S. HRG. 117–672

NATIVE AMERICAN VETERANS: ENSURING ACCESS TO VA HEALTH CARE AND BENEFITS

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NOVEMBER 30, 2022

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NATIVE AMERICAN VETERANS: ENSURING ACCESS TO VA HEALTH CARE AND BENEFITS

WEDNESDAY, NOVEMBER 30, 2022

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Murray, Brown, Blumenthal, Hirono, Sinema, Hassan, Moran, Boozman, Cassidy, Rounds, Tillis, and Sullivan.

OPENING STATEMENT OF CHAIRMAN TESTER

Chairman TESTER. I call this hearing to order. Good afternoon. I am sure that Senator Moran will be here shortly, but I thought I would get done with my opening statement and then we will go to the panel, and hopefully we will have a few more folks here. But we need to get this on the road because there are a bunch of votes this afternoon.

I would say good afternoon to all of you. I want to thank you for joining us to discuss the delivery of health care and benefits to Native American veterans.

Native Americans have served in every American conflict dating back to the Revolutionary War. However, they continue to experience unique challenges that greatly affect their quality of life and the timeliness and quality of care and services to which they are entitled.

Recently, VA Secretary McDonough announced a new office within VA, the Office of Tribal Health, to help improve Native American veterans' access to VA health care. I am pleased the Biden administration is putting more focus on the health care needs of Native veterans, and I will work to ensure that these efforts get the appropriate support here in Congress.

Yesterday, I reintroduced the Tribal HUD-VASH Act to build upon a Tribal housing initiative between the VA and HUD, that provides rental and housing assistance to veterans in Indian Country who are homeless or are at risk of being homeless. The bill also ensures that at least 5 percent of the HUD-VASH vouchers are set aside for Native veterans.

Last Congress I worked with members of this Committee on several provisions to allow Native veterans to gain easier access to VA

health care and VA benefits. We required VA to establish an Advisory Committee on Tribal and Indian Affairs, which has now met three times to provide advance and guidance to the Secretary on all matters related to Indian Tribes, Tribal organizations, and Native veterans. And we required VA to stop collecting copays from Native veterans. However, I am disappointed that despite Congress mandating VA to stop collecting copays by January 2022, VA has still not implemented this law.

Today I want to hear from the VA about what they plan to do to make this right and ensure our Native veterans have equal access to both VA and IHS health care facilities.

On our second panel we have representatives from several organizations who serve Native American veterans. I would like to hear about their top priorities, what they are hearing from their members about access to VA and IHS services and benefits, including health care, transportation, and housing.

Native veterans have answered the call to service throughout our country's history, and we all have a responsibility to ensure that they have access to the care and benefits that they have earned.

With that I think we are going to go to Panel 1 introductions and for your opening remarks. First, on our first panel, I want to introduce, from the Department of Veterans Affairs, Dr. Mark Upton, Deputy to the Deputy Under Secretary for Health. He is accompanied by Stephanie Birdwell, Director of Office of Tribal Government Relations, and John Bell, Executive Director of the Home Loan Guaranty Program.

From the Indian Health Service we have the Honorable Roselyn Tso, Director of Indian Health Service. She is accompanied by Benjamin Smith, Deputy Director of the Indian Health Service.

I want to thank you all for being here today. This is a very important hearing. We will start with you, Dr. Upton. You may begin with your opening statement.

PANEL I

STATEMENT OF MARK UPTON
ACCOMPANIED BY STEPHANIE BIRDWELL AND JOHN BELL

Dr. UPTON. Thank you, Mr. Chairman and Ranking Member Moran, and members of the Committee. We appreciate you inviting us here today to discuss our efforts to ensure that American Indian and Alaska Native veterans have access to the VA health care and benefits they have earned. Today we will discuss what VA is doing to improve the provision of benefits and services to these veterans as well as our ongoing coordination with our partners in the Indian Health Service.

American Indian and Alaska Native veterans serve in the military at one of the highest rates of all racial and ethnic groups. They also disproportionately suffer the medical and psychological consequences of service. They reside in urban areas and some of the most highly rural parts of this country and experience health care disparities that are aggravated by barriers to access to care, care navigation, and coordination.

As a VA health care provider myself and a member of the Veterans Health Administration senior leadership team, it is personally important to me that we strive to achieve the absolute best access, experiences, and care outcomes for veterans, and that we work to eliminate health care disparities. VA is committed to ensure that our Native veterans receive the outstanding care and benefits they so rightly deserve and that we use the authorities you have provided to us, under the PACT Act, to the fullest extent. We owe Native veterans our best.

VA and IHS have worked collaboratively for decades to advance the health care and well-being of American Indian and Alaska Native veterans. VA and IHS first drafted a memorandum of understanding in 2003, and in 2021, VA and IHS made our most recent updates to that MOU through a formal process of Tribal consultations and urban confers. The revised MOU reflects the evolving health care and health information technology landscape, and for the first time VHA and IHS have worked together to create an operational plan. This plan includes strategies, objectives, and measurable outcomes for implementing the MOU's goals. This year's operational plan is currently in the midst of Tribal consultation, and we greatly appreciate the feedback from our Tribal partners.

As you mentioned, Mr. Chairman, VA appointed the first-ever Advisory Committee on Tribal and Indian Affairs on October 4, 2021. This committee provides advice and guidance to the Secretary on all matters related to Indian Tribes, Tribal organizations, Native Hawaiian organizations, and American Indian and Alaska Native veterans. We are grateful to Congress for the legislation that allows veterans' voices to be heard so that we can best meet their needs. I personally had a chance to meet with the committee a few weeks ago and truly appreciated the thoughtful engagement and dialogue that we had.

In order to provide Native veterans the health care and benefits they have earned it takes a whole-of-VA approach. VBA offers a variety of benefits to Native veterans, including our VBA home loan benefit program that provides eligible veterans the opportunity to purchase or construct a home with no down payment, no mortgage insurance, competitive interest rates, and low closing costs.

NCA administers VA's Veterans Cemetery Grants Program, which has funded grants for the establishment, expansion, or improvement of 121 State and Tribal veteran cemeteries in 46 states and 3 territories. Since 2011, Tribes have received more than $37 million for the cemeteries they operate on Tribal trust land.

The Veterans Health Administration is committed to providing veterans with excellent patient-centered care, and we have many ongoing initiatives currently underway at the local, national, and regional levels to improve mental health and substance abuse treatment, reduce homelessness, and work to ensure culturally competent care is provided to our Native veterans.

The COVID–19 pandemic had a profound impact on this country with substantial impact to our Native communities. In 2020, VA implemented interagency agreements with IHS that allowed us to provide personnel, medications, personal protective equipment, and other resources to our IHS facilities. Through this pandemic, our

dedicated VA employees have stepped up on numerous occasions to provide direct health care and support to IHS facilities, Tribal health programs, and open the doors of our VA medical centers to accept non-veteran patients through our fourth mission. In VISN 22 alone, over 430 medical personnel have been deployed to IHS and Tribal health facilities during the pandemic.

Lastly, while VHA has worked extensively to support our Native veterans, the fact remains there is more work to do. Understanding this need, the VHA Office of Tribal Health was established earlier this year and provides VHA with leadership, strategic direction, and policy guidance in our efforts to support Native veterans. In a few short months, they have engaged closely with our VHA leaders, the Tribal Advisory Committee, VA employees, and most importantly, Tribal leaders and Native veterans and their families. We look forward to keeping the Committee updated on their continued progress.

In conclusion, the health and well-being of all of our Nation's veterans is of the utmost importance. VA strives to consistently provide high-quality services to the veterans, caregivers, family members, and survivors who have earned them. We are deeply committed to ensuring American Indian and Alaska Native veterans have access to the health care and benefits they have earned.

Thank you for your time and your focus on this important topic. We appreciate the partnership of this Committee and the Indian Health Service, and I am happy to answer your questions.

[The prepared statement of Dr. Upton appears on page 50 of the Appendix.]

Chairman TESTER. There will be questions, but first we are going to hear from Director Tso.

STATEMENT OF THE HONORABLE ROSELYN TSO ACCOMPANIED BY BENJAMIN SMITH

Ms. TSO. Good afternoon, Chairman Tester, Ranking Member Moran, and members of the Committee. Thank you for the opportunity to testify on Native veterans' access to Department of Veterans Affairs health care and the Indian Health Service.

I would like to begin with the IHS mission, which is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives. This includes, of course, our Native American and Alaska Native veterans.

IHS provides health care services to approximately 2.7 million American Indians and Alaska Natives, from 574 federally recognized Tribes and 37 states, through a network of more than 680 health care facilities. As health care needs change, the IHS, VA, and our Tribal partners combined our expertise, resources, and efforts to help nearly 145,000 Native Americans and Alaska Native veterans living in the United States.

The IHS and the VA veterans health continue to provide eligible Native veterans access to care by bringing that care closer to their home, promoting a culturally competent and quality care, and focus on increasing care coordination, collaboration, and resource sharing.

The MOU that was referenced earlier establishes the framework for the Indian Health Service and the VA to leverage our resources and investing in support of our mutual goals. We believe that the newly signed MOU builds on nearly two decades of experience and will continue to support our objectives to improve access to health care outcomes for our Native American veterans.

The MOU has four mutual goals: to increase access and improve quality of health care and services; focus on patients and facilitate enrollment and seamless navigation; facilitate and integrate the electronic health record and other health information technologies that affect the health care of our Native veterans; and improve access through resource sharing, including technology, providers, training, human resources, services, facilities, communication, and reimbursement.

More recently, Congress directed the VA to reimburse Urban Indian organizations, the IHS, purchased and referred care provided to eligible veterans. Since the implementation of the reimbursement provision in 2012, the VA has reimbursed over $186 million for direct care services provided by IHS and Tribal health programs, covering approximately 15,000 Native veterans. We are working with the VA on implementing the newly enacted legislation, including the exemption from most of the VA health care copayments for Native veterans and clarification on the related purchase and referred care under the applicable laws.

The IHS and the VA continue to deliberate on adjusting Tribal consultation and urban confers to increase national awareness of the goals identified in the MOU in order to gather meaningful outcomes and deliverables.

In wrapping up my comments, I want to ensure this Committee that IHS remains firmly committed to improving quality and access to care for our Native veterans. As the daughter of a Korean War veteran, I had the privilege of caring for my father toward the end of his life. I understand firsthand the challenges of navigating between the IHS and the VA. For my father and all Native American veterans, I have made improving care coordination for our Native veterans a priority at the Indian Health Service.

We appreciate all of the efforts in helping us provide the best possible care to the veterans that we serve. Thank you, and I am happy to answer any questions.

[The prepared statement of Ms. Tso appears on page 45 of the Appendix.]

Chairman TESTER. Dr. Upton and Director Tso, thank you very much for your testimony. I appreciate it very much.

I want to start with what I addressed in my opening statement about the copay prohibition. I am disappointed the VA has not implemented the law that we passed 2 years ago to end copays for VA health care for Native veterans. It passed 2 years ago. This creates a disincentive for Native veterans to use the VA health care facilities, which is opposite of what should be occurring.

In September, Secretary McDonough made a commitment that the VA copays for Native American veterans would be eliminated this year. We are almost at the end of this year. So Dr. Upton, is

VA on track to implement the copay prohibition by the end of next month?

Dr. UPTON. Thank you, Mr. Chairman, and I will just say we absolutely understand the urgency and importance of this, for the exact reasons you mentioned, to eliminate that disincentive. The Secretary has shared publicly that we are going to have this done at the end of the year, and I have talked to him directly about it as well.

What I can share with you, Senator, is we are actively working the operational and regulation associated pieces to meet that goal, and that is ongoing as we speak. Because this is still in the regulation process I have to be cautious because it is still predecisional, as you can understand.

But I would like to share one thing, if that is okay, because I know how important this is to our community.

Chairman TESTER. Yes.

Dr. UPTON. One of the areas that we are very strongly looking into—and again, because it is predecisional I have to phrase it that way—we are looking into the ability to make the copayment benefit retroactive to the date that Congress intended, which is January 2022.

So as we move forward in this process we commit to keeping you and the Committee updated, our veterans updated, and that includes in the coming weeks, as you referenced.

Chairman TESTER. So just to follow up with what you just said, that means you are going to reimburse the veterans for any copays they paid in 2022?

Dr. UPTON. That is the process that we are actively looking into, Senator, which would be for veterans—again, this is predecisional—for veterans who have paid copayments since January 5, 2022, we are looking into the ability to be able to reimburse those as part of this process.

Chairman TESTER. And what will determine whether you have that ability?

Dr. UPTON. As we go through the regulation process that will determine. And so we should know more soon, and I apologize that I cannot share more.

Chairman TESTER. That is no problem. When did the regulation process start?

Dr. UPTON. It has been in process for a number of months now, if not longer, Senator. There are some important complexities to this. We did Tribal consultation, sought public comment, and the feedback we received about some components of this were mixed. And we care very deeply about the feedback from our Tribal partners as well as from our new Office of Tribal Health, and that is feeding into helping us make sure we get this right.

Chairman TESTER. So let me get this right. You got feedback from some of the Tribal partners that said they wanted to have a copay?

Dr. UPTON. No. The procedural pieces of it, Senator, including how Native status is verified, some of the pieces in place that go into effectuating the benefit. Certainly not that the copayment should be there, to my knowledge, but how we act on it in a veteran-centric way that is very sensitive to our population.

Chairman TESTER. Right. So this Committee, for all the time that I have been on it, has pushed the different Secretaries from different parties, pushed. And by the way, I do not think that is a bad thing. I think that this Committee has an obligation to, when we see something wrong, to try to fix it and try to push the VA to address that. It is what happened in the PACT Act, okay, to the max.

I guess the question that I have is that we did pass this bill 2 years ago. Government is renowned for working slow, and this kind of dots that I, but this does not seem like a big issue to me. And I could be wrong. I am not right all the time. But it does not seem like a hugely big issue. I am going to get to IHS in a second because they do not charge copays.

So why has this been—I will not say we are wrapped around the axle, but maybe we are.

Dr. UPTON. What I can say, Senator, is that I understand your frustration and I know that this is so important for our Native veterans, and that is what this is all about. So I apologize for the delay.

Chairman TESTER. You do not need to apologize. I just think that one of the things that I think that our veterans expect out of the VA, and I certainly expect out of the VA, and I am not a veteran, is that they act in a timely manner. And I think Congress did their job, and oftentimes it is hard for Congress to do its job. So when we finally do our job it should not take 2 years to get it done. But thank you.

Director Tso, just talk a little bit about IHS. It is not charging copays. Tell me why eliminating the copays for the VA is important, from your perspective. And that is not your house, okay. You have got the IHS side of things.

Ms. TSO. Thank you for that question, Senator. There are a number of reasons why we need to make sure that we eliminate the copay. Number one, there is already, in many parts of Tribal Country, where our veterans have to travel a long distance to get their health care services, and on top of that, to layer any kind of copay, in any amount, prohibits and really creates that barrier for our veterans to get care.

Not only that, if they need care for multiple services they are paying multiple copays, and so that, in itself, creates a barrier. So anything we can do to eliminate any barriers for our veterans is what we are asking for.

Chairman TESTER. I appreciate that. I would just tell you I think the point you made is really important. It is not a point that I took into account, and I am from Montana, where we have large land-based Tribes. Some of those reservations are as big or bigger than some of the States we have in this country. And for those folks to drive a long way and then get hit with a copay too, it really is a disincentive.

So I appreciate that you are on it, Dr. Upton, and hopefully you will continue to make sure that this gets taken care of.

I want to talk a little bit about mental health, and since I am the only one here you can shut the damn clock off because I am just going to keep asking questions until I get through them all.

