National Indian Health Board

SENATE VETERANS AFFAIRS COMMITTEE
HEARING ON NATIVE AMERICAN VETERANS:
ENSURING ACCESS TO VA HEALTH CARE AND BENEFITS

TESTIMONY OF NATIONAL INDIAN HEALTH BOARD
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Chairman Tester, Ranking Member Moran, and Members of the Committee, thank you for holding this important hearing on ensuring Native American Veteran access to Veterans Affairs Health Care and Benefits. On behalf of the National Indian Health Board (NIHB) and the 574 federally recognized sovereign Tribal Nations we serve, I submit this testimony for the record.

This Committee and the NIHB share a common goal of improving the lives of Native Veterans. Improving access to health care is a key objective under this goal that can only be achieved through a sustained, institutional, coordinated effort between the Department of Veterans Affairs and the Department of Health and Human Services. This Committee's roles in overseeing this coordination and removing statutory hurdles is essential to success. Today's testimony will focus on both roles.

Native Health Care and the United States' Trust Responsibility

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 Tribes. The terms codified in those Treaties include, in perpetuity, quality and comprehensive health resources and services to Tribal nations in exchange for millions of acres of land. These Treaties are still the supreme law of the land and have been reaffirmed by the United States Constitution, the Supreme Court, federal legislation and regulation, and Executive Orders. Together, they form the basis for the federal trust responsibility for Indian Tribes.

After a long and disjointed history of poorly administered and funded health services to Tribal communities, Congress established the Indian Health Service (IHS) in 1955 to coordinate health resources and provide for "comprehensive" Indian health services. Today, the agency's stated mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level. The IHS provides a health service delivery system for approximately 2.6 million AI/ANs who belong to 574 federally recognized Tribes in 37 States.

Over time, and in recognition of its chronic underfunding of the IHS, the federal government turned to other federal health care programs—Medicare, Medicaid, Children's Health Insurance Program, and the VHA—to supplement services unmet through the IHS alone. In 2010, Congress solidified this arrangement by designating IHS as the payor of last resort. The policy forced AI/AN patients—veteran and non-veteran—to navigate a complicated and imperfect bureaucracy before the federal government would meet its trust responsibility. The problem continues to this day.

The Need to Improve the Health Status of Native Veterans

AI/ANs enlist to serve this nation at nearly five times the national average and at higher rates per capita than any other ethnicity, but, statistically, our People enter the Armed Services already at a disadvantage when compared to the general population. Average AI/AN life expectancy during the COVID-era has declined faster than any other group of Americans, and now averages 65.6 years—equal to the general U.S. population in 1944! AI/AN continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.[i]

After completing their service, Native Veterans continue to experience some of the worst health outcomes and face the greatest challenges to receiving quality health services, among all Americans. Destructive federal Indian policies and unresponsive human service systems have left these Veterans and their communities with unresolved historical and intergenerational trauma.

From 2001 to 2015, suicide rates among Native Veterans increased by 62% (50 in 2001 to 128 in 2015).[ii] In FY 2014, the Office of Health Equity within the VHA reported significantly higher rates of mental health disorders among Native Veterans compared to non-Hispanic White Veterans, including in rates of PTSD (20.5% vs. 11.6%), depression symptoms (18.7% vs. 15.2%), and major depressive disorder (7.9% vs. 5.8%).[iii] Among all Veterans, Native Veterans are more likely to have a disability, service-connected or otherwise.[iv]

Improve Access to Quality Health Care at the VA

The 2021 Veterans Health Administration (VHA) Survey of Veteran Enrollees' Health and Use of Health Care reports 225,793 VHA patients who self-identified as AI/AN – representing 2.6% of the agency's enrolled patient population.[v] Of these, an estimated nearly 145,000 are Native Veterans.[vi]

