



**Statement By**

**RADM Chris Buchanan  
Deputy Director  
Indian Health Service  
U. S. Department of Health and Human Services**

**Before the**

**Senate Committee on Indian Affairs**

**Legislative Hearing**

***S.2365, Health Care Access for Urban Native Veterans Act of 2019  
S.1001, Tribal Veterans Health Care Enhancement Act***

**November 20, 2019**

Good afternoon, Chairman Hoeven, Ranking Member Udall, and Members of the Committee. I am RADM Chris Buchanan, Deputy Director of the Indian Health Service (IHS). Thank you for the opportunity to discuss S.2365, Health Care Access for Urban Native Veterans Act of 2019 and S.1001, Tribal Veterans Health Care Enhancement Act.

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 IHS also enters into agreements with 41 Urban Indian Organizations (UIOs). These 41 UIOs are 501(c)(3) non-profit organizations that provide culturally appropriate and quality health care and referral services for Urban Indians throughout the United States in 22 states.

### **S. 2365**

In the late 1980's, the IHS and the Department of Veterans Affairs began 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)<sup>1</sup>. The Patient Protection and Affordable Care Act of 2010 permanently reauthorized the IHCIA, authorizing IHS to enter into (or expand) arrangements for the sharing of medical facilities and services between IHS, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs (VA) and the Department of Defense (DOD)<sup>2</sup>. The law also directs the VA or the DOD (as the case may be) to reimburse the IHS, Indian Tribe, or Tribal Organization for the services provided to eligible beneficiaries of either Department in the respective facility. While the law clearly extends this authority to IHS, Indian Tribes and Tribal Organizations, it does not mention UIOs.

In March 2012, as Federal agencies worked to implement this new authority, IHS and VA jointly engaged in Tribal consultation on a draft national agreement for VA to reimburse IHS for direct healthcare services provided to eligible American Indian and Alaska Native Veterans at IHS federally-operated facilities.

On December 5, 2012, VA's Veterans Health Administration (VHA) and IHS executed an agreement for reimbursement for direct health care services under which VA reimburses IHS for covered healthcare services provided to eligible American Indian and Alaska Native Veterans that receive services at IHS facilities. The IHS and VHA have amended the VHA-IHS reimbursement agreement three times – to extend the period of agreement and to clarify the extent to which pharmaceuticals are reimbursable under the agreement. The most recent amendment extends the terms of the agreement through June 30, 2022.

VA also has individual reimbursement agreements with Tribal health programs (THP) under which VA reimburses THP for direct healthcare services provided by THP to eligible American Indian and Alaska Native Veterans. Since implementing the reimbursement agreements, to date, VA has reimbursed IHS and THPs over \$94 million for direct care services covering over 10,100 eligible American Indian and Alaska Native Veterans.

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<sup>1</sup> 25 U.S.C. § 1680f, Indian Health Service and Department of Veterans Affairs health facilities and services sharing.

<sup>2</sup> 25 U.S.C. § 1645, Sharing arrangements with Federal agencies.

Aside from the statutory exception that designates and treats two UIOs as federal service units,<sup>3</sup> the law does not authorize the VA to enter into individual reimbursement agreements with UIOs and reimburse UIOs for providing direct health care services to eligible American Indian and Alaska Native VHA beneficiaries. This requires a change to law.

S.2365 proposes to amend the IHCIA provision for Sharing Arrangements with Federal Agencies (25 U.S.C. § 1645), which authorizes the HHS Secretary to enter into arrangements with VA or DoD, to reference the UIOs along with IHS, Indian tribes, and tribal organizations. Approximately 71 percent of the American Indian and Alaska Native population now live in urban areas. The IHS-funded UIOs expressed the need for developing sharing arrangements for the sharing of health care services with other Departments, here VA and DoD, for the American Indian and Alaska Native population in urban settings. S.2365, if passed by Congress, would authorize reimbursement to a UIO by the VA or DoD for services provided to eligible American Indian and Alaska Native beneficiaries under an arrangement between the UIO and VA or DoD, as the case may be.

### **S. 1001**

S. 1001 proposes to amend the IHCIA by adding a new provision regarding the liability for payment (25 U.S.C. § 1621u), to allow IHS to cover the cost of a copayment assessed by the VA to eligible Indian veterans for covered medical care under Contract Health Services, now known as Purchased/Referred Care (PRC). In addition, S.1001 would amend Title IV of the IHCIA (25 U.S.C. § 1641 et seq.) to require the IHS, VA, and impacted THP to enter into a memorandum of understanding on a national or regional basis for IHS or tribal health programs to pay copayments owed to the VA by eligible Indian veterans for covered medical care.

Currently, the IHCIA prohibits a tribal veteran from being charged a copayment when they seek treatment at an IHS facility. When seeking treatment at a VA medical center, tribal veterans currently are charged a copayment that the individual pays. Current law (25 U.S.C. § 1621u) does not permit a provider, including VA, to impose financial liability on a patient pursuant to an authorized IHS PRC referral. As a payer of last resort, IHS would only pay for cost-sharing when there are no alternative resources and all of the other PRC requirements have been met. Under IHS's current payment structure and policy, cost-sharing is the responsibility of the patient when a Tribal Veteran elects to seek treatment without a PRC referral. Currently, cost sharing is waived for PRC referrals in Medicaid, as well as referrals when a patient is covered by insurance obtained through the individual market place.

IHS has the lowest per capita spending of Federal health programs.<sup>4</sup> The proposed legislation would redirect funds away from direct services and may reduce services at IHS, would change the way certain services are funded, and result in disparate treatment for IHS beneficiaries. These changes could impose serious challenges to IHS's ability to provide quality care to its beneficiaries. This is not only problematic for IHS, but also concerning given the Federal

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<sup>3</sup> Treatment of certain demonstration projects – Tulsa Clinic and Oklahoma City Clinic (25 U.S.C. § 1660b).

<sup>4</sup> See U.S. Government Accountability Office, Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs (GAO-19-74R), available at <https://www.gao.gov/assets/700/695871.pdf>.

government's legal responsibility to provide health care for American Indians and Alaska Natives.

The IHS offers the following comments on S. 1001 and is prepared to provide the Committee technical assistance on the legislation.

The IHCIA defines the "Service" as the "Indian Health Service" (See 25 U.S.C. § 1603(18)). S. 1001 predominately refers to the "Service," which would not include tribal health programs. It is unclear whether Congress is intending certain changes to apply to anyone other than IHS.

S. 1001 envisions that such copayments would be facilitated by the development of new national or regional Memoranda of Understanding (MOU) between the Department, VA, and "any tribal health program, if applicable." It is unclear whether each tribal health program would be expected to sign the national MOU or appropriate regional MOU. The development of either a national or regional MOU would be extremely difficult, if the required parties are more than the Department and VA. However, if the tribal health program(s) would be bound by the MOU terms without signing it, this would be contrary to self-determination and self-governance. Moreover, IHS understands that there are multiple MOUs currently in place between the VA and individual tribes. A requirement for a national or regional MOU could be disruptive to current services and relationships in place. To the extent the referral process becomes more complicated, access to services could become burdensome and confusing for Native American Veterans who choose to use IHS and tribal health care facilities for their primary health care.

We remain firmly committed to improving quality, safety, and access to health care for American Indians and Alaska Natives, in collaboration with our sister Federal agencies. We appreciate all your efforts in helping us provide the best possible health care services to the people we serve. Thank you, and I am happy to answer any questions you may have.