Despite serving in record numbers, the needs of our Native veterans has been historically not something I have been particularly proud of, quite frankly. I am pleased to see that the Fox Suicide Prevention Program created by the Scott Hannon Act placed a strong emphasis on providing suicide prevention resources to Tribes and organizations serving Native Americans. This includes the Great Plans Veteran Service Center located in a reservation that is pretty close to where my farm is, the Rocky Boy's Indian Reservation.

I know the VA has also been working to improve its care options for Native veterans. Dr. Upton, can you speak to how the VA works hand-in-hand with Tribes and Native veterans to provide culturally competent mental health care?

Dr. UPTON. Yes, I would be happy to, Mr. Chairman, and thank you for mentioning the Staff Sergeant Fox grant as well, that fund community suicide prevention. In fact 21 out of 80 that we awarded go to areas that cover Tribal communities.

To answer your question, sir, there are a number of ways that we work to address culturally component mental health care. We think it is critical that both veterans have trust to seek our care, that we build those relationships with our Tribes at the local level as well as the work we do regionally and nationally, so that they trust to seek the care within our system. And once they seek that care it needs to ensure that they are respected for their cultures, beliefs, and values.

And so just very briefly our Office of Mental Health and Rural Health have placed a focus on this in our Native American population. For example, there has been a group working with multiple medical centers, with their local Tribes, to essentially develop a suicide prevention program focused on Native veterans, both partnering with Tribes, because that is so critical, partnering with the community, as well as culturally specific care associated with that.

We have a number of other examples, like our Veterans Crisis Line workers have an outreach team that after a veteran calls our Crisis Line there typically is follow up to make sure the veteran is okay to check in. Those secondary responders are trained in Native American culture as well as other pieces. And then there are a few other examples I could share, sir, including culturally appropriate care for telehealth. We have a project working on that.

But there is certainly more work to do, and our Tribal Advisory Committee has talked about suicide prevention as a key priority, and we are committed to working closely with them on that.

Chairman TESTER. Okay. Before I turn to Senator Rounds, I do not know if this is a fair question for you, Stephanie but I am going to ask it. In your travels have you seen the impacts of the VA's mental health from a cultural standpoint?

Ms. BIRDWELL. I have seen of VA's mental health services from a cultural standpoint. I have seen examples of excellence in different pockets of the country. I have seen that occur with a project with Camp Chaparral, which is a partnership between the VA and the Yakama Nation, that happens every summer. There is a veterans camp where you bring together American Indian and Alaska Native veterans and VA providers for a week-long kind of immer-

sion program. It is something that is very powerful and has been ongoing for quite some time.

And then there is also sweat lodge ceremonies, partnerships with traditional healers in different parts of the country. We have a strong impact with that in New Mexico with the Albuquerque VA Medical Center.

So like I say, I see pockets of that excellence, but I think that there is still work to do in a uniform way, on an enterprise-wide basis. But also considering 574 Tribes, 574 unique ways of doing things traditionally, so there is a lot of work to do and a lot to learn as well.

Chairman TESTER. Senator Rounds.

SENATOR MIKE ROUNDS

Senator ROUNDS. Thank you, Mr. Chairman. Let me just begin, I want to thank our guests for taking the time to join us here today.

Before I begin my questions I would like to take a moment to talk about the Native American Direct Loan Program. I think this is a program which, as you are probably perhaps familiar with, that actually is one that would provide a number of our Native American veterans with an opportunity for a home loan that they may not have today. And so the idea that we have Native American veterans that are not able to get a home loan because they are, in many cases, living on Tribal trust land, seems to me that it is something that we could address.

It is no secret that this program is not meeting its full potential to improve home ownership opportunities for Native American veterans, which is why Chairman Tester and I have introduced the Native American Direct Loan Improvement Act, S. 4505. We did that earlier this year. The VA provided testimony on this bill during our legislative hearing in July, and I appreciate the support and the technical assistance the Department has provided since them.

I spoke with Secretary McDonough yesterday, and he informed me that the VA is also taking some steps internally to improve its NADL operations while S. 4505 moves through the process. This is promising news, and I want to thank the Secretary and his team for their continued support for my bill while staying active on this important issue.

While I am encouraged by the VA's recent efforts there is still more work to be done, and I remain committed to getting S. 4505 across the finish line to make certain that Native American veterans are able to use this home loan benefit, which they have earned through their service. And Mr. Chairman, I really think it is time for us to get this done.

I do have a question for Mr. Bell. Since the release of the GAO report earlier this year your staff has been taking steps to improve the NADL program on an administrative level, and I appreciate that. I also appreciate the technical assistance your staff has provided with crafting an amended version of S. 4505. I think it is pretty clear that it is going to take some legislative action to get this thing fixed for deserving Native American veterans in my State and across Indian Country.

I guess my question would be, do you agree that there is still a lot of room for improvement within this program?

Mr. BELL. Yes, sir, and thank you, Senator, for allowing me to address the panel. First of all, 4505, to us, is very important. We appreciate the partnership we fully support with appropriation, 4505, because it does a few things for our program that we just cannot do. One is it removes the MOU requirement completely, which will provide VA the flexibility in establishing agreements with various Tribal organizations to expand the NADL program.

Second, it expands our NADL loan types, which is huge. Because while we have seen a very big increase in the use of the guarantee by Native Americans, American Indians, as well as Alaska Natives over the past 2 years, it is still important for them to be able to purchase, refinance their properties where they want to purchase and refinance their properties. This allows us to go across the finish line and offer a non-NADL loan the chance to refi into a NADL loan, as well as from a cash-out standpoint the ability for them to use their equity that they have earned as cash-out. Because maybe they want to stay there and renovate, and why would they not have the opportunity to do that as well?

And then third, and certainly not least, is the CDFI relationships that it allows us to create, just to make it even easier for Native Americans to purchase land, to purchase and build properties where they want to.

So while we have seen those huge increases, we still need 4505 to get us across the finish line, and why we think that it is so important.

But to answer your first question as well about administratively, we are very excited, and while we are working on 4505 we still believe that there are things that we can do from an MOU standpoint to remove some of those impediments and really open up the aperture, especially in the State of Alaska, where we have been unable to get our NADL loan some success in those areas.

So very exciting and promising in that arena, so thank you.

Senator ROUNDS. Thank you, and I appreciate all the help and the technical support that you have provided us in moving this bill forward.

Thank you, Mr. Chairman.

Chairman TESTER. Senator Rounds, I would just say that we are going to hotline 4505, and if you can clear it on your side I will clear it on mine. How is that?

Senator ROUNDS. Let us go to work on it.

Chairman TESTER. All right, baby.

I have got to turn the gavel over to Senator Moran because I have got to go vote.

SENATOR JERRY MORAN

Senator MORAN [presiding]. Mr. Chairman, thank you. I do have an opening statement but I will submit it for the record, so I ask unanimous consent that that occur. Without objection, so ordered. And my understanding is that Senator Hirono is next to ask our witnesses questions.

[The opening statement of Senator Moran appears on page 41 of the Appendix.]

SENATOR MAZIE HIRONO

Senator HIRONO. Thank you, Mr. Chairman. Dr. Upton and the rest of our panel, thank you very much for joining us today to discuss issues facing Native veterans.

As a Senator from Hawaii, I am very disappointed, Dr. Upton, that your testimony neglected to mention Native Hawaiian veterans. As you know, like other Native communities, Native Hawaiians serve in our military at disproportionately higher rates. I know the VA understands the importance of ensuring Native Hawaiian veterans are treated with the same concern as American Indians and Alaska Native veterans, especially following the Secretary's recent visit to our State in October for a field hearing.

But it is critical, given the historical lack of parity Native Hawaiian have received from the VA that Native Hawaiian veterans are always included in our language and our policies. Would you be willing to correct the record to include Native Hawaiians in your testimony and to show how you are engaging with Native Hawaiians as part of the Native American veteran community?

Dr. UPTON. Thank you, Senator, and I appreciate the acknowledgement of our Native Hawaiians who are so important and important in our veteran population. As noted in our testimony, they are an important part of our Tribal Advisory Committee, and I really appreciate that voice being on the group that advises our Secretary.

In talking with our region of VAs that works very closely with the team in Hawaii, I know that they are taking the work with our Native veterans very seriously, working on efforts with the University of Hawaii as well as other outreach to the population there. We certainly welcome the input on how to do better and to continue those partnerships.

Senator HIRONO. So my main point is that Native Hawaiians should never be deemed an afterthought, and that when we talk about focusing on programs that support Native communities or Native American veterans that would be three large groups of Native peoples, and you know who they are. So I am asking that we need to always include Native Hawaiians when we start talking about all the things that we are doing.

I am aware that there are specific programs that support Native Hawaiians. So like other Native communities, Native Hawaiian veterans have long experienced significantly more challenges in accessing resources, an issue that former Senator Akaka, Senator Dan Akaka from Hawaii, who had chaired this Committee, fought to fix for years, and one that I am committed to as well.

VA's own 2021 National Veteran Health Equity Report chart book on Native Hawaiians and other Pacific Islander veterans reported that Native Hawaiian veterans often expressed more issues with care as compared to white veterans. It is clear that the VA needs to increase its understanding of Native Hawaiian culture, outreach to Native Hawaiian community, and build ties with organizations trusted by the community to ensure Native Hawaiian veterans receive the care they deserve. And I would greatly appreciate a VA partnership on issues important to veterans in Hawaii.

We have a lot of veterans in Hawaii. A big group of them are Native Hawaiians, including, of course, as I mentioned, Secretary

McDonough's visit to Hawaii earlier this year. But it is clear that the VA still has serious work to do to better support Native Hawaiian veterans, and I hope that we can continue working together to ensure Native Hawaiian veterans are getting the care and benefits they earned through their service to our country.

This really requires, in many cases, very different ways of outreach to this community. It requires understanding of the Native Hawaiian veteran community. So I realize you do a person who sits on your advisory group and I will continue talking with him as to what more support we can provide.

I have a question about homelessness in the time I have left. Homelessness among veterans is a huge issue for the VA, and at one point one of our Secretaries said that eliminating homelessness among veterans was his top priority. Clearly that is still an issue. So we are talking about the 2022 Point-in-Time Count showed that Native Hawaiians or other Pacific Islander veterans make up the second-largest share of homeless veterans on islands, and that veterans overall had twice as many health conditions as compared to the broader population included in the PIT Count.

In your testimony you mentioned VA's toolkit to provide, and I quote, "background, planning, resources, and programmatic options for organizations interested in finding solutions for homelessness among Native veterans," and this tool does not, again, mention Native Hawaiian veterans at all. Does VA have any strategies that specifically address Native Hawaiian veterans experiencing homelessness, and if so, do these strategies integrate Native Hawaiian cultural practices and norms?

Dr. UPTON. Thank you, Senator, and please know I take all of that feedback very seriously. I do not know offhand about specific programs impacting homelessness for Native Hawaiians but I will absolutely take that for the record and we will follow up with you.

Senator HIRONO. Thank you. So homelessness as well as so many other health issues, including mental health issues and suicides of Native Hawaiian veteran group experience much higher rates than the larger population. So Mr. Chairman, thank you for your indulgence. I am a little bit over time, but clearly we have work to do. Thank you.

Senator MORAN. Senator Hirono, thank you very much.

Before I ask my questions I again want to—it is not again because I did not make my opening statement, but I thank our witnesses from both IHS and VA for being here this afternoon. And before I get to my questions I want the Committee members to know that I think this is valuable for us as we presumably are bringing this session to a conclusion.

We have been working on these issues for a long time, and progress has been made. There is much further progress we can make before we can make certain that American Indians and Alaska Native veterans are able to take advantage of all the services that they are due and have timely, easy access to health care and benefits from both agencies.

I also want to note that for more than a year now this Committee and our House counterparts have been negotiating two end-of-the-year legislative packages, the Dole-Cleland Act and the STRONG Act. Both of these bills have provisions in them that

would help veterans and their families across the country, including in Indian Country. We are very, very close to reaching a final agreement on those bills and being able to get them to the President's desk this Congress. In order to do that we would need to start the Senate hotline process no later than next week, meaning that we would need to reach a final agreement between the four corners this week. It would be a shame for the topics that we are talking about today, but for a variety of other veteran issues, if we are unable to get to that point after so much time and effort has been spent.

Almost every, if not all, members of this Committee have something at stake in that legislative package, and I certainly am willing to do everything I can to get there, and I would ask my colleagues on both sides of the aisle to help us get to that point and send another year-end package of important legislative items to the White House.

Let me ask my first question, and that is to Dr. Upton. Recognizing the barriers that Tribal communities often have had in accessing VA health care and benefits, how is the VA targeting outreach and communications regarding the PACT Act to toxic-exposed veterans and survivors in Indian Country?

Dr. UPTON. Thank you for that question, Senator, and it is so important that we do this outreach, and thank you to you and the Committee for passing the PACT Act. It is allowing us to help so many veterans.

As I look at the landscape of the work being done across VA, and I have connected with many leaders across our organization, including those who work closely with the team in Kansas, the importance of the Tribal relationships in the local community are so critical. And so there are a number of ways that our local VA medical centers as well as the VISNs are connecting with Tribes, holding events, meeting with Tribal veteran representatives, specifically talking about enrollment and now the PACT Act. I have a number of examples that I would be happy to share with the Committee, if interested, about some really neat ways that our teams have come together, with VBA and others in our Tribal community, to share those benefits.

Ms. Birdwell, you may have some background on this too, because she has been doing this for a while, but know it is a priority.

Senator MORAN. We would welcome you sharing those examples with us, with the Committee, in the future.

Ms. BIRDWELL. Sure, so good afternoon, Senator.

Senator MORAN. Good afternoon.

Ms. BIRDWELL. Since 2018, our team has worked very closely with the Veterans Benefits Administration, VHA, and IHS to hold what we call—they are claims events or claims clinics, where we go onsite and we provide intensive services to assists veterans with filing their claims with the VA, filing for health care benefit through VHA. And so that has been an outreach that has been ongoing. Again, it is something that has become a permanent part of VA business practice for about 4 years now. So that is something that I would anticipate that the PACT Act outreach would roll into that.

Now I will pause on that to say that it is a very timely question. I have calls already being scheduled next week. Our team has been contacted directly by VA medical center directors and then local IHS area directors, to say we need to start having some conversations about coordinating how we are going to be doing PACT Act outreach rollout. So the work plan and the conversations are happening, and the plan is basically being built and growing as we speak.

I also want to mention that the VA Advisory Committee on Tribal and Indian Affairs, I think their voice and their recommendations will have a very strong influence on how outreach is done.

Senator MORAN. Have they met specifically on implementation of the PACT Act?

Ms. BIRDWELL. They had their most recent meeting about 2 weeks ago, and they will have another meeting coming up in April. They also have subcommittee meetings in between their full public FACA meetings. So I cannot speak for the TAC but I think that is something that is very much a priority on their radar, that they will be talking about internally.

Senator MORAN. Thank you.

Ms. BIRDWELL. And also something else I just want to mention to you, that is very much on the table when it comes to outreach and getting Tribal input, is broader Tribal consultation to get feedback on how effective we are doing and to kind of really hold us accountable, moving forward.

Senator MORAN. Are there any questions that you would have me ask the second panel that would help elicit that kind of input?

Ms. BIRDWELL. I think asking them the same question really that was presented to us, you know, just really straight up, what are the most effective ways of reaching and informing veterans in our local, Tribal, and urban communities with respect to this information. And then, you know, for better or worse, where the TAC has seen areas where VA can improve, apply some of those to PACT Act outreach as well. So I would just ask them the question directly what they recommend.

Senator MORAN. One of the things that at least initially surprised me is the number of times we learn about veterans who do not enroll in the VA, who do not know they are eligible for health care or for benefits. I do not know off the top of my head, although I have a group of experts behind me who could probably answer this question, the percentage of veterans that fail to take advantage of what they are entitled to at the Department of Veterans Affairs. Do you know whether that percentage, that number, is different between Native American and Alaskan Native veterans than it is the general veteran population?