Across the board, AI/AN Veterans continue to report higher rates of issues around quality of care and accessibility that have undermined trust in the VHA system and left AI/AN Veterans significantly more vulnerable to adverse health outcomes, including for COVID-19. The VHA's November 2022 National Veteran Health Equity Report continued to find more challenges with access to care and person-centered care when compared with non-Hispanic White Veterans, and concluded that work is needed to improve the Veteran experience of care among AI/AN Veterans.[vii]

For instance, Native Veterans of all age groups reported that access to care through the VHA had either stayed the same or had gotten worse. Furthermore, Native Veteran patients reported lower rates compared to non-Hispanic White Veteran patients in the following areas:

<u>All Ages</u>

- Controlling diabetes;

Ages 18-44 Years

- Seeing their provider within 15 minutes of their appointment time;
- Someone from their provider's office always discussing medications with them;

Ages 45 Years and Older

- Receiving timely appointments for routine care;
- Their provider always listening to them carefully;
- Provider always showing respect for what they had to say;
- Provider always spending enough time with them during their clinical visit;

Ages 50-75

- Colorectal cancer screening;

Ages 65 Years and Older

- Receiving follow-up on test results from someone in their provider's office; and
- Hypertension control.

Given these experiences of Native Veterans with VA health care, it is not surprising that Native Veterans use VA health care disproportionately less than other veterans despite having a disproportionately higher percentage of veterans with a disability.[viii] The VHA must improve its cultural competency if it is to ensure Native Veteran access to VA health care. **The NIHB recommends that the VA take decisive action improve cultural and linguistic competency and the diversity of the VA health-related workforce.**

While these equity reports continue to be instructive, they are not helpful unless they are paired with real, measurable personnel actions and policies to correct the problems. The VA 2022-28 Strategic Plan says striking little about what it will do, other than to "develop a measurable, achievable enterprise-wide roadmap-wide [sic] roadmap for evaluating and addressing the unique needs and circumstances of this Veteran population."[ix] Similarly, the 2019 VHA Health Equity Action Plan makes no mention of the federal government's unique trust responsibility to Native Veteran patients. **The NIHB recommends that the VA work with the VA Tribal Advisory Committee (TAC) and consult with Tribes to inform the implementation of the VHA Health Equity Action Plan.**

Improve Access to Quality Health Care at the IHS

An estimated 51.7% of Native Veterans eligible for both IHS and VA health care receive care either exclusively through the IHS or in combination with the VA.[x] Regardless of whether Native Veterans receive care through the IHS by choice or necessity, the IHS remains an essential component of federal Native Veteran health care policy.

The IHS is charged with a mission similar to that of the VHA relative to administering quality health services, with the following key differences:

- The federal government has Treaty and trust obligations to provide health care for all American Indians and Alaska Natives;
- The IHS is severely and chronically underfunded in comparison to the VHA, with per capita medical expenditures within the IHS at $3,779 in Fiscal Year (FY) 2018 compared to $9,574 in VHA per capita medical spending that same year[xi];
- The VHA is protected from government shutdowns and continuing resolutions (CRs) because it receives advance appropriations; and
- The VHA is protected from budget sequestration.

In 2018, the Government Accountability Office (GAO) cited VA officials who reported that advance appropriations have helped with VHA provision of health care services, health care program planning, provider recruitment and retention, and commercial contracts and vendor negotiations.[xii] The further reported that advance appropriations protect federal programs from disruptions caused by government shutdowns and CRs. **The NIHB recommends equal protection of the IHS budget from sequestration, government shutdowns, and continuing resolutions, as is already provided for the VHA budget.**

President Biden's FY 2023 budget request to Congress included protecting the IHS from legislatively mandated process of budget control known as "sequestration" and consisting of automatic, across-the-board spending reductions to enforce budget targets to limit federal spending. In its justification, the IHS noted that all "programs administered by the Department of Veterans Affairs are exempt from a sequestration reduction ordered under the BBEDCA and the BCA. Through this exemption Congress expressly indicated how critical it is for services provided by the VA not to be disrupted or reduced as a result of sequestration."[xiii]

In 2021, President Biden included FY 2023 advance appropriations for the IHS in his FY 2022 budget request to Congress. Level-funding advance appropriation authority was included in the Senate's FY 2022 budget resolution, and a level-funding appropriation was included in the Senate's FY 2022 Interior-Environment appropriations bill. The measure was ultimately dropped during conference negotiations.

