S. Kevin Howlett, Department Head, Confederated Salish and Kootenai Tribal Health Department

Daniel K. Akaka, Chairman
U.S. Senate - Committee on Veterans Affairs 412 Russell Senate Building
Washington D.C. 20510

Mr. Chairman and Members of the Committee:

I am pleased and honored to appear before you today to present testimony related to the health care for Native American Veterans.

For the record, I am S. Kevin Howlett, a member of the Salish and Kootenai Tribes and Director of the Tribes Health & Human Services Department.

Let me thank our Senator Jon Tester for his recognition and support for my being here and his commitment to providing health care to our veterans.

Today, I will address those areas I feel that affect the access and quality of care I spoke of when then Secretary Peake visited Montana. Let me assure you that while I speak as one Tribal Health Director, the issues I will address span the universe of Indian country and the needs I believe exist in every reservation community.

Specifically, there has been a long-standing belief that health care for Native Americans was the responsibility of the Indian Health Service. While I agree that IHS has principal responsibility as the federal agency designated to provide care, I also know that as citizens of the states in which Indians live they are also entitled to the services provided to the citizens of that state. In addition, by having served our country in the armed services, veterans have earned the right to care provided by the Veterans Administration Medical system.

Most reservations are remotely located, under funded and under staffed resulting in a very real rationed care scenario. While Tribal / IHS clinics do the best they can, the level of care is quite often less than needed. This is amplified by a severe shortage of clinical personnel evident in virtually every clinic setting.

When the level of care is not available in the local clinic IHS uses what is referred to as the contract health services (CHS) program to refer to outside specialty care providers or in-patient facilities when in-patient care is not available. The CHS program has operated on a shoestring budget for many years. The care that can be approved utilizing CHS funds must be life threatening if IHS assumes financial responsibility; consequently these services are not provided.

We are aware of the existence of a Memorandum of Understanding between the IHS and the VA. We are also aware that it represents more symbolism then action. Without question the full implementation of the existing MOU, linked with Tribal specific recommendations would go a long way in providing a more comprehensive level of care for our veterans. Specifically, the agencies agree to many things including the sharing of information technology and an interagency workgroup to oversee proposed national initiatives.

Mr. Chairman, if the agencies who are a party to this agreement would as a matter of priority establish an internal and external (tribal) work group to begin developing a strategy then we could discuss how that strategy should be resourced and implemented.

An item not covered in the existing MOU concerns payment to Tribal facilities for care rendered to eligible veterans in Tribal clinics. The tribes rely heavily upon third-party collections to support the clinic operations. It seems logical that for Medicare / Medicaid, and privately insured individuals, the clinics can seek reimbursement. We are aware that the VA does have the ability to contract with the private sector to pay for the care of veterans, yet tribally operated clinics cannot as we understand seek the same. It would be easily incorporated into statute if this committee were so inclined. Absent the reimbursement, we will still provide what care we can, but resources or the absence of resources controls the scope of care.

Mr. Chairman, I could speak for hours about the specific needs of the 480 veterans living on my reservation. My purpose and goal today was to enlighten you from my perspective about the organization, structural and resource issues that comprise the maze of health care for veterans on the Flathead Indian Reservation. I truly believe that the level of care that is afforded must be equal to the services they have rendered.

I also believe that we can find solutions if we stay focused on the task, and spend less time trying to point fingers. We need to utilize the tools we have, and the commitment all of us in this room share.

I look forward to this committee providing the guidance and direction to the VA and IHS to ensure that those who have worn our uniform have the best care possible, to maximize limited resources, and to work collectively in all areas of health care including behavioral health. We owe these dedicated men and women nothing less.