Ms. BIRDWELL. I do not know that definitively. It is my impression that that is accurate, however, that American Indian and Alaska Native veterans enroll in VHA health care at a far lower rate than their non-Native counterparts.

Senator MORAN. Thank you. My time has more than expired, and while I thought I had a free rein and free run, the Senator from North Carolina has arrived and he is recognized.

SENATOR THOM TILLIS

Senator TILLIS. Thank you, Senator Moran, and thank you all for being here today.

I want to talk a little bit—and will try not to belabor the Committee hearing—but I want to talk a little bit about efforts to ensure Native American veterans can access and utilize health care and the benefits they have earned and deserve. And I know firsthand some of the challenges that Native American veterans face receiving VA and non-VA health care and benefits, particularly in the rural part of the country. It may come as a surprise to some but North Carolina has the sixth-largest population of Native Americans in the country, and it is home to the largest Tribe east of the Mississippi, the Lumbee.

Native Americans have a long and distinguished history of military service, serving in armed forces at a higher rate than any other demographic, and I think even more so for the Lumbee, not too far away from Fort Bragg.

Despite their service, Native American veterans have lower educational attainment, higher unemployment rates, higher suicide rates, and are more likely to have service-connected disability than veterans of other races.

I want to talk a little bit about the progress. I am sorry I could not be here; we have had votes and competing meetings. I will review some of your statements. But before I get into one or two questions I want to ask, give me hope. What specifically are we doing for Native American veterans and expanding care and addressing some of the disproportionate, poor outcomes that we have in that population, and maybe if you could speak to some of the root causes.

Dr. UPTON. Very important question, Senator, and I will start and turn to Ms. Birdwell, as well as potentially our IHS colleagues as well because it is so important.

I would say, number one, when it comes to VA health care, the importance of trust and engagement and listening to our Tribal partners is the number one thing I hear all the time. And it is so important that when we work with our Tribal partners and our Tribal leaders that they are at the table, that we make joint decisions together, and we understand the needs of the local communities. We know there are 574 federally recognized Tribes, and a lot of different customs, values, beliefs, and approaches, and history and trust that we need to build with them.

So I will say if there is one common thread I have heard across the board is that local engagement, the trust building, the dissemination of resources by trusted partners, and then when they get in the door, ensuring that they are treated with respect and sensitivity to their culture. There is definitely work to do, as you mentioned, Senator, and just for the sake of time I will turn to you, Stephanie. But it is something that is so important.

Ms. BIRDWELL. Senator, I would say that there is actually quite a bit of good things that are happening. One of them, most recently, has been the advent of the VA Advisory Committee on Tribal and Indian Affairs. That advisory committee is a voice directly to the Secretary, and I have seen firsthand how seriously the Secretary takes that relationship and the role that they play in ad-

vancing the status of our American Indian and Alaska Native veterans.

Another very positive success story has been the reimbursement agreements that have happened between the VA and IHS. I believe that to date there have been approximately 15,000 American Indian and Alaska Native veterans who are now enrolled in VHA health care over the last decade that previously had no visibility or access to VA. And then at the same time the Indian Health Service and over 115 Tribal health programs have been reimbursed approximately $180 million, which is something that is very much needed in the Tribal community.

And we have got the Office of Academic Affiliations. It has been a long, iterative process, but they have authorization to VA fund 100 graduate medical education students who will do their residency rotations in IHS and Tribal health facilities.

You know, I could go on, but really it is very exciting. I mean, there are still some very serious challenges, of course, in serving our Native veteran population, but if you look at where we were 10 years ago, there has been a tremendous amount of progress that has been made in a relatively short period of time.

Senator TILLIS. I will follow because I am more about trend lines, programs that are working, and really programs that are not working. You know, sometimes when we put programs in place, particularly if they are congressionally mandated, and they do not work, they still stay there. So the question we have to ask ourselves is what is working that we should double down on and what is not working that we should quiesce. We will make sure that we reach out to your staffs to get more details. I will not take you to that level now.

Ms. Tso, I want to ask you a question. The Lumbee Tribe, I think, first sought recognition about 130 years ago. In the mid '50s, they were simultaneously recognized and unrecognized. More recently, we have seen bipartisan support from the Governor, the State legislature. Former President Obama called for recognition. Former President Trump called for recognition. During the campaign, in President Biden's first term, he also said it was time for recognition, and I believe Vice President Harris was down in Robeson County and said that to the Lumbee Tribe members when she was down there.

Is it still your understanding that President Biden supports recognition of the Lumbee Tribe?

Ms. TSO. I am going to ask my colleague here to respond to that question.

Senator TILLIS. Mr. Smith?

Mr. SMITH. Yes. Thank you very much for the question. This is a question that we would first recommend being directed to the Department of the Interior, and we can certainly take this back and check in with our colleagues at the Interior. But as you know there are really two processes for Federal recognition for Tribes, one that is administratively managed through the Department of the Interior and then the other——

Senator TILLIS. And then congressionally.

Mr. SMITH. Yes.

Senator TILLIS. Yes, and I think in that case I think that President Biden, when they made the conscious decision during the campaign to say that they thought it was time for recognition, understands the two paths, one path that for 130 years has not worked, and another path that is before us in this Congress, and every other Congress for over a century. So I was just curious if there had been a change in posture. I have had some discussions with Lege Council, and I have gotten the impression that they are still behind it, and we are going to continue to work on it.

The last thing I would just offer to you all, to the extent that we are talking about the Tribal population in North Carolina, of course we have the Eastern Bank of the Cherokee, the Lumbee, but we have seven other Tribes, that I feel like sometimes if we are going to really increase their access to care and benefits you have got to go where they are. If you have a program, you hope that they come to it. But I would like to talk to you all about potential opportunities we would have to go down into the State and make it very clear that we want to get them every benefit they deserve. Thank you.

Chairman TESTER [presiding]. Thank you, Senator Tillis. Senator Sullivan.

SENATOR DAN SULLIVAN

Senator SULLIVAN. Thank you, Mr. Chairman, and I appreciate the panel being here. Really, really important issue, certainly in my State, and I just want to begin by acknowledging what we all know, but I just think it bears repeating, about the incredible what I refer to as special patriotism of the Native American people and Alaska Natives who serve at higher rates in the military than any other ethnic group in the country. Think about that. It is really remarkable when you think about this is a group of Americans who, let us face it, have not always been treated well by their own government. And yet generation after generation they sign up to sacrifice, protect, and die for their country. It is unbelievable.

I had the great honor, and literally it was the honor of a lifetime, to be asked to speak at the Veterans Day ceremony this year at the National Museum of the American Indian on the Mall, for the dedication of the really powerful memorial to American Indian, Alaska Native, Native Hawaiian veterans. It was great. The Secretary of the VA came too. It was a fantastic ceremony. So I think this is a really appropriate hearing. We all need to do better for these wonderful veterans and their families.

So let me first—and I will just throw this out to the panel—this is the question I had asked the Secretary in a hearing just a couple of weeks ago, and then he and I had a discussion yesterday about this. This is the Native American Direct Loan Program, which really has not worked for Lower 48 Indians well, but it really has not worked for Alaska Natives. A 40-year-old program and not one Alaska Native veteran has ever gotten one loan.

So the Secretary committed to me again, in a phone call, which I really appreciated, that the VA was going to work for ways to get an administrative fix to this so we can start doing what the bill was intended to do, and the program.

Can any of you, Mr. Bell, maybe, take this one on?

Mr. BELL. Thank you, Senator, and good news to report. At least we were on the verge of one.

Senator SULLIVAN. Oh. One in 40 years. You have got to start somewhere.

Mr. BELL. Yes, sir. I am not looking for a pat on the back, just a fact——

Senator SULLIVAN. Well, that is helpful.

Mr. BELL [continuing]. That we are trying to——

Senator SULLIVAN. Where are they from? Can you tell me?

Mr. BELL. It is the Metlakatla Tribe.

Senator SULLIVAN. Yes. So that is great, and I love Metlakatla. I was out there for the dedication of their VA cemetery, which was unbelievable. I mean, so powerful. So many veterans on Metlakatla. But let us make sure it is not just Metlakatla. As you probably know, Metlakatla is the only Indian reservation in Alaska, which is great, but this needs to extend beyond Indian Country, because we do not have Indian Country other than Metlakatla.

Mr. BELL. Yes, sir.

Senator SULLIVAN. But thank you. Can you do that? Are you ready to fix it that way, do you think?

Mr. BELL. Yes, sir. That was part of the call yesterday, that we are——

Senator SULLIVAN. Were you on the call yesterday?

Mr. BELL. No, sir. Here is what we know. S. 4505, the legislation, the bill that we are trying to get passed—Senator Rounds has been working with our staff certainly since July—gives us a lot of tools in our toolbox to be able to open up and make NADL loans available in those areas where we have the 12, you know, for-profit centers with shareholders in those lands, that we have not just been able to get into.

The hope is that by expanding the administrative part while we wait on 4505—so we are trying to expand the administrative look, or understanding, sorry, and the statutory language that we have so that we can establish an MOU with that area, with those partnerships, so that we can start doing loans in those areas.

Senator SULLIVAN. Okay.

Mr. BELL. So that is one thing. The other thing is, the reason why 4505 is so important to us is it does away with the MOU requirement, period.

Senator SULLIVAN. Okay.

Mr. BELL. So we do not have to worry about that issue.

The positive thing about our American Indian, Alaska Native population is we are seeing that, from a Native American housing standpoint—so if you look at the guarantee and you look at the direct loan, they qualify for both. It just depends on what land that they are wanting to build or purchase or refinance. The number of guaranteed loans continue to rise——

Senator SULLIVAN. Okay. In Alaska too?

Mr. BELL. In Alaska too. Yes, sir.

Senator SULLIVAN. Okay.

Mr. BELL. So the guarantee portion of the program is growing. It is now how do we get the direct loan program to grow along with it. And so hopefully that MOU requirement will help us do that, by lifting some of those issues.

Senator SULLIVAN. Okay. Mr. Chairman, do I have time for one more question?

So we want to work with you on that. The Secretary is committed. I appreciate that. He said it in a hearing. He said it to me yesterday on the phone. We all know the end goal here should be Native Americans, Alaska Native should be able to utilize these programs. That is why they were designed. So we want to work with you on that. It is complicated in Alaska, given our land status and ANSCA, but that should not be a bar to home ownership from the VA, if you have served and sacrificed for your country, just because we have a different land setup—by the way, which was passed by Congress, right.

So here is my second question, and again, maybe for everybody. And I am sure this is not just an Alaska issue. This is probably a Montana issue. But many of our Native veterans live in rural communities where housing vouchers are not an appropriate solution for vets in need of housing, because there is no rental market at all or the vouchers are based too-low fair market rents. And these are actually in communities where there is not any housing and there is often multigenerational, crowded family homes.

So how can you design a program that is not like, hey, this is a VA loan for that nice house in the city or that nice house in the suburb, but in a very rural community with very little housing stock, when it based on rental vouchers that just do not, like, work. And I guarantee you there is a problem in Montana and other rural States, not just Alaska. But it is a huge problem in Alaska.

Any takers on this? I am beyond the NADL issue for other general VA veteran Native loans. Mr. Upton, do you want to take this on?

Dr. UPTON. Sure. I would be happy to take that, Senator, and I appreciated your very thoughtful opening about the veterans as well. I really appreciate that.

Senator SULLIVAN. I care deeply about this issue, for that reason.

Dr. UPTON. Absolutely. So with regard to housing, the bottom line is it is significantly challenging, as you have talked about. We have a very dedicated group within VA, focused on tackling homeless. And as I have talked to them and they do this work, there are a lot of things they work to do with our Tribal communities, but they often say the housing stock is a significant limiting factor.

We have a Tribal HUD-VASH program that works specifically on Tribal lands with our Tribal partners, and there are 29 of those that are in existence right now, and I am happy to share some more background, that help with some of the voucher pieces you talked about. But there is a lot of work to do, and we would look forward to——

Senator SULLIVAN. Well, we would like to work with you and the Committee on this. It is just an issue that one size does not fit all in the housing market and we should not penalize Native Americans, Alaska Natives, Native Hawaiians who have this heroic record just because they live in very rural areas. We should design a program around that challenge.

So we want to work with you. I think, Mr. Chairman, this would be a good area of bipartisan work on this Committee as well.

Chairman TESTER. For sure.

Senator SULLIVAN. Thank you.

Chairman TESTER. You bet. I have got one follow-up and it goes with Senator Sullivan's questions on the direct loan program as it specifically applies to Alaska. The MOU situation, if it is fixed, as it in 4505, does that make this bill workable in Alaska, the program, the direct loan program workable?

Mr. BELL. Well, it makes it available for us to offer the direct loan program in those areas, because the issue was around the type of land and the type of trust that that property was actually in. So the limitation was the MOU, so yes, sir.

Chairman TESTER. Okay. So what we are going to do, because Senator Rounds was in a little earlier, we are going to try to hotline 4505, so we may need your help to get that done.

Senator SULLIVAN. Yes, that would be great. Just to clarify, so this does not—so Metlakatla's trust land, Indian Country, our own reservation, the rest of Alaska, the 44 million acres that the Native people got during the Alaska Native Claims Settlement Act, is actually fee-simple land.

Mr. BELL. Yes, sir.

Senator SULLIVAN. But that should not—like who cares, right? It is still for Native veterans. So it just needs to make sure it is not somehow tied to trust land or Indian Country or reservation land, because we do not have any in Alaska except for Metlakatla. So is that fixed?

Mr. BELL. Yes, sir. So of course with Metlakatla, they fit the parameters of the MOU.

Senator SULLIVAN. Yes, that is great. We love that.

Mr. BELL. Right? So the issue was our authority to establish the MOU that we had for national did not fit the other 258 Tribal villages in Alaska, which basically made it impossible for us to establish that direct loan program in those areas. If you remove that piece and you—either, one, you remove the piece by 4505, or two, administratively, we take the risk to make that right until we can get 4505 done, then that also allows us to go into those areas, get a memorandum of understanding done, or not, and start asking the next question—now that the direct loan program is here, what can we utilize across those areas to work with the direct loan program if a veteran needs it, such as down payment assistance or other available programs so that they have the same capabilities as they do across the——

Senator SULLIVAN. So, Mr. Chairman, if we can take one more final look at that before we move to hotline it, that would be great.

Chairman TESTER. Absolutely. So it has been heard in Committee. Look, I appreciate what the VA is doing, but it is much better if we do it and then you follow our lead. And so if we can get 4505 done I think it fixes your problem, specifically.

Senator SULLIVAN. Okay. Great. Thank you very much.

Chairman TESTER. Yes, thanks.

I want to thank the panel for being here. I appreciate you guys' time, what you do, your attention, and I appreciate you being here and answering the questions forthrightly. Thank you, and pass my thanks on to everybody you work with too, for the job that they do in the different agencies, whether it is the VA or IHS. Thank you all.

We will get the next panel up.

[Pause.]

Chairman TESTER. So welcome to our panelists on the second panel. I am going to introduce our virtual person first. His name is Leo Pollock. He is an enrolled member of the Blackfeet Nation and Marine Corps veteran, Administrator for the Blackfeet Veterans Alliance, who does great work in my home State of Montana. As I said, Leo is joining us virtually.

Next is Larry Wright, Jr. Welcome, Larry. Larry is from the Ponca Tribe of Nebraska, Army National Guard veteran, and the Executive Director of the National Congress of American Indians. I do not know what you do in your free time but it does not sound like you have much of it.