In 2022, the Senate's FY 2023 Interior-Environment appropriations bill again includes IHS advance appropriations. **The NIHB urges Members of the Senate Veterans Affairs Committee to voice support to the Appropriations Committee and Leadership for including IHS advance appropriations in the final FY2023 conference agreement.**

Improve Coordination Between the VA and the IHS

Improving services for Native Veterans has been an essential component of the NIHB's legislative and policy agenda for 2022. The NIHB has been working with the VA and the IHS on the following policy recommendations. The NIHB appreciates this Committee's oversight role to ensure that the recommendations are fully implemented.

Consultation

Recognizing their shared responsibility to Native Veterans, the IHS and the VA formalized a coordination policy beginning in 2003 through a Memorandum of Understanding (MOU), and updated the policy most recently in November 2021. The NIHB has been advocating for the VHA and IHS consult with Tribes regarding the MOU operational plan to develop quantifiable goals and objectives similar to those of Tribal Health Programs (THPs), including quality services and culturally responsive care for Native Veterans.

In September, NIHB hosted Tribal consultation for the VA on the VA/IHS MOU Draft Annual Operational Plan. Too often, federal agencies fail to explain how and why the information obtained during Consultation was used. It is essential that the VA and IHS evaluate each recommendation received during Consultations and clearly communicate how each recommendation was considered for the final MOU operational plan.

Workgroup

This Committee was instrumental in ensuring enactment of the PRC for Native Veterans Act, which clarifies that the VA and the U.S. Department of Defense (DoD) are required to reimburse IHS and Tribal health programs for healthcare services provided to AI/AN Veterans through an authorized referral. Oversight of the Act's implementation is needed. **The NIHB recommends that the VA establish a workgroup, in conjunction with IHS, to develop the Purchased Referred Care (PRC) addendum to ensure that all issues related to PRC services, patient and escort travel, and billing and reimbursement processes are taken into consideration the VA.**

In September, the NIHB hosted Tribal consultation for the VA on a draft template to assist in finalizing the Tribal health program (THP) Reimbursement Agreement template for the lower 48 States. As with the VA-IHS MOU, agency feedback on Tribal consultation recommendations is critical.

Collaboration

One of the leading collaboration practices identified by the 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 a consistent understanding of the options available for referral of Native Veterans for specialty care.

The NIHB has been informed that some Native Veterans prefer to simply hand carry their electronic health records (EHRs) from their IHS provider to their VHA provider to avoid this confusion among providers. In short, the lack of written policy perpetuates this burdensome, pointless, and complicated process that only serves to frustrate and potentially harm patients, worsen administrative red tape, and increase expenditures. **The NIHB recommends that the VA and IHS establish written guidance, agreements, and policies to identify how the VHA and IHS can collaborate to streamline care and access to health care for AI/AN Veterans.**

The VA-IHS MOU mentions a goal of interoperability between the IT systems used by both agencies. **The NIHB recommends that agencies should establish an advisory group composed of Tribal leaders, Tribal technical assistants, subject matter experts, and federal representatives to ensure continued progress to this goal. The VHA also must provide technical assistance (TA) to Tribes at the local and regional levels to ensure and implement coordination of electronic health records.**

