	Phoenix Indian Medical Center	VA-644-IHS-0036	$713,803.88	177
22	644	Wassaja Memorial Health Center (Fort McDowell Yavapai Nation)	VA258-15-A-0010	$0.00	0
22	644	Whiteriver Indian Hospital	VA-644-IHS-0032	$105,874.73	19
22	649	Chinle Service Unit	VA-649-IHS-0008	$399,125.88	175
22	649	Hopi Health Care Center	VA-649-IHS-0026	$264,759.40	75
22	649	Kayenta Health Center	VA-649-IHS-0035	$12,754.53	13
22	649	Native American Cardiology Program	VA-649-IHS-0072	$0.00	0
22	649	Parker Indian Hospital	VA-649-IHS-0023	$111,509.53	29
22	649	Peach Springs Health Center	VA-649-IHS-0024	$32,068.01	12
22	649	Tuba City Regional Health Corporation (Navajo Nation)	VA649-THP-0018	$122,187.39	48
22	649	Winslow Indian Health Care Center (WIHCC)	VA258-14-A-0030	$107,056.64	45
22	664	Indian Health Council, Inc.	VA262-14-A-0003	$3,435.00	6
22	664	Southern Indian Health Council, Inc.	VA262-14-A-0002	$378.00	1
22	664	Sycuan Medical & Dental Center (Sycuan Band of the Kumeyaay Nation)	36C26218S0001	$0.00	0
22	678	Fort Yuma Indian Health Center	VA-678-IHS-0027	$14,246.48	8
22	678	San Carlos Apache Rural Healthcare Center (San Carlos Apache Tribe)	VA258-16-A-0048	$84,523.29	49
22	678	Sells Indian Hospital San Xavier Health Center San Simon Health Center Santa Rosa Clinic	VA-678-IHS-0010	$1,549.00	2
22	678	Tohono O'odham Nation	36C25818A005	$20,099.00	13
22	691	Santa Ynez Tribal Health Clinic	VA262-14-A-0127	$0.00	0
23	437	Cass Lake Hospital	VA-437-IHS-0058	$148,297.18	92

23	437	Quentin N. Burdick Memorial Health Care Facility (Belcourt/ Turtle Mountain Band)	VA-437-IHS-0050	$247,718.40	39
23	437	Red Lake Hospital	VA-437-IHS-0051	$202,689.24	28
23	437	Spirit Lake Health Center	36C26318M0002	$427.00	1
23	437	White Earth Health Center	VA-437-IHS-0003	$71,587.00	30
23	437	Woodrow Wilson Keeble Memorial Health Care Center (Sisseton Wahpeton Oyate)	VA-437-IHS-0002	$127,614.33	55
23	438	Flandreau Santee Sioux Tribe (FSST)	VA263-14-X-0152	$8,326.00	7
23	438	Fort Thompson IHS Health Center	VA-438-IHS-0061	$27,974.20	10
23	438	Lower Brule IHS Health Center	VA-438-IHS-0047	$50,681.77	25
23	438	Wagner Healthcare Center – IHS (Yankton-Wagner Service Unit)	VA-438-IHS-0004	$31,046.17	29
23	568	Eagle Butte PHS Indian Hospital (Cheyenne River Service Unit)	VA-568-IHS-0007	$278,651.53	92
23	568	Fort Yates IHS Hospital	VA-568-IHS-0062	$63,211.57	78
23	568	Kyle Health Center	VA-568A4-IHS-0066	$25,463.70	19
23	568	McLaughlin Health Center	VA-568-IHS-0068	$140,556.87	37
23	568	Pine Ridge Indian Health Service	VA-568A4-IHS-0064	$134,106.16	89
23	568	Rapid City IHS Hospital (Rapid City Service Unit)	VA-568-IHS-0006	$84,360.71	59
23	568	Rosebud IHS Hospital	VA-568A4-IHS-0067	$116,921.01	66
23	568	Wanblee Indian Health Service Center	VA-568A4-IHS-0065	$17,655.25	14
23	618	Fond du Lac Reservation	VA263-14-X-0002	$2,625.09	4
23	618	Lac Courte Oreilles	VA263-14-X-0165	$10,490.00	9
23	618	Red Cliff Community Health Center (Red Cliff)	VA26315X0040	$5,088.00	4
23	636	Carl T Curtis Health Ed Center (Omaha Tribe of Nebraska)	36C2318M003	$0.00	0
23	636	Ponca of Nebraska	VA263-14-X-0007	$0.00	0
23	636	Santee Health and Wellness Center (Santee Sioux Nation)	VA263-17-S-0138	$0.00	0
23	636	Winnebago IHS Hospital	VA-636-IHS-0049	$0.00	0
23	636A8	Meskwaki Tribal Health (Sac and Fox Tribe of the Mississippi in Iowa)	VA263-14-H-0191	$27,971.04	9
			Grand Total	**$20,028,301.72**	**5,296**