Next we have Nickolaus Lewis, an enrolled member and Councilman of the Lummi Nation, that has been talked about earlier here today, Vice Chair for the National Indian Health Board, a Navy veteran who serves on the VA Advisory Council on Tribal and Indian Affairs. Thank you for being here with us, Nickolaus.

And finally joining us also virtually is Sonya Tetnowski, President of the National Council of Urban Indian Health and CEO of the Indian Health Center of Santa Clara Valley. Sonya is an enrolled member of the Makah Tribe, an Army veteran, and also a member of the VA Advisory Committee on Tribal and Indian Affairs.

I appreciate all four of you being able to testify in this hearing. We will start in the order that I introduced you, and will have Mr. Pollock virtually. Please begin.

PANEL II

STATEMENT OF LEO POLLOCK

Mr. POLLOCK. Chairman Tester, Ranking Member Moran, the rest of the Committee, thank you for having me here today.

Funny enough, we are actually here with this meeting that we are here today. To be here for you to give my testimonial I actually left another meeting for access for VA health care for our veterans here, not just on the Blackfeet Reservation, for all of Montana.

Our current IHS, the last veteran that was ever served was in 2014. We are actually in talks with IHS, the Billings area office, as well as the county unit so that we can reestablish that. We are also working with our Southern Piegan Health Clinic to see if there is any way that they can provide services that may be lacking in between the VA and the IHS, that they can help fill that gap. And as we head through to do those shared services.

One of the big things that I know we were looking at is that our reservation, you know, it is not a small reservation. It is over 3,000 miles that we are looking at, square miles that we are looking at. We have two counties that are actually part of our reservation, the Blackfeet reservation. That is Glacier County, which does make up the bulk of that, and our other is Pondera County, which is the south, and that actually encompasses the small village of Heart Butte.

The reason why we are fighting so hard to reestablish our outpatient clinic for our veterans here on the Blackfeet Reservation as well as surrounding communities is that as we all are aware, Montana winters, they are not easy to navigate. Sometimes some of us are stranded for days on end until we are able to get back into civilization.

We have small communities such as Babb/St. Mary that are to the north of us, and oftentimes that should be a 30-minute trip with ideal driving conditions. However, given our severe weather that we are in right now, we are actually in a winter weather advisory until tonight or early tomorrow morning. And we did have some VA representatives that came up from Helena. They actually drove as far as Great Falls yesterday so that the trip was a little safer and easier for them to be here at a decent time for us for our meeting earlier today.

So one of the biggest things we are looking at for our veterans here and why we want to make sure that we can reestablish our outpatient clinic is, like we said, when you have ideal conditions, and what should be a 30-minute drive one way, all of a sudden that turns into a hour drive one way. And give the ever-changing weather conditions that we have here, that can easily turn into 2 hours, which, you know, the numbers just keep adding up as we go.

We currently have, from what I have gathered, we have well over 700 veterans here in Glacier County. That is not including Pondera County. We just want to make things easier for them. But one of the things that we also face with that and why we want to reestablish our clinic here in the reservation is that a lot of times it is the financial barriers that our veterans face here. They may not even have the financial means to get to any other VA appointments, more so if those appointments are in Fort Harrison and Helena. Many of our veterans cannot afford a vehicle or do not have the transportation means to get to those appointments.

Sadly, what happens with a lot of our veterans is that when they do not have that they kind of just give up and they just move on from there and kind of relegate themselves to this life that nobody is going to help them. However, you know, we are here to help them and we have been doing that. I have only been in this position for, I will be coming up on starting my third year in January, and in that time we have slowly begun to recreate some other services for our veterans. And we would just like to make sure that we can expand on that for our veterans and make the accessibility that much easier for them, vice having to fight all of these other barriers that we look at here in Montana. Blackfeet Reservation, I know it not just our reservation, but the other reservations within Montana as well.

So that is what I am here for, is to help be that voice for my fellow veterans and that we can do that and give them the care that they so deservedly should have.

[The prepared statement of Mr. Pollock appears on page 60 of the Appendix.]

Chairman TESTER. Thank you for your testimony, Leo. I appreciate you joining us today.

Next we have got Larry Wright, Jr. You have the floor, Larry.

STATEMENT OF LARRY WRIGHT, JR.

Mr. WRIGHT. Good afternoon, Chairman Tester, Ranking Member Moran, and members of the Committee. My name is Larry Wright, Jr. I am a former Tribal Chairman for the Ponca Tribe of Nebraska. I served 11 years in that role. I currently serve as Executive Director for the National Congress of American Indians, and I thank you for this opportunity to testify on behalf of Indian Country and Native American veterans.

As was shared earlier in your opening remarks, Chairman, this Committee is well aware of the valor and service of American Indian, Alaska Native, and Native Hawaiian veterans to this country. Also we know the high rate that our Native people serve in the military, and I also know that despite this impressive record of service the Committee knows that the lack of health care provided to these veterans upon returning home is unacceptable.

Obtaining health care for Native American veterans often means navigating both Veterans Health Administration and the Indian Health Service. The primary health care provider in most Native communities, for many of our Native veterans, is IHS. Thus, one mechanism for improving the health of Native veterans is to improve the IHS system, which has long been woefully underfunded.

Additionally, unlike the VA system, IHS continues to be subject to the harmful and disruptive effects of government shutdowns and short-term stopgap measures because it does not yet have advanced appropriations. This is precisely why NCAI has long been in support of advanced appropriations for IHS, and it is one step that can be taken immediately to help both Native veterans and Native communities, more broadly.

Focusing on Veteran Health Administration more directly, there are many barriers Native veterans encounter in accessing care. One alarming statistic is that Native veterans use VA health care disproportionately less than non-Native veterans, despite having the disproportionately higher percentage of veterans with a disability. One reason for this is that Native veterans seeking to get to a VA facility might have to make a 200-mile round trip, and in the case of Alaska Native veterans it may be much, much higher.

NCAI recommends that the VA, in coordination with the Department of Transportation, work with Tribal governments to facilitate transportation from Tribal community hubs to Veterans Health Administration hospitals. Additionally, we urge the continued exploration of alternative options, such as telehealth services, to ensure that all Native veterans are being reached.

When Native veterans are able to get an appointment and make it to VA health care facilities, all too often they are met with a poor understanding of Native culture, which creates another barrier to Natives trying to access services. We are hopeful that the recently created Tribal Advisory Committee within the VA will assist with some of these issues, and applaud the efforts made to create that entity under law and to fill its seats.

That said, more needs to be done to address the cultural competency. For example, many forms and questionnaires do not address cultural context or risks, additionally, as a result of incurring

traumatic brain injuries, and some Native veterans struggle with second language retention and require services to be administered in their Native languages instead of English.

And finally, there is a dearth in Native professionals and individuals with adequate understanding of Tribal communities to truly allow individuals with health concerns to be open and honest and trusting of the system, something that is essential to achieving positive outcomes for those in need. Given the importance of cultural competency, NCAI Veterans Committee has expressed the need to increase access to Tribal veteran service organizations to assist American Indian and Alaska Native veterans with benefits claims and accessing other VA services. Similarly, more government-to-government consultation between the VA and Tribal nations can also generate new methods for improving cultural competency across health services.

Before I close my remarks I also want to briefly highlight one other issue impacting Native issues, and will note that I have highlighted a few others in my written comments.

Despite the service that they provide to our country, homelessness and housing insecurity remains a major concern for our Native veterans. A simple but critically important step to combat this issue is to reauthorize and make permanent the Native American Housing Assistance and Self-Determination Act. NAHASDA reorganized the system of housing assistance provided to Native American through the Department of Housing and Urban Development by eliminating several separate programs of assistance and replacing them with a block grant program. This block grant program has successfully been used by Tribal nations across the country to focus on specific housing needs in their own communities. However, NAHASDA expired 9 years ago, and we cannot afford to let this critical legislation go unauthorized any longer.

NCAI urges the members of this Committee to support S. 2264, the NAHASDA Reauthorization Act of 2021. This legislation has been reported out of the Senate Committee on Indian Affairs, marking the most progress any NAHASDA reauthorization bill has made since 2013.

Additionally, many of the provisions in S. 2264 are included in the Senate Transportation and Housing and Urban Development Appropriations Bill, and we strongly urge this Committee and other Members of Congress to support these efforts. Reauthorizing NAHASDA will also help Native veterans struggling with homelessness by improving the HUD Veterans Affairs Supportive Housing program. The program has been a nationwide success because it combines rental assistance, case management, and clinical services for at-risk and homeless veterans. Unfortunately, this program is not fully available to Native veterans living on Tribal lands, which again is why NAHASDA reauthorization is critical.

Also in the housing space, NCAI urges the passage of S. 4505, the VA Native American Direct Loan Improvement, and we appreciate those comments on it today. This program has only provided 190 loans to Native Americans nationwide over the last 10 years. This legislation would help to increase the number of NADL-administered loans by allowing veterans to refinance existing non-VA mortgages utilizing the NADL product, and would also allow vet-

erans who have built homes with other sources of construction financing such as Native CDFI loans, to still use this as permanent financing. It also provides grant funding for Native CDFIs, Tribal nations, tribally designated housing entities, and nonprofits to assist with outreach, homebuyer education, and other technical assistance to Native veterans seeking home ownership financing.

Finally, I want to take a moment and acknowledge that when the U.S. Government does engage in meaningful dialogue and consultation with Tribal nations solutions can be found. We do not need to look any further than the Native American Parity in Access to Care today, the PACT Act, which was signed into law nearly 2 years ago. That piece of legislation has improved accessibility to Veterans Health Administration services by eliminating copayments for our American Indian and Alaska Native veterans, and we are grateful for Senator Tester and his leadership on getting this passed. It is a valuable demonstration of what we can accomplish for our people, and as was said earlier, even though that was passed 2 years ago, we still need to get rid of those copays. Thank you.

[The prepared statement of Mr. Wright appears on page 65 of the Appendix.]

Chairman TESTER. Thank you, Larry.

Next up is Nickolaus Lewis. You have the floor, Nickolaus.

STATEMENT OF NICKOLAUS LEWIS

Mr. LEWIS. Good afternoon, Chairman Tester, Ranking Member Moran, and honorable members of this Committee. Thank you for holding this important hearing and inviting the National Indian Health Board here to testify with you all today. The National Indian Health Board, or NIHB, serves on behalf of all 574 federally recognized Tribes.

My name is Nickolaus Lewis. My traditional name is Juts-kadim' and I serve as Vice Chairman on the NIHB and as Chairman of the Northwest Portland Area Indian Health Board, and as a member of the VA TAC. I also have the honor to serve my people of the Lummi National as a councilmember for the last several years and as a proud Navy veteran of 8 years. I signed up for the Navy when I was 17 years old, so please know that serving this country and my people with honor has always been a priority to me since a young age.

Chairman Tester and Ranking Member Moran, I know you understand and have long been champions for Indian Country, so in the interest of time I will be brief and ask that my full testimony be submitted for the record.

More than half of Native veterans are estimated to get their health care through IHS or in combination with the VA. That is why coordination between the VA and IHS and this Committee's oversight for that coordination is vital. It is not enough for any agency officials to testify that they are committed to this coordination unless and until coordination is institutionalized and all staff are trained and held responsible, and any improvements made now and through this work would erode over time.

When it comes to veterans' health through IHS, coordination is not the only issue, as IHS has not received an annual budget on time since 2015. The new normal is stopgap funding through continuing resolutions which results in our primary health system suffering from disruptions and providing services to our people, but most importantly, our veterans. And when the Federal Government shuts down, which it has, the problems get worse and our lives are put at risk because of this.

The Northwest Portland Area Indian Health Board has passed a resolution at our last quarterly board meeting entitled "Condemnation of harm to Indian Health Care System caused by disruptions in Federal appropriations and resultant continuing resolutions," which we would be happy to share with you all as well.

As you know, the VA receives an annual advanced appropriation protecting them from shutdowns and stopgap funding. In 2018, the Government Accountability Office reported how advanced appropriations have helped the VA. Our veterans are looking for that same help for IHS. For many of us, getting our health care through IHS, as we have heard from others on this panel, is not only a choice but it is a necessity which I personally can attest to as I only receive my health care personally through Indian Health Service. The Indian Health Service is vulnerable to shutdowns and stopgap funding, and that is not right, and it needs to end, and we need your help in fixing this injustice.

We respectfully ask the Committee to talk with your colleagues on the Appropriations Committee and those in leadership about including IHS advanced appropriations in the final fiscal year 2023 agreement. Please, make them explain why they cannot get this done, because the excuses we have been hearing so far when we travel back here to the Hill about why VA deserves advanced appropriations but IHS does not seem unreasonable, unfair, and downright cruel. It violates the trust responsibility that our ancestors sacrificed everything for when they signed The Treaties with the United States Government. And when you help in stabilizing IHS, you are not just helping our people. You are also helping our Native veterans who we are here all advocating for today.

Finally, I want to turn to homelessness and housing. Mr. Chairman, I know these issues are things that you feel strongly about, as do I. Homelessness and housing are public health issues. We need to look closer to the social determinants of health across the board, and we need the VA to focus on those things as well, going forward. Studies show that homelessness and substandard housing are risk factors for so many of the health problems we have seen across Indian Country today. Our veterans are more likely to be homeless, with studies showing that 26 percent of our low-income Native veterans are affected by homelessness compared to only 13 percent of low-income veterans overall.

Work is still needed to address homelessness for veterans, and we call on the Senators to help us in removing these funding barriers, to provide direct and reoccurring and sustainable funding to Tribes and Tribal organizations, and to explore innovative solutions to end the housing crisis in Indian Country.

Today the VA, HHS, and HUD are announcing a Native Veteran Homeless Initiative to increase access to care and services. The ini-

tiative will ensure that Native veterans are aware of and have access to available resources. This awareness of resources for Native veterans themselves as well as for the Tribes supporting their veteran members is an issue that we have identified that can be addressed by increased targeted and ongoing administration outreach and messaging. For example, the Tribal HUD VA Supportive Housing program, or Tribal HUD-VASH, has existed since 2015, but awareness of the program and its policies are still lacking in our Tribal communities. Mr. Chairman, to quote you, sir, "The VA can outsource work when it makes sense, but it cannot outsource the responsibility for taking care of their veterans, whether they receive care at the VA or care in the community. They are responsible for both." And we would add that IHS is included in that.

What you are trying to do with S. 2172, the Building Solutions for Veterans Experiencing Homelessness Act of 2021, is a good thing and a step in the needed right direction, and we will do what we can to help get you across the finish line with that bill. In fact, we welcome the opportunity to work with you and Ranking Member Moran and any member on this Committee on any piece of legislation that supports improving the health outcomes for all of our veterans in this country.

This now concludes my testimony, and I want to thank you all for the opportunity to be here with you all and your continued efforts in improving the lives of our veterans. Thank you.

[The prepared statement of Mr. Lewis appears on page 72 of the Appendix.]

Chairman TESTER. Thanks, Nickolaus.

You know, we started this panel hearing from snowy Montana. Our last testimony, our last panelist, is Sonya Tetnowski, from sunny California. So Sonya, you are up, virtually.

STATEMENT OF SONYA TETNOWSKI

Ms. TETNOWSKI. Thank you. Good afternoon. My name is Sonya Tetnowski. I am a citizen of the Makah Tribe, President of the National Council of Urban Indian Health, and Chief Executive Officer of the Indian Health Center of Santa Clara Valley. I also serve as the chair of the health subcommittee within VA's first-ever Advisory Committee on Tribal and Indian Affairs. We are grateful to you, Chairman Tester, and to Senator Sullivan for your partnership on the VA Tribal Advisory Committee Act of 2020.

I am sharing my views here today as the President of NCUIH and not in my capacity on the advisory committee, to remain in compliance with Federal Advisory Committee Act.