Peer-to-Peer

The Rural Native Veteran Navigator Program increases Rural Native Veterans' (RNV) access to healthcare and Veteran-associated benefits, and subsequently improves health outcomes. While pairing Native Veterans with Patient Navigators has been helpful, the program can be strengthened by adding or expanding a peer-to-peer component. **The NIHB recommends that the Rural Native Veteran Health Care Navigator Program should incorporate a peer-to-peer or veteran-to-veteran element that would allow AI/AN Veterans to serve as navigators for other AI/AN Veterans seeking resources.**

Veterans Liaison List

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. **The NIHB recommends that the IHS Director and VA Secretary consult with Tribes and work through their MOU with IHS to create and publish an active list of available Veterans Liaisons and Tribal Veterans Representatives across all IHS and VHA regions. The VA website must include a section dedicated to AI/AN Veterans' resources and programs.**

Increase Emphasis on Mental and Behavioral Health

Our Tribal communities have endured many pandemics and tragedies in our history. Our People still experience significant historical and intergenerational trauma because of genocide, forced relocation from our homelands, forced assimilation into western culture, and persecution of our Native cultures, customs, and languages. As a result, our People experience some of the highest rates of suicide, drug overdose, Post-Traumatic Stress Disorder (PTSD), and mental illness among all U.S. populations.

Indeed, the AI/AN communities experienced some of the starkest disparities in mental and behavioral health outcomes before the COVID-19 pandemic began. According to the Centers for Disease Control and Prevention (CDC), from 1999 to 2017, suicide rates increased by 53% among women of all ages, and 26% among men of all ages. But among AI/ANs specifically, suicide rates increased by 139% among our women, and by 71% among our men.[xiv] Rates of PTSD among our People are twice as high as the general population,[xv] while a staggering 84% of our women experience violence in their lifetime.[xvi]

These are just some of the challenges our Tribal communities continued to face during the COVID-19 pandemic. While our People remain resilient and committed to advancing innovative health care, the COVID-19 pandemic added more tragedy upon the historical trauma passed down for generations from our ancestors who experienced historical plagues, such as smallpox and tuberculosis, without appropriate health care. Many of our Tribes reported increased rates of intimate partner violence, substance use, and overdose due to the increased isolation and inaccessibility of care during the pandemic.

The VA's Veteran Outreach Toolkit lists AI/ANs as an "at-risk" population, citing the troubling suicide rate. For the children of AI/AN veterans, high rates of complex behavioral health issues are compounded by the return of a Veteran parent who may suffer from 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. **The NIHB recommends that the VHA and IHS must prioritize AI/AN Veterans' mental and behavioral health and work with other federal agencies to develop more AI/AN Veterans' resources. The unique experiences must inform these resources of AI/AN Veterans.**

Provide Culturally Competent Health Care for Native Veterans

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Health and Human Services (HHS) has developed general requirements that, while they apply to Certified Community Behavioral Health Clinics (CCBHCs) for culturally competency, recognize particular health care delivery methods specific to AI/ANs including "traditional approaches or medicines."[xvii] Culturally competent care was noted as "the first brick of building compassion."[xviii] It improves the potential of building trust between patient and provider and increasing the likelihood that the Native Veterans will seek continuity of care. That need for patient-provider trust takes on a whole new level of significance in light of the 2018 Survey results.

Culturally competent care includes, in part, the traditional approaches, medicines, and methods that have been practiced in Native communities for generations. Traditional healing may encompass different techniques including physical, psychological, or nutritional therapies that can vary among Indian Tribes. However, culturally competent care also encompasses the need for understanding of and acknowledgement of a patient's background.[xix]

The background is of particular importance to understand because the health providers must recognize the historical trauma, PTSD, and how these problems acutely affect Native Veterans. This background should inform treatment plans, at a minimum, but should also inform far greater platforms for health care reform and improvement. Without recognizing the importance of cultural competency in health care delivery systems, then an opportunity for significant improvements is overlooked.