As a U.S. Army veteran and as an Urban Indian organization leader it is imperative that our physical, mental, and cultural needs are addressed in a culturally competent way. As you know, 67 percent of Native veterans live in urban areas, and more than 50 percent use Indian health care providers. We need the ability to go to a facility that understands, respects, and recognizes our unique needs.

Urban Indian organizations provide a wide range of health and wellness services. In fact, we currently serve 7 of the 10 metropolitan areas with largest Native veteran population. Therefore, it is

critical that VHA work with us to improve the health outcomes of Native veterans across the I/T/U system of care.

Since more than 50 percent of Native veterans use the I/T/U system for their health care needs, securing advanced appropriations for the Indian Health Service is critical. Gaps in Federal funding put lives at risk. In fact, five patients died during the last shutdown. The risk is too big and the price is too high for us to continue without advanced appropriations. When the VHA received advanced appropriations the President said, "The care that our veterans receive should never be hindered by budget delays." Yet we have not protected our Native veterans who receive care from our I/T/U system.

During the last government shutdown, my clinic supported another urban program so that they could remain open. This should not be happening to our patients, and specifically to our veterans. All this due to funding delays caused by the shutdown. Therefore, I urge this Committee to help secure stable funding for all Native veterans by supporting advanced appropriations for IHS.

It has been about 2 years since we worked with you both, Chairman Tester and Ranking Member Moran, on the PACT Act, to remove copayments for Native veterans receiving VH health care. In September, VA committed to putting this legislation into effect and eliminating copays for Native veterans by the end of this year. But it needs to go one step further. We ask this Committee to encourage the VA to allow self-attestation in determining Native identity for VA copayment purposes, because many Native veterans may not have the kind of ID that defines them as Indian or Urban Indian.

NCUIH advocated for years, and I testified many times for the inclusion of Urban Indian organizations in the VA reimbursement program. We are grateful to this Committee for fixing this parity issue. However, many urban programs are experiencing difficulty in enrolling, and only 1 in 41 completed the process. We need additional technical assistance and the ability to modify these agreements so that they work within the scope of services of our respective sites.

I would like to thank the VA for working with Urban Indian health programs, but urban confer policy between VA and our clinics would solidify this relationship.

During the rollout of COVID–19 vaccines some veterans who went to the VA received vaccines and were told to go back to their Indian clinic. This highlights the need for greater coordination among all entities serving our Native veterans.

In June, the Health Equity and Accountability Act was introduced with the first-ever legislative text establishing urban confer policy with the VA. We would love to see this Committee including language in future packages related to Native health care.

In conclusion, Native people have a long history of distinguished service to this country, and we owe it to them to address these issues and remove these barriers to ensuring greater access to care. Thank you for allowing me to speak on these critical issues affecting Native veterans. My full testimony was submitted for the record, and I am happy to answer any questions. Thank you.

[The prepared statement of Ms. Tetnowski appears on page 83 of the Appendix.]

Chairman TESTER. Well, thank you for your testimony, and I hope it is sunny in California. I am going to defer to Senator Murray for her questions.

SENATOR PATTY MURRAY

Senator MURRAY. Mr. Chairman, thank you very much for holding this hearing. You know, 13 years ago we had a similar hearing where a number of issues were raised about access for Native Americans to VA health care and benefits, and we made a promise to take care of our veterans after their service, and it is clear that more work does need to be done to live up to that promise to our Native veterans.

I do want to thank all of our witnesses for being here today to speak on these important issues, and I especially want to thank Nick Lewis from the Lummi Nation. You heard from him, that he served in the Navy, and has been a leader in his community and works on these issues on a national stage. So welcome and thank you to all of you.

Mr. Lewis, let me start with you. I have been a very strong supporter of the HUD-VASH program to get supportive housing and case management services to veterans with high needs. But we know that HUD-VASH program has had its challenges, especially with the shortage of affordable housing in our State of Washington, and challenges VA faces while recruiting staff to serve our rural areas. In the Pacific Northwest a number of Tribal housing authorities use the Tribal HUD-VASH program for veterans who are at risk or are already experiencing homelessness in areas that can sometimes be very hard to reach in bad weather or that have long drive times to the closest VA medical center.

How would you suggest to all of us that VA improve its outreach in the Tribal HUD-VASH program in general, to make sure that Native Americans are actually able to access and utilize the program?

Mr. LEWIS. I think one of the things that comes to mind, and I was talking with our staff in the back, and many of the organizations that we sit on as Tribal leaders, and this is just something simple, is creating a listserv for Tribal veteran directors and Tribal communities, that veteran directors can opt into to receive updates. When we get those kinds of emails, whether it is through NCAI or NIHB in the work that we do, those organizations put a lot of good information out, and that would be something that I think our veteran director back home in Lummi would appreciate, but we are not aware of that when I asked him specifically.

I think one of the other things that is a challenge, and Senator Sullivan kind of alluded to it earlier as well, when he talked about his Tribal members in Alaska, is you can have a good program like the HUD-VASH program but if there are no houses in that community or when there is, the rent is so high that it is not able to be used.

One of the things we have recommended through the VA TAC, and it has not gone through its full process yet, and I cannot speak

on behalf of the full TAC, but we have advocated for increased HUD-VASH assistance.

I think one of the other things that we would recommend is working with HUD more, between the VA and HUD, because the VA does not build houses. HUD does. And so one of the things that we could do is work with HUD a lot more to work on specific HUD veteran housing across Indian Country, because a lot of the things that we have heard from the testimony is there is no housing, especially in Indian Country. So those would be big helps.

Senator MURRAY. Okay. I very much appreciate that. And on the issue of health care access, in your testimony that I read you mentioned some of the shortfalls with VA's existing MOU with IHS. In Washington State we worked really hard with the VA to make sure veterans do have timely access to high-quality care, and given some of the geographic challenges and wait times, veterans sometimes have to use non-VA providers through the Community Care Network to fill access gaps.

What would it mean for Native veterans' health outcomes to have services closer to home and providers that are culturally competent?

Mr. LEWIS. I think that means everything when you are seeking health care. One of the things, as I mentioned, my health care, I only go through IHS and our Tribal clinic. That is because I am comfortable with them. They know me. We have a history.

And one of the things—and I am going to speak personally, around mental health. And I have heard a lot about mental health. There are some things that we have all gone through during COVID, where we all struggled. I had to go through mental health, and I made appointments to go to that. I actually quit going because it did not feel right going to an office that I knew somebody that was being paid for to provide a listening session for me. But what worked, for me, is one of the things that we say in Lummi, our culture, our schelangen, is in nature. It is up in the mountains. It is in the water. And for many of those that know me, I think especially during a time that we have had to use Zoom, I would take meetings in the mountains or on the water, because that is where it was filling my spirit.

So when we talk about getting care in our communities, it is that. It is in a place that fills your spirit and your soul, that you cannot get going to somewhere that is foreign to you.

Senator MURRAY. Okay. Excellent. I really appreciate it, and again, I appreciate all of our witnesses today. Thank you. Thank you, Mr. Chairman.

Chairman TESTER. Thank you, Senator Murray. Now we have Senator Moran.

Senator MORAN. Chairman, thank you. This is really a question for all the panelists. The PACT Act was signed into law, as we know. Its effort is to expand access to VA health care and benefits to toxic-exposed veterans and survivors. I want to be certain that VA is doing everything it can to spread the awareness among veterans and their families about the PACT Act so that they can enroll in VA health care systems and file claims for benefits they are entitled to.

This is the question. How can the VA improve outreach about the PACT Act to toxic-exposed veterans in Indian Country, and will your organizations help spread the word about the PACT Act or tell me what you are doing to do so, to those toxic-exposed veterans and their families in those communities?

Mr. WRIGHT. Thank you for the question. I think one of the things that we hear time and again from our Native veterans especially, in our committee, are the Tribal veteran service organizations and the help that they can bring in on the local level, regional level, that is Tribal-specific, culturally specific, where they have trust from the veterans in those specific areas and help them navigate the system as a whole. But in this particular case, when you talk about the PACT Act, having that understanding of somebody who is willing to do the outreach, has the ability to meet them where they are at makes a big difference, especially if it is somebody from the community that they have that long-time trust in. And I think the more we take advantage of that particular program, the more opportunities that will present themselves to Native veterans who may just be disenfranchised from the system as a whole, or because of frustration, whatever that might be, and then when you take in the logistical pieces to it as well.

But I think expanding that program, strengthening that program will help go a long way in Indian Country.

Senator MORAN. Mr. Wright, let me take your answer, and again, others are welcome to respond. So is the VA doing that? Is there evidence they are going to do that? Have there been conversations that suggest that that is what is going to take place?

Mr. WRIGHT. I—go ahead.

Mr. LEWIS. I can add a little bit to that. In sitting on the VA TAC—and I am glad that Sonja is here as well. I sit on the committee with her. She chairs our health subcommittee. And one of the things that the previous panel, Stephanie, had mentioned, we had meetings a few weeks ago, and our next meeting will be in April, and I am thankful to our TAC and to the VA staff that we work with that they will be hosting the next meeting in our area in Portland. And one of the things that we have talked about, and we have talked about this as Tribal leaders a lot, you know, hearing from Senators and Congresspeople, when we come to these meetings and we travel a long way, to sit here and just get talked to, it is not meaningful, right. And one of the things that, as a veteran myself, and what Larry had mentioned, trust is a big thing. And when you look at veterans across the country, whether they are Tribal or not, there are a lot of our veterans that have lost trust, for one reason or another.

And what I am going to be working with the VA TAC on and proposing, those details have not been worked out so I cannot speak that this is going to happen, but what we are pushing for, and pushing, I think, more broadly, is that when we host those advisory meetings that we also afford our veterans in the community that we listen to them, not talk to them. So one of the things that we are proposing at our VA TAC is that we work with veteran organizations in the Northwest—Washington, Oregon, and Idaho—where we meet with veterans where they are. We create the space for their voice to be heard. And our job, as an advisory committee, is

to amplify and bring up their concerns to you all, so that we can remove these barriers in good faith.

Senator MORAN. Anyone else?

Mr. POLLOCK. Yes. Thank you. You know, that is one of the toughest things we have, and one of the best things that seemed to work for here in Blackfeet Country is to do the VA town halls. It gave our veterans the voice. It gave them the floor. The last time the VISN 19 team came out, they basically asked, they said, "What is it you want us to do?" and we cut the mic loose and we were able to turn that, and we gathered so much more information with that short—I think it was, what, a 2-hour meeting, and we gathered so much more because our veterans had the voice. They had the floor. They were able to tell the VA, directly and specifically, what each veteran wanted, because not each veteran is or has the same wants and needs, depending on what it is.

So I think for us, given the size of our demographic that we have here, the town hall seemed to be one. As long as we could get those spread out it helped us spread the word and also gather information for all of our veterans here.

Senator MORAN. Useful advice for the Department of Veterans Affairs. Useful advice for elected officials in this Committee and in Congress.

My time has expired and I think we have votes that began at 4:45, so I will ask this for the record and then I will make another brief question and then be done.

I would be happy to hear from any of you what concerns you have regarding the VA's partnership with Tribes to help make certain that Native veterans have access to culturally competent and geographically acceptable burial sites. And again, I will save that. What could the Department do to improve that circumstance. And if any of you have opinions about that please submit them in writing.

And then, just generally, I would raise the question of American Indian and Alaska Native veterans. A lot of the circumstances you face are distance. What can we better do to utilize community care, telehealth, and other mechanisms that close that distance, to make it much less of a burden when those veterans are seeking care? And I would indicate that one of the things that I am troubled by is any suggestion that the Department of Veterans Affairs is going to alter the standards by which community care can be attained, as far as distance and time. And again, if any of you have those thoughts or have thoughts for me in those regards, I would welcome that input.

Mr. LEWIS. I have one brief comment on that. I watched your hearing on community care recently, and I was thankful to hear a lot of the comments that I heard from the Senators around the table as well as some of the responses from Secretary McDonough when he was here. But when I think of community care—and others may have a difference of opinion—but when we are talking about our veterans going through IHS in our communities, that is community care. And one of the things our veterans have been asking for is they cannot always, as many of our panelists have said, they cannot always travel to the VA. In the hearing on community

care, the VA has shortages just as well as anywhere else. The VA does not always have capacity.

And I am not saying that Indian Health Service is always perfect either, but our veterans would rather go through, and as the data shows—I sit on the SAMHSA Advisory Committee, and they Stated that 52 percent of veterans do not utilize the VA. That means that 52 percent, of the SAMHSA data that was reported, are going through community care. And our veterans, we have over 90 veterans in Lummi. Only 2 are utilizing the VA service, is what I was told by our billing department. So it is showing that our veterans are going through our health system more.

So what we are asking for is the full faith and credit, and then we are going to be working on amending the MOU between our Tribe and the VA. But our veterans are saying they want to get their health care through our IHS facility instead of being able to be forced to travel 2 hours to get to Seattle. I just wanted to add those comments.

Senator MORAN. I appreciate that, Mr. Lewis, and I was thinking during the testimony that probably in much of Indian Country, Indian Health Service is the community care. When I think about it, more likely as the local doctor or the local hospital in Tribal Country, that very well may be Indian Health Services. I will ask my staff here but it causes me to wonder whether the use of Indian Health Service care is considered community care under the Community Care Act. I do not know that but I wonder what criteria are necessary for you to do that. And maybe it is just the MOU. I will follow up with my team to make sure I understand how this works. Thank you.

Mr. WRIGHT. If I may.

Senator MORAN. Go ahead.

Ms. TETNOWSKI. Can I add something?

Chairman TESTER. Sure. Go ahead, Sonya.

Ms. TETNOWSKI. Thank you. I guess I just wanted to ensure that there is thought around our Urban Indian health programs as well. Because there are no Tribes within many of our geographical areas but most of our clinics were placed in relocation sites, including mine, in San Jose, most of our Native community and Native veterans would rather be seen by us as a Native provider.

So although I absolutely support and completely agree with all of what Councilman Lewis just shared, it also applies in the urban setting. So I just did not want to disregard that as well. Thank you so much for the opportunity to share.

Chairman TESTER. Absolutely. Larry?

Mr. WRIGHT. No, and I appreciate that because my comments were going to be very similar. My Tribe was terminated in the '60s and federally reinstated in the '90s, and we were reinstated without a reservation. And part of our restoration, by Congress, established 15 counties across Nebraska, Iowa, and South Dakota, and several of our counties are in the two biggest cities in Nebraska.

And so when we have health clinics in those areas, and VA hospitals just down the road, and even when you take out all the logistical scheduling, financial barriers for travel and geography, even when it is right down the road, taking a bus, our veterans want to come to our facility because of the cultural competency, be-

cause of that care and trust that they feel that they have there. And we see many other Native veterans taking advantage of that as well, even though the VA is just down the street.

And so I think when you look at the issues, as a whole, it is systemic, and we can point to several things. But I do not think you can fix one without addressing all of them, and they all really do go together.

Senator MORAN. A take-away—Senator Tester and I were just talking about this earlier—a take-away is that then means that Indian Health Services has to be a consistent, constant provider, open for business on an ongoing basis, based upon the reliance that Native Americans place in that service. Okay.

Chairman TESTER. Thank you, Senator Moran. A lot of water went under the bridge in the last 6, 7 minutes. I will say, going back to town hall meetings by the VA, that is very good advice by the Ranking Member and it also applies to elected officials. Listening is really important. That is why we have consultation with Tribes. You guys know that.

There are challenges in Indian Country that are specific to Indian Country, and one of those challenges was brought up by Mr. Pollock. With large, land-based Tribes in particular—and I really do not care where it is at. I mean, you have either got snow, you have got heat, you have got problems when you have got distances.

And I would just like to know from you, Mr. Pollock, you talked about geographical and logistic and financial barriers. You are working with the Blackfeet Veterans Alliance. How are you guys working to overcome those challenges of bad weather and no money?

Mr. POLLOCK. Chairman Tester, one of the biggest things we are working with is we try to build partnerships with other veteran services and organizations, not just located here on the Blackfeet Reservation. Like I stated, there is one Rocky Boy, they recently rebranded there, called the Great Plains Veteran Services Center. And one of their departments is Transportation Department. Right as I came on we built a partnership with them to where they are actually one of our primary transportation providers, to provide transportation to our veterans to appointments at no cost to the veteran besides maybe a meal. However, that is one of the things that between my program and their program, we are working on to where we can create some kind of funding to even buy a meal for those veterans that may not be able to do that.

So one of the biggest things for us, given this, and we continue to do that, start reaching out to the Fort Belknap Tribe, most recently with Spirit Lake Reservation in North Dakota. I gave a presentation and let them know, hey, we are here, that we have got to work together. There are times where resources are stretched thin, no matter what it is, if that is finance, transportation, all of the above. That is our biggest thing, is to create and build those partnerships across all Tribes, no matter where they are located. If there is something we can do to help or maybe we have somebody that we can get in contact with, because we also have veterans who still have ties to the reservation. However, you know, they do not live here. They live in Great Falls. They live in Havre. They live in Missoula. So we try to make sure we create all these partner-

ships throughout the State to get whatever it is we need for our veterans, to better serve them, no matter where they are located.

Chairman TESTER. Thank you. Thank you, Leo.

Mr. Wright, Executive Director of NCAI, which is probably the premier Native American group out there, representing a lot of different Tribes. You talked about the copay issue a little bit in your opening statement. Can you give me some information about how you are hearing, or you are seeing, the copay issue play out with Tribal members, generally speaking?

Mr. WRIGHT. Yes. I appreciate that. We know that the PACT Act was a very crucial piece of legislation for Indian Country, knowing that it got passed and it is still not implemented. When we talk about the impact of just costs, in general, when you compound that issue with trying to just get to the clinic, to get to your appointment, and the costs that are associated with that, and knowing that going to VA, for Native veterans, they have to have this copay on top of it. And sometimes scheduling, when you add the scheduling factor in, where they may be behind and it gets canceled, and they have already incurred that cost, or the Tribal Nation, as the gentleman said before, they are taking on the extra cost to help get veterans there.

And so all of those things are just another layer of a barrier. And when you add that copay on there, especially for Native veterans and Native people, knowing that that is trust and treaty responsibility that our ancestors fought very hard for, and with the formulation of this country, and have paid many times over for land given up, blood, sweat, and tears, to have that as a Native veteran on top of everything else is very hard.

And whether that is a personal issue or leads to that, again, that disenfranchisement, where we feel that we are not good enough. And we know that may just be another factor of saying, for a Native veteran, "I am not going here because I am not valued, but I can go to my Tribal clinic, my Indian Health Service, where they know those values, and take that on." But that creates another burden on that system. Or of it is an IHS clinic, or if it is a tribally run clinic, which even compounds that further. And so we have not said that much, but that is still another factor in there.

Chairman TESTER. So one of the things that you brought up in that answer, that a lot of the folks that we serve with do not understand, is trust responsibility. I know for a fact that Senator Moran is not one of those. He understands trust responsibility very, very well. But it is specific to Native American veterans. And I do not know another group that has that kind of an agreement. And so I think it is really important we keep that in mind, and for that reason it is an issue that I brought up in both panels, and hopefully we can get it solved.

Look, we have had a good hearing today. I want to thank everybody for being on each panel. Thank you to the witnesses. I look forward to continuing to work with VA and IHS and Tribes and tribal organizations to ensure that Native American veterans have access to the health care and the benefits that they have earned for this service to this country.

I would also like to say that it has always been something that we have tried to achieve here, where the VA and IHS becomes

seamless, as far as service provided. Now look, I know follow the money, because that is typically where it is going to go. But the truth is that we have had challenges with hiring nurses and doctors and everybody in the VA. We have also had challenges in IHS. It is the same thing. And it is about resources, truthfully. So we need to continue to work toward that, because I think it is the right thing to do for our Native American veterans who serve at a higher rate than any other minority in this country.

So with that we will keep this record open for a week, and this hearing is adjourned.

[Whereupon, at 4:54 p.m., the hearing was adjourned.]

A P P E N D I X

Prepared Statements

Sen. Moran Opening Remarks

"Native American Veterans: Ensuring Access to VA Health Care and Benefits"

November 30, 2022

Thank you, Mr. Chairman.

I appreciate the opportunity to be here today to discuss the care, benefits, and services that VA provides to veterans across Indian Country.

Like many other members of this Committee, I come from a state with a vibrant and irreplaceable Native American community.

I am also proud to serve not just on this Committee but also, alongside the Chairman, on the Senate Committee on Indian Affairs.

November is National American Indian Heritage Month and it is fitting that we close this month out by placing a special focus on the approximately 145 thousand American Indian and Alaska Native veterans who have served in uniform.

Native Americans volunteer to serve in the military at higher rates than other populations and have certain unique barriers to care, including often lacking the proper representation when filing claims for their service-connected disabilities and having a higher likelihood of living in a rural, highly rural, or medically underserved area.

Removing those barriers and making certain that American Indians and Alaska Natives are able to take full advantage of the health care and benefits that they have earned and are entitled to is a priority of mine, not just in November but every day of the year, which is why I am so proud to serve on both SVAC and SCIA [***SKEE-A***].

I am grateful for the many meaningful improvements that we have made so far – including enacting legislation last Congress that Chairman Tester and I spearheaded to prohibit VA from collecting copayments from American Indian or Alaskan Native veterans.

However, I am mindful that we have much more work to do.

That is why I hope that today's hearing will just be the start of an ongoing conversation with this Committee and SCIA [***SKEE-A***] about how to better support American Indian and Alaska Native veterans and strengthen the partnership between VA, the Indian Health Service, veterans service organizations, and individual tribes and tribal organizations – each of whom play an important role in serving veterans and their families.

I am grateful to our witnesses for being here both in person and virtually, to share their expertise with us this afternoon and I look forward to hearing their testimony.

Thank you, Mr. Chairman and, again, I hope that this hearing is the springboard to future discussions on how to properly care for our American Indian and Alaska Native veterans.

With that, I yield back.

Statement By

Roselyn Tso
Director
Indian Health Service
U. S. Department of Health and Human Services

Before the

Committee on Veterans' Affairs
United States Senate

Oversight Hearing
"Native American Veterans: Ensuring Access to VA Health Care and Benefits"

November 30, 2022

Good afternoon, Chairman Tester, Ranking Member Moran, and Members of the Committee. I am Roselyn Tso, Director of the Indian Health Service (IHS). Thank you for the opportunity to testify on Native Veterans' access to the Department of Veterans Affairs (VA) 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 2.7 million American Indians and Alaska Natives from 574 federally recognized tribes in 37 states, through a network of over 680 health care facilities, including hospitals, clinics, health stations, and other facility types.

The American Indian and Alaska Native (AI/AN) population experiences health and other disparities that disproportionally affect their quality of life. American Indians and Alaska Natives have an average life expectancy that is five years shorter than that of the general U.S. population, and they 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, VA, and their tribal partners will continue to combine their expertise, resources, and efforts to help the nearly 145,000 AI/AN veterans living in the United States.[2] The IHS and VA's Veterans Health Administration (VHA) continue work to provide eligible AI/ANAI/AN 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.

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, Tribal organizations , and VA.[4] The law also directs VA to reimburse the IHS, Indian tribes, or tribal organizations for the services provided to eligible beneficiaries of VA. More recently, Congress amended the statute to direct VA to reimburse Urban Indian organizations for the services provided to eligible beneficiaries of VA, and to clarify that this section includes Purchased/Referred Care[5].

Since implementing this provision in 2012, VA has reimbursed over $186 million for direct care services provided by IHS and Tribal Health Programs (THP), covering approximately 15,000 AI/AN veterans. Currently, IHS and VA operate under a national reimbursement agreement, inclusive of 74 IHS federal facilities. Likewise, VA has entered into 119 individual reimbursement agreements with THP, and 1 Urban Indian Organization facility.

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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).
[5] Section 1113 of the Consolidated Appropriations Act of 2021 (25 U.S.C. § 1645(c)).

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.

We are also working with VA on implementing newly enacted legislation, including an exemption from most VA health care copayments for Indian and urban Indian Veterans added to section 1730A of title 38, United States Code, by the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (Public Law 116-315) and clarifications related to Purchased/Referred Care (PRC) added to section 405(c) of the Indian Health Care Improvement Act (25 U.S.C. 1645) by the Proper and Reimbursed Care for Native Veterans Act (Public Law 116-311).

IHS-VA MOU

In October 2021, the IHS and VHA announced a new memorandum of understanding (MOU) aimed at improving the health status of AI/AN) veterans. The MOU establishes a framework for coordination and partnering between our federal agencies to leverage and share resources and investments in support of our mutual goals. We entered into an initial MOU in February 2003 to improve access and health outcomes for AI/AN veterans and subsequently updated the MOU in October 2010. We believe this newly signed MOU builds on nearly two decades of experience and will continue to support our objective to improve access and health care outcomes for AI/AN veterans. The new MOU identifies four mutual goals:

1. Access - Increase access and improve quality of health care and services for the benefit of eligible Al/AN veteran patients served by VHA and IHS. Effectively leverage the strengths of VHA and IHS at the national, regional, and local levels to support the delivery of timely and optimal clinical care.

2. Patients - Facilitate enrollment and seamless navigation for eligible Al/AN veterans in VHA and IHS health care systems.

3. Information Technology - Facilitate the integration of electronic health records and other Health Information Technology systems that affect the health care of Al/AN veterans.

4. Resource Sharing - VHA and IHS will improve access for their patient populations through resource sharing, including technology, providers, training, human resources, services, facilities, communication, reimbursement, etc.

Now that we have executed a new MOU, we have begun the process of creating a new operational plan that will identify operational goals and performance metrics. We are currently seeking input from Tribes and Tribal Organizations through Tribal Consultation as well as conferring with Urban Indian Organizations on a draft operational plan. Conducting annual

Tribal Consultation and Urban confer will be essential to ensuring ongoing involvement by Tribal leaders and Urban Indian Organization leaders with the MOU.

Recently, VHA established an Office of Tribal Health, which will coordinate and lead the MOU partnership on the VHA side. Additionally, on September 27, 2022, the National Indian Health Board (NIHB) hosted an in-person Tribal Consultation session on the MOU Operational Plan and Reimbursement Agreement in Washington, DC, and following up on the in-person Tribal Consultation session, the NIHB also held a virtual VHA and IHS Tribal Consultation on October 11, 2022 and an Urban Confer session on October 25, 2022.

On December 5, 2012, VHA and IHS entered into an agreement for reimbursement for direct health care services (Reimbursement Agreement) to facilitate reimbursements from VA to IHS operated facilities for certain health care services provided to VHA-enrolled AI/AN veterans who are eligible to receive services at the IHS. Similarly, VHA has entered into numerous individual reimbursement agreements with THP for certain health care services provided to VHA-enrolled AI/AN veterans who are eligible to receive services at their facilities. The IHS is not a party to any agreement between VHA and a THP.

Since 2012, the Reimbursement Agreement between the IHS and VHA has been amended four times. While the first two amendments extended the period of the agreement, the first substantial change occurred in June 2018 through an amendment to the Reimbursement Agreement that extended the period of the agreement and added a section on Pharmacy Services to clarify formulary and outpatient pharmacy services.

In September 2020, both agencies amended the Reimbursement Agreement to clarify the definition of the term "direct care services" to include services provided through telehealth; to clarify language in the quality section of the agreement relating to certification and accreditation requirements; to extend the period of agreement an additional 2 years beyond the existing term, through June 30, 2024; and to add a new section for reimbursement for care or services provided by the IHS through a contract established by the IHS (i.e., the IHS Purchased/Referred Care program) for health care provided outside of the facility during the COVID-19 emergency period that meets certain conditions. Moving forward, both of our agencies will continue to work together to review and identify needed updates to the Reimbursement Agreement consistent with current law.

In addition to the aforementioned MOU, VA and the IHS signed a memorandum of agreement and an interagency agreement (IAA) in October 2020, for VA to support the IHS during the COVID-19 public health emergency (PHE). The agreements permitted VA to provide hospital care and medical services for IHS non-veteran beneficiaries in VA facilities and provide staff, supplies, equipment, and consumables for IHS facilities. As a result, IHS entered into agreements with 11 VA medical centers (VAMC) to accept IHS patients and entered into six agreements to accept deployment teams for necessary staff support of nurses and x-ray technicians.

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.

Health Information Technology Modernization

In 2020, IHS launched a multi-year effort to modernize our health information technology (IT) systems for IHS, tribal, and urban Indian health care programs. The Health IT Modernization program will replace our Resource and Patient Management System (RPMS) electronic health record (EHR), which handles everything from patient registration to billing insurance.

IHS and VA collaborate on Health IT Modernization through the Federal Electronic Health Record Modernization (FEHRM) to share lessons learned, artifacts, methods, and experiences through monthly updates and participation in the IHS executive steering committee.

IHS and VA completed an interoperability pilot in 2021 to ensure our new technology would effectively share data to support coordination and quality of care enhancements for Native veterans who utilize both systems of care.

After significant Tribal Consultation and Urban Confer, IHS decided to replace RPMS with a commercial solution. On August 4, 2022, IHS took an essential next step in the Health IT Modernization by releasing a Request for Proposals (RFP) for commercial products to replace RPMS, including the complex work of implementing, training, and supporting the new solution across the country. The new EHR will connect isolated data and improve health care coordination for patients throughout Indian Country, creating a sustainable system for future generations over the next several years.

The IHS remains firmly committed to improving quality and access to health care for AI/AN veterans. We appreciate all your efforts in helping us provide the best possible health care services to the veterans we serve.

Thank you. I am happy to answer any questions you may have.

STATEMENT OF MARK UPTON, MD, FACP
DEPUTY to the DEPUTY UNDER SECRETARY for HEALTH
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
NATIVE AMERICAN VETERANS:
ENSURING ACCESS TO VA HEALTH CARE AND BENEFITS
NOVEMBER 30, 2022

Chairman Tester, Ranking Member Moran, and other Members of the Committee, thank you for inviting us here today to discuss our efforts to ensure that American Indian and Alaska Native (AI/AN) Veterans have access to the VA health care and benefits they have earned. In this testimony, we will lay out actions taken across VA to improve benefits and services to these Veterans as well as our ongoing partnership with the Indian Health Service (IHS). I am accompanied today by Stephanie Birdwell, Director, Office of Tribal Government Relations and John E. Bell III, Executive Director of the Veterans Benefits Administration's Loan Guaranty Service.

AI/AN Veterans serve in the military at one of the highest rates of all racial and ethnic groups and yet they disproportionately suffer the medical and psychological consequences of military service. The most rural of Veteran groups, their significant health care disparities are aggravated by barriers related to access to care, coordination, and care navigation. Their health care often traverses multiple systems that include the Veterans Health Administration (VHA), IHS, and Tribal Health care systems.

We owe them our best, and this testimony will address how VA is responding to the challenges rural and urban AI/AN Veterans face in accessing culturally competent VA health care, including behavioral health care, as well as in utilizing VA benefits, such as housing and burial programs. We will also provide an update on the implementation of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (Public Law (P.L.) 116-315), and P.L. 116-311, the Proper and Reimbursed Care for Native Veterans Act.

VHA Office of Tribal Health

Over the course of our history, VHA has undertaken many efforts to ensure AI/AN Veterans have access to the health care services they have earned. We recognize, however that there remains more to do. VHA's recent establishment of an office solely focused on Tribal Health is an important and consequential step forward in ensuring that we provide the best care possible for Native Veterans.

The VHA Office of Tribal Health (OTH) was established earlier this year and provides VHA with leadership, strategic direction, and policy guidance in our efforts to support AI/AN Veteran health care, access, and Fourth Mission activities across the

enterprise. OTH's mission is to strengthen VHA's commitment to AI/AN Veterans through supporting exceptional, culturally competent health care. OTH elevates the AI/AN Veteran's care experience by providing informed guidance and serving as a strategic advisor to leadership across VHA. Additionally, OTH will enhance government partnerships and act as a liaison between VA/VHA, the White House, federal agencies, and State and Tribal Governments. VA will initiate, build, and strengthen collaboration and resource sharing by engaging IHS, Tribal Health Programs (THP), and Urban Indian Organizations (UIO) to provide AI/AN Veterans the best care possible, address health disparities, and enhance the AI/AN Veteran's experience. Since its establishment, OTH has met with VA's Advisory Committee on Tribal and Indian Affairs and has coordinated outreach and site visits to multiple sites in Alaska, Colorado, Montana, and Utah to meet with Tribal representatives and VA employees.

Behavioral Health Care for AI/AN Veterans

The VHA Office of Mental Health and Suicide Prevention (OMHSP) is working with OTH to build stronger relationships with AI/AN Veterans, earn their trust, spread the word about the critical resources available, and learn how we can better serve them. For VA's mental health professionals, it is a privilege and duty to provide culturally responsive mental health care to our Nation's AI/AN Veterans. We want to ensure they see themselves included and reflected when they consider VA services. We also want them to be certain they will receive culturally competent care whether they choose VA or care in the community.

OMHSP starts by ensuring AI/AN Veterans are reflected in the images and experiences shared on AboutFace,[1] a video gallery featuring Veterans sharing their experiences with trauma and trauma treatment, as well as on Make the Connection,[2] a site where hundreds of Veterans from all walks of life share their stories of help and hope. Programs like the OMHSP Justice, Equity, Diversity, Inclusion (JEDI) Consultation Program have been built to support staff at all levels and areas of our mental health programs in their efforts to deliver exceptional care to Veterans of diverse backgrounds by providing current, empirically supported consultation and support. Specific consultation areas include clinical care, program development, education and training, and data and research. JEDI's team consists of VA staff and providers from diverse backgrounds, including clinicians and epidemiologists who identify as Native American, with expertise in culturally responsive mental health care. This interdisciplinary team of subject matter experts may provide recommendations on assessment, case conceptualization, evidence-based treatments, and clinical management to support VA providers in this mission.

In addition to consultative services, VHA provides educational materials on Native American history, testimonials from Native Americans who have chosen to serve, articles about the history and experiences of Native Veterans, and articles on mental

[1] AboutFace | National Center for PTSD (va.gov)
[2] Make the Connection | Videos & Info for Military Veterans

health disparities. In addition to history and context, we provide toolkits – available to VA providers and to providers in the community[3] – to empower and encourage providers to improve the cultural responsiveness of the services they provide. We also have awarded grants to support Tribal groups through the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant program, which includes many grantees in Tribal Nations. Through this program, VA has identified 80 awardees to cover in 43 States, the District of Columbia, and American Samoa. Twenty-one (21) entities will cover tribal lands including the following tribes: Navajo Nation, Cherokee Nation, and Choctaw Nation.

The National Center for Posttraumatic Stress Disorder (NCPTSD) offers resources to any provider treating Veterans in any context, this includes a PTSD Consultation Program[4], where health care providers treating AI/AN Veterans in VA can consult with an expert PTSD clinician at no cost. Our consultants and continuing education courses help to promote culturally sensitive treatment and address issues related to trauma and race or ethnicity. The National Center also offers relevant continuing education such as an upcoming webinar in the PTSD Consultation Program Monthly Lecture Series[5] (January 18, 2023): Understanding Native American History as a Foundation of Culturally Aware PTSD Treatment, by Charlotte McCloskey, PhD. and through articles such as Psychological Trauma for American Indians Who Service in Vietnam[6] published on NCPTSD's website.

Additionally, VA's Suicide Prevention efforts include action to directly support AI/AN Veterans. VA's Governor's and Mayor's Challenge teams work with AI/AN Veterans through several of the State and county-level teams to improve suicide prevention. Local VA health care systems are also providing outreach to and working with the AI/AN Veteran population in their areas. Outreach efforts include providing suicide prevention and other VA training and resources at Stand Downs (community events that provide assistance and outreach), health fairs, Pow Wows, Summits, and other events. Suicide prevention coalitions have been created that include State Indian Health Systems representing all Tribal Nations across the State, Tribal Veterans Service Officers, and Veterans Service Organizations.

Over the last several years, the Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) and the Veterans Rural Health Resource Center in Salt Lake City have been collaborating to address AI/AN Veteran suicide prevention. Their focus is on developing a suicide prevention program to support VA suicide prevention teams in effective collaboration with Tribal communities. This includes developing a learning community of VA and Tribal communities, adapting suicide prevention training, and developing a process and set of tools for enhancing engagement. This effort is currently working with the Iron Mountain VA Medical Center

[3] https://www.mentalhealth.va.gov/communityproviders/veterans-Native-American.asp
[4] www.ptsd.va.gov/consult
[5] PTSD Consultation Program: Lecture Series - PTSD: National Center for PTSD (va.gov)
[6] Psychological Trauma for American Indians Who Served in Vietnam - PTSD: National Center for PTSD (va.gov)

(VAMC) and local Tribes in northern Michigan and Wisconsin, and the Puget Sound VA Healthcare System with multiple Tribes in the State of Washington.

Among the more than 250 Mental Health Residential Rehabilitation Treatment Programs, many have developed programming specific to AI/AN Veterans and several offer services specific to AI/AN Veterans including programs that provide access to Sweat Lodges and support other ceremonial activities on station. Veterans Integrated Services Networks (VISN) 19 and 23, which include states with the highest populations of Native Americans such as North and South Dakota, Nebraska, Oklahoma, Montana, Wyoming, and Colorado, collaborated to increase access points in both regions for Veterans in need of mental health residential treatment. VISNs 19 and 23 have formalized this work through a Memorandum of Understanding (MOU), which standardizes processes to promote coordinated and timely care. *Implementation of Virtual Mental Health Care for AI/AN Veterans*

Over the past decade, the VHA Office of Rural Health (ORH) in collaboration with VISN 19 and the University of Colorado's Centers for American Indian and Alaska Native Health developed a model of "culturally-centered" mental health care . The model weaves together evidence-based Western medicine and rural Native communities' strengths through four main components: mental health care, technology (access), care coordination, and tailored adaptation. VHA further adapted the model into an implementation facilitation framework that mentors staff at local VAMCs to increase the use of VA Video Connect (VA's mobile video-conferencing platform) with AI/AN Veterans. ORHis currently working with multiple VAMCs around the country serving AI/AN Veterans. It provides support within and across these VA facilities to address challenges of technology adoption, cultural issues and expanding outreach and best practices for engaging AI/AN Veterans with VA Virtual Mental Health Technology.

Tribal-VHA Collaboration on Suicide Prevention

ORH, in partnership with the MIRECC for Suicide Prevention, worked to support VA suicide prevention teams' outreach and assistance efforts for AI/AN Veterans through culturally competent suicide prevention. Suicide among rural Veterans is disproportionately high compared to both urban Veteran and civilian counterparts, and research indicates AI/AN Veterans are at a particularly high risk.

In fiscal year (FY) 2017-2019, this collaboration reviewed multiple data sources and found:

- Population-based data indicated that AI/AN Veterans are twice as likely to engage in suicide-related behaviors compared to rural non-Hispanic White Veterans.
- VHA data confirmed that for Veterans under 40, AI/AN Veterans exhibit a higher suicide rate than the national Veteran suicide rate for the same age group.
- Findings from a review of programs appropriate for AI/AN Veterans indicated that many of the VA evidence-based or best practice programs are available system-wide, but few were designed specifically for rural Veterans, and none tailored for

> AI/AN Veterans. Conversely, many non-VA culturally specific programs implemented in Native American communities were rarely disseminated beyond reservation borders, and none were specifically developed for Veterans.

Based upon these findings, to advance suicide prevention for AI/AN Veterans, VA ORH and the MIRECC for Suicide Prevention developed drew upon evidence-based practices, existing VA infrastructure and frameworks, and Tribal-specific cultural approaches to suicide prevention to develop a new project expanding Tribal-VHA collaboration on suicide prevention between Tribal Veterans and four VAMC suicide prevention teams. The work increased outreach strategies built a community of learning for VA and Tribal organizations and adapted and piloted a core VA suicide prevention tool (S.A.V.E. Training) for Tribal communities. At the conclusion of this project (FY 2022), a Toolkit was created and is currently being finalized to widely support VAMC suicide prevention teams and others wanting to collaborate with Tribal communities in suicide prevention.

Mental Health and Wellness Mobile App Development for AI/AN Veterans

ORH is also partnering with NCPTSD's Palo Alto team, which has expertise in the development of mobile mental health applications, to develop a mobile health app that supports AI/AN Veterans healing from trauma and addresses mental health issues, including suicide prevention. VA's mobile app will be packaged as a standalone download to function regardless of internet connectivity, including in remote areas. Currently, this project is carrying out iterative design, review and testing, and revision adapting "the best in class" from VA mental health apps and tailoring these apps for AI/AN Veterans and their family members. We anticipate an initial version of the app to be complete at the end of FY 2023 for wider production and dissemination in FY 2024.

Rural Native Veteran Health Care Navigator Program Development

ORH is developing an AI/AN Veteran Health Care Navigator Program to increase access to health care to subsequently improve health outcomes. As the most rural of Veteran groups, AI/AN Veterans face significant health care disparities aggravated by barriers related to access to care, care navigation and coordination, and fragmentation of health care as users of multiple systems, including VHA, IHS and Tribal Health care systems. VHA develop an initial Navigator program model from literature reviews, interviews, and discussions with VA, Federal and Tribal entities. This work identified required resources, personnel, expertise, and created an implementation and evaluation framework. In FY 2023 and 2024, this program will be piloted at multiple VAMCs to refine, replicate, expand, and evaluate the program in accordance with metrics targeted at continuous quality improvement and patient outcome measures for wider dissemination through VHA infrastructure.

AI/AN Veteran Homelessness Toolkit

Addressing homelessness among Veterans is one of VA's top priorities. To achieve that goal, VA offers a wide variety of programs, such as Grant and Per Diem, Supportive Services for Veteran Families, and Native American Direct Loan (NADL) Program, continually advances innovative approaches. Rural homelessness among AI/AN Veterans, who often live on remote, rural, traditional lands, poses unique challenges. Resources for addressing AI/AN Veteran homelessness are often difficult to identify and locate because they are spread across many organizations, reports, and websites. To address this, ORH created a toolkit to provide background, planning resources, and programmatic options for individuals or organizations interested in finding solutions to homelessness among AI/AN Veterans who live on reservations or in Alaska Native Villages.
https://www.mentalhealth.va.gov/communityproviders/assets/docs/populations/2018_Native_American_Veteran_Homelessness_Toolkit_v1.pdf

Memorandum of Understanding (MOU) between VA and IHS

VHA has worked to improve the health and well-being of AI/AN Veterans through collaborations between VA program offices and other Federal agencies, including the Indian Health Service. These initiatives have focused on reducing health care workforce disparities and enriching rural research and new models of care for AI/AN Veterans.

VHA and IHS have worked collaboratively for decades. VA and IHS first entered into an MOU in 2003, with the aim of improving access and health outcomes for AI/AN Veterans. The purpose was to establish a framework for coordination and partnership to leverage and share resources and investments in support of each agency's goals. The goal of this MOU was to facilitate a broad range of collaboration between the agencies that would allow for the development of additional agreements around specific activities, while acknowledging that implementation may require local adaptation through local MOUs to meet the needs of individual Veterans and their families, as well as local VHA, IHS, THPs, and UIOs. The 2003 MOU was replaced and superseded by a 2010 MOU between VA and IHS to reflect the changing health care environment. Between 2010 and 2020, VHA mailed 5.6 million pharmacy prescriptions to AI/AN Veterans and increased access to mental health services for AI/AN Veterans through VA Video Connect. In 2021, in collaboration with IHS, VA updated the MOU once more, taking into account the input received during Tribal Consultations and Urban Confers. As a result, the revised MOU, entered into by VHA and IHS in 2021, reflects the evolving health care and health information technology landscape.

Pursuant to the updated MOU, VHA and IHS aim to:

- Access – Increase access and improve quality of health care and services for the benefit of eligible AI/AN Veteran patients served by VHA and IHS. Effectively leverage the strengths of the VHA and IHS at the national, regional, and local levels to support the delivery of timely and optimal clinical care.
- Patients – Facilitate enrollment and seamless navigation for eligible AI/AN Veterans in VHA and IHS health care systems.
- Information Technology – Facilitate the integration of electronic health records

and other Health Information Technology systems that affect the health care of the AI/AN Veterans.
- Resource Sharing – VHA and IHS will improve access for their patient populations through resource sharing, including technology, providers, training, human resources, services, facilities, and communications.

For the first time, under the updated 2021 MOU, VHA and IHS will work together to create an annual Operational Plan. The Operational Plan will include strategies, objectives, and tactics for implementing MOU goals. It will also include metrics and targets to demonstrate achievement of MOU goals. Every year, formal Tribal Consultation and Urban Confer will be conducted for each draft plan.

IHS / THP / UIO Reimbursement Agreements Program (RAP)

In 2012, VA and IHS signed a national reimbursement agreement for VA to reimburse IHS for direct care services provided to eligible AI/AN Veterans. Also, in 2012, VA began entering into individual agreements with THPs, and in January 2022, VA expanded its program to include UIOs, consistent with Division FF, Title XI, Western Water and Indian Affairs, section 1113 of P.L. 116-260, Consolidated Appropriations Act, 2021. Under these Agreements, Veterans can seek services at IHS, THPs, or UIOs without VA preauthorization, and VA will reimburse IHS, THP, and UIO facilities for direct care services that are included in VA's medical benefits package provided to eligible AI/AN Veterans. To date, VA has 74 IHS, 119 THP, and 1 UIO facility participating in the reimbursement program. Since 2012, over 15,000 unique Veterans have been provided health care pursuant to these agreements, and VA has dispersed almost $186 million to facilities.

The Proper and Reimbursed Care for Native Veterans Act (P.L. 116-311) clarified the requirement for reimbursement of these health care services, to include Purchased/Referred Care (PRC) and contracted travel. New agreements will be issued to ensure expansion details are captured in a clear way that stakeholders can understand, while reducing the number of modifications/new agreements executed and communicated to the field. VA engaged in multiple activities towards this end. VA held a series of informational calls between VHA, IHS, and the IHS Director's Workgroup on Improving PRC to understand how PRC works and operational aspects of the program. VA hosted two national listening sessions in January 2021, and December 2022, to gain broad stakeholder input for a new agreement and specific comments on PRC.

VA Tribal Advisory Committee

VA appointed its first-ever Advisory Committee on Tribal and Indian Affairs on October 4, 2021. This Committee was established in accordance with section 7002 of P.L. 116-315 and 38 U.S.C. § 547. The Committee provides advice and guidance to the Secretary of Veterans Affairs on all matters relating to Indian Tribes, Tribal organizations, Native Hawaiian organizations, and AI/AN Veterans. The Committee

serves in an advisory capacity and advises the Secretary on ways the Department can improve the programs and services of the Department to better serve Native American Veterans. This Committee allows our Nation's citizens to provide advice and assistance to the Committee in affecting policies and programs of the Secretary and keeps the Secretary informed of issues important to the Native Veteran community. We are grateful to Congress for this law, which allows these Veterans' voices to be heard so we can best meet their unique needs.

Native American Veterans and Home Loans

The VA home loan benefit program offers eligible Native American Veterans two options for financing a home—the guaranteed home loan program (generally for Veterans not residing on trust land) and the Native American Direct Loan (NADL) loan (for Veterans residing on trust land). Both loan options offer Veterans the opportunity to purchase or construct a home with no down payment, no mortgage insurance, competitive interest rates, and low closing costs. For Veterans residing on trust land, VA's recent efforts to centralize NADL operations and outreach to a team of seven full-time staff have led to improved outcomes for Native American Veterans. NADL loan volume doubled from FY 2020 to FY 2022, with more than 30 construction and purchase loans closed.

VA expanded its outreach efforts in FY 2022, participating in more than 38 virtual and in-person events and providing tailored outreach letters to all Federally recognized Tribes and Tribal entities twice per year. VA also conducted two in-person trips to meet with Federal, State, and Alaskan Tribal agencies and leadership to discuss potential opportunities for improved Federal mortgage lending across the State of Alaska. Home loans are also available through VA's guaranteed home loan program; lenders issue loans, and VA then backs these loans with a 25%-50% guaranty. AI/AN Veteran use of VA's guaranteed home loan program has grown significantly in recent years. In FY 2022, VA guaranteed over 87,000 loans to Veterans who identified as AI/AN.

VA is encouraged by these positive trends but understands that there is still work to be done. In the coming months, VA will assess the results of a human-centered design study completed in FY 2022 to better understand home loan awareness and access issues amongst AI/AN Veterans and determine next steps. VA remains committed to finding opportunities to ensure AI/AN Veterans can utilize their earned housing benefits, whether under the NADL program or the guaranteed loan program.

Burial and Memorial Services for Tribal Veterans

The National Cemetery Administration (NCA) administers burial and memorial benefits and services to Veterans and their eligible family members worldwide. As of today, VA operates and maintains 155 national cemeteries in 44 States and Puerto Rico and provides headstones and markers, niche covers for columbaria, medallions, and Presidential Memorial Certificates, to individuals all over the world.

In addition, NCA administers VA's Veterans Cemetery Grants Program (VCGP), which has funded grants for the establishment, expansion, or improvement of 121 State and Tribal Veterans' cemeteries in 46 States and 3 territories (Guam, the Commonwealth of the Northern Mariana Islands, and Puerto Rico). Since 2011, Tribes have received more than $37 million for cemeteries they operate on Tribal trust land. The newest Tribal Veterans cemetery, the Metlakatla Veterans Memorial Cemetery (Alaskan Native), is the 14th Tribal Veterans' cemetery funded through the VCGP and was dedicated this past July.

VA is working closely with Tribal leadership to make sure Tribal culture and traditions are honored with design elements and features reflecting the unique heritage of each Tribe. To this end, Under Secretary for Memorial Affairs Matthew Quinn and NCA leadership have embarked on outreach efforts to contact all the tribal leadership to focus on best practices and how VA and NCA can better serve and support our Native American Veterans. For example, last May, NCA leadership participated in a video conference meeting with the Crow Tribal Cemetery Leadership of Montana discussing best practices and the proper maintenance of the turf and placement of the bronze head stone markers to improve the appearance of the cemetery. In October 2022, the Under Secretary and NCA leadership participated in a video conference meeting with the Pascua Yaqui Tribal Leadership of Arizona. The meeting focused on cultural considerations and future burials at the Monte Calvario Cemetery in Tucson, Arizona.

The President signed the Burial Equity for Guards and Reserves Act, Division CC of the Consolidated Appropriations Act, 2022 (Public Law 117-103), on March 15, 2022. The new law expanded VA's authority to pay a plot allowance for qualifying burials in cemeteries owned by a Tribal organization on trust land or held in trust for a Tribal organization. Previously, only State Veterans' cemeteries could receive the burial plot allowances for eligible Veterans interred at their locations.

Tribal Representation Expansion Project

The Tribal Representation Expansion Project (T. REP), initiated in October 2021 by the VA Secretary and led by the Office of General Counsel (OGC), aims to collaborate with Tribal governments to promote access to culturally competent representation to the approximately 160,000 AI/AN Veterans who served our military. Individuals may represent Veterans before VA in the preparation, presentation, and prosecution of claims only if they are authorized as an accredited representative of a VA-recognized organization, agent or attorney, or specially authorized by VA's General Counsel. For Tribes that do not currently have sufficient options for representation, OGC aims to help facilitate access to representation by traditional means, but also through utilizing the General Counsel's discretionary authority to authorize certain individuals affiliated with Tribal governments to represent claimants before VA.

Some of the many accomplishments of this effort include the following:

- OGC provided outreach to Tribes to encourage participation in T. REP, including by hosting a Tribal consultation in March 2022, mailing Dear Tribal Leader

Letters and presenting at events including the Alaska Federation of Natives Convention, the National Congress of American Indians Convention, the New Mexico Native American Veterans Collaborative Meeting, and VA's own Tribal Advisory Council, to name a few.

- To ensure those Tribes wishing to seek out special authorization are competent in their representation of Veterans, VA secured Vietnam Veterans of America (VVA) as a partner willing to provide free training on VA claims representation.
- From February 2022 through November 2022, OGC individually met with 19 Tribes that have come forth as interested participants of T. REP, through OGC's T. REP outreach efforts.
  - Nine of those Tribes requested VVA's free training as a step toward seeking out the General Counsel's special authorization.
  - Four of those Tribes, to include the Navajo Nation, have expressed interest in VA's veterans service organization recognition; and
  - The remaining Tribes are still considering participation in T. REP as an option forward.

Most notably, through the T. REP initiative, the Navajo Nation Veterans Administration (NNVA) sought out VA recognition as an organization pursuant to 38 U.S.C. § 5902, and its implementing regulation, 38 C.F.R. § 14.628(b). Secretary McDonough recognized NNVA as the first Tribal organization authorized to prepare, present and prosecute benefit claims before VA on May 2, 2022, and visited the Navajo Nation to commemorate the historic event in June 2022.

Conclusion

The health and well-being of all our Nation's Veterans is of the utmost importance, and VA strives to consistently provide high quality services to Veterans, caregivers, family members, and survivors. As outlined in this testimony, VA is deeply committed to ensuring Native Veterans have access to the health care and benefits they have earned. Thank you for your time and for your focus on this important topic. We look forward to continuing to advance the delivery of services to AI/AN Veterans and appreciate the work of this Committee as well as the Indian Health Service.

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Testimony of Leo Pollock, Blackfeet Veterans Alliance Administrator

On behalf of the Blackfeet Veterans Alliance (BVA) of the Blackfeet Nation

Senate Veterans Affairs Committee

November 30th, 2022

The Blackfeet Veterans Alliance and the Blackfeet Tribe would like to thank Chairman Tester, Ranking Member Moran, and Members of the Senate Veterans Affairs Committee for this great opportunity to provide this written statement on the challenges that our veterans face on the Blackfeet Reservation. The Blackfeet Reservation covers three thousand square miles and it is often forgotten that within the exterior boundaries of our reservation, there are two counties that are served by the Blackfeet Nation. These counties are Glacier County which makes up the majority of the reservation and a portion of Pondera County on the southern end which is the community of Heart Butte. Valier and Dupuyer are border towns on the Blackfeet Reservation. Glacier County consists of the following towns; Babb/St Mary, Browning, Cut Bank, East Glacier and Santa Rita. Pondera County includes Brady, Conrad, Dupuyer, Heart Butte and Valier.

Blackfeet Veterans Alliance was created in 2001 to assist the American Legion Post #127 which was established after World War II and also to help the Blackfeet Warrior Society which was created in 1998. BVA was created to be an advocate on the Local, State, and National level for veterans in both groups as well as the veterans who choose not to participate in those groups but still need a voice.

The National Congress of American Indians states that, "According to the 2010 census, it is estimated that over 150,000 veterans identified as

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American Indian and Alaska Native alone." Administrators before me were tasked with building a living document to keep track of the veterans who live and reside in both Glacier and Pondera Counties as well as the veterans who may reside off the reservation but still maintain close ties with home. Some of the list has been lost due to the changing of Administrators as well as building and location changes. Upon my arrival to this position in January of 2021, I was able to locate one list that had over 500 veteran names both living and deceased. Over the past two years we have re-built that list to a running total of 894 veterans living and deceased and broke that list down to a total of 766 veterans that are still living and maintain close ties with the reservation.

This number is close to a survey completed by Stacker.com in July of 2022 showing a total of 764 veterans in the Glacier County area and 494 Pondera County veterans which gives a total of 1258 Veterans. Montana Veteran Affairs Division (MVAD) currently assists 299 veterans in Glacier County and 78 veterans from Pondera County. Dr. Judy Hayman, current Executive Director of Montana VA Healthcare Systems had said there were only 278 veterans in Glacier County, however this was the number given by the Glacier County Clerk and Recorder as 2002 was when they began recording the veterans DD214 electronically instead of manually. A count of 278 veterans would exclude every veteran who has served our country from 2001 on back to when they began recording these records in World War I as well as the proper veteran count from Pondera County.

Barriers

I bring these numbers to light due to the geographical, logistical and financial barriers that we face here on the reservation. Most larger VA Urban centers are located at a minimum of two hours away with Ft. Harrison in Helena MT which is a 4-hour drive one way from Browning

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with ideal driving conditions. This drive can easily become a 6–8-hour drive in winter conditions. Our logistical and financial barriers that our veterans face on the Blackfeet Reservation is that these 30 minutes to 2-hour trips becomes more than just a quick trip for a VA appointment. This now becomes a trip where they have to plan on making this their monthly shopping trip to gather other supplies that they may need on top of the appointment in itself. Several other veterans do not even have the transportation or the finances to make these trips. They then have to ask friends and relatives for transportation help to make these trips. We here at the BVA are available to assist our veterans in getting them to their appointments whether that be through financial support, giving them a ride ourselves, or coordinating with the Great Plains Transportation from Rocky Boy to assist them in getting them to their appointments in a timely manner. We also understand the DAV vehicle is available as well.

VA/IHS MOU

It has recently come to our attention that the last time a veteran was able to receive care at the Browning Unit Indian Health Service (IHS) was around 2014. After this time frame, several veterans began shifting their care to the Cut Bank VA Clinic which is 30 minutes from Browning. For our veterans further north in the communities of Babb and St. Mary this becomes a One-hour trip one way, once again during ideal driving conditions. After moving their primary care from Browning to IHS, we had run into issues where several veterans chose to take the trip to Ft. Harrison instead of staying local with the Cut Bank VA Clinic due to mistreatment from the staff.

In the end of July 2022, we held a benefits fair for the veterans in all of the surrounding communities. One of the constant questions was, "Why

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can't we go to IHS anymore?" This lead us back to the establishment of the MOU between the VA and IHS and why our veterans weren't being provided the services that was worked out in a National MOU between the two parties.

VA Rocky Mountain Network better known as VISN 19 began a series of meetings starting with a Town Hall with our veterans and then a meeting with the VA Healthcare Systems, IHS and the Blackfeet Tribal Business Council (BTBC) in September 2022.

After leaving the meeting with the Acting CEO of the Browning IHS and the VISN 19 team with no real answer to why IHS couldn't honor the MOU, we shifted our attention and efforts to asking the Southern Piegan Health Center (SPHC) if they could help re-establish an Outpatient VA Clinic. SPHC has shown a willingness to work with the VA to provide services to all of our veterans in the surrounding areas and currently already see non-enrolled members for regular appointments.

SPHC currently has one Medical Doctor, two Family Nurse Practitioners, a Physical Therapist and a Licensed Addiction Counselors as well as the support staff in place to help our veteran population in the surrounding areas. The VA is currently renting a room at the New Eagle Shields that was previously used for the Outpatient Clinic as well as the telehealth appointments. SPHC has said in the interim time they can bring the supplies needed to attend to our veterans needs until the VA can supply what is needed on their end. I think this is a great opportunity for everyone involved as well as a truly beneficial end result.

In closing, I will continue to fight for our veterans not just here on the Blackfeet Reservation, but for those located close to us who may feel more at ease with someone they may haven known for years and have

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already created a mutual trust with the provider who will be there for years to come. This will create many opportunities, break down barriers, and give our veterans a peace of mind knowing they just need to make it in to town for the care and help that they need. Thank you all for your time today.

Senate Veterans Affairs Committee
Hearings to examine Native American veterans, focusing on ensuring access to VA health care and benefits
November 30, 2022

Larry Wright, Jr.
Executive Director, National Congress of American Indians
Testimony

Introduction

Good afternoon, Chair Tester, Ranking Member Moran, and members of the Senate Veterans Affairs Committee. My name is Larry Wright, Jr., and I am a former Chairman of the Ponca Tribe of Nebraska and currently serve as the Executive Director for the National Congress of American Indians (NCAI). NCAI was founded in 1944 and is the oldest, largest and most representative American Indian and Alaska Native organization serving the broad interests of tribal governments and communities. On behalf of NCAI, thank you for this opportunity to provide testimony on issues affecting Native American veterans.

I believe that the members of this Committee are aware of the valor and service of American Indian, Alaska Native and Native Hawaiian veterans to this country. Per capita, Native people serve at a higher rate in the Armed Forces than any other group of Americans, and they have served in all the nation's wars since the Revolutionary War. Native veterans have even served in several wars before they were recognized as U.S. citizens and before they had the right to vote at the polls.

Despite this impressive record of service, I believe that the members of this Committee are also aware that the lack of health care provided to these veterans upon returning home is both shocking and unacceptable—particularly considering all they have done to protect our homelands.

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

Obtaining health care for Native veterans often means navigating both the Veterans Health Administration (VHA) and the Indian Health Service (IHS). The primary health care provider in most Native communities—and for many of our Native veterans—is IHS. Thus, one mechanism for improving the health of Native veterans is to improve the IHS system which has long been woefully underfunded. Additionally, unlike the VA system, IHS continues to be subject to the

harmful and disruptive effects of government shutdowns and short-term stopgap measures because it does not yet have advanced appropriations.

Following the 2019 government shutdown, NCAI adopted Resolution #ECWS-19-001,[1] 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,[2] which calls for advance appropriations for IHS. Preventing federal budget impasses from jeopardizing the health, safety, and wellbeing of American Indian and Alaska Native (AI/AN) veterans—and all those living in tribal communities—is a major priority for Indian Country. Again, while the Veterans Health Administration (VHA) 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. This is precisely why NCAI has long been in support of advanced appropriation for IHS, and it is one step that can be taken immediately to help both Native veterans and Native communities more broadly.

Improve Direct Access to VA Services

Focusing on the Veterans Health Administration more directly, there are many barriers Native veterans encounter in accessing care. One alarming statistic is that Native veterans use VA health care disproportionately less than non-Native veterans despite having a disproportionately higher percentage of veterans with a disability. There are a number of reasons why this is the case, and one is simply related to the remoteness of VA health facilities from many tribal communities.

In 2009, NCAI's sitting President, Jefferson Keel, testified in front of this same Committee and stated the following: "Native veterans are likely to have scarce financial resources to spend on travel to IHS or VA hospitals. [...] These proud veterans, who in some instances used their last dollars to travel long distances to either facility, deserve better treatment."[3] President Keel's words remain true to this day. Native veterans seeking to get to a VA facility might have to make a 200-mile round trip, and in the case of Alaska Native veterans, it may be much, much further. Because of this, thirteen years ago, NCAI recommended that the VA, in coordination with the Department of Transportation, "work with tribal governments to facilitate transportation from tribal community hubs to Veterans Health Administration hospitals". This has yet to occur. As such,