For example, the potential for incorporating traditional healing into health care systems is not realized when those services cannot be reimbursed either by the VHA or by Medicaid or when they cannot be covered by Federal Tort Claim Act coverage. The National Indian Health Board would recommend that Congress and the Administration work together with Indian Tribes to ensure that the benefits and the potential of culturally competent care continue to be examined and advanced through legislation including H.R. 912, the American Indian and Alaska Native Veterans Mental Health Act, passed by this Committee or through the full implementation of VA-IHS/Tribal MOUs.

Address Native Veteran Homelessness as a Public Health Priority

The federal government's trust responsibility for health extends to every federal agency and department, not just Health and Human Services or Veterans Affairs. For example, substandard housing and housing shortages in Tribal communities contribute to the ongoing and pervasive health provider shortages experienced across the Indian health system. Other federal departments including Housing and Urban Development thus share responsibility for the solution.

Moreover, homelessness, unstable housing, and overcrowded housing in Indian Country are strong determinants of health outcomes, whereby Tribal housing issues and challenges exacerbate the health disparities and lower health status experienced by AI/ANs. Studies demonstrate that homelessness and substandard housing are risk factors for domestic violence, human trafficking and Missing and Murdered Indigenous women and girls, substance abuse, mental illness, and other health problems in Indian Country.

AI/AN communities are disproportionately impacted by housing issues with roughly 23 percent of existing homes in Tribal areas in need of repairs, upgrades, and reconstruction compared to 5 percent of all U.S. households. Housing and homelessness issues are exacerbated by the fact that AI/AN communities face the highest rates of poverty of any demographic at 26.2 percent compared to 14 percent nationwide, with median household income levels 32 percent below the national average.

There are estimated to be up to 85,000 homeless AI/ANs living in Tribal areas, contributing to significantly higher rates of overcrowded housing on Tribal reservations and lands, with 16 percent of AI/ANs experiencing overcrowded housing compared to 2 percent of all households nationwide. Native Veterans are exponentially more likely to be homeless, with some studies showing that

26% of low-income Native Veterans experienced homelessness at some point compared to 13% of all low-income Veterans.[xx]

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 Indian Tribes, the IHS, and other federal agencies to create more resources specifically for Native Veterans.

The NIHB strongly supports addressing the housing crisis in Indian Country as a public health priority given its outsized negative impact on health outcomes and status among AI/ANs and calls upon Congress and the Administration to remove barriers to funding, and provide specific Tribal funding set-asides for Tribal governments, and Tribal organizations, in all funding offered, as a part of the Trust Responsibility.

The NIHB further calls upon Congress and the Administration to provide direct, recurring, and sustainable funding to Tribes and Tribal organizations to end the housing crisis in Indian Country.[xxi]

Additional Legislative Recommendation

There is a severe, longstanding, and well-documented shortage of healthcare professionals in Indian Country. Because of this shortage, Indian healthcare programs rely extensively and increasingly on the services of other types of licensed and certified non-physician practitioners, including Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), Certified Community Health Aides and Practitioners (CHAPs), Behavioral Health Aides and Practitioners (BHAPs), and Pharmacists. The LMFTs, LPCs, and higher-level BHAPs are qualified to furnish many of the same services that psychiatrists, CSWs, and psychologists do.

Among other services, pharmacists in Indian programs deliver clinic-based, protocol-driven care on behalf of physicians, including tobacco cessation, and medication-assisted treatment (MAT) for substance use disorders. All these providers furnish essential, effective, and high-quality care that is covered by many Medicaid programs, yet Medicare does not cover them, nor do the many non-governmental healthcare plans and health insurers that follow Medicare's lead. This deprives Indian health programs of critically needed federal reimbursement for vital healthcare services to American Indians and Alaska Natives, particularly Native Veterans.

The NIHB recommends that Congress include Pharmacists, Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors, and other providers as eligible provider types under Medicare for Reimbursement to Indian Health Care Providers.

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 Senate Veterans' Affairs Committee 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 behavioral and mental health outcomes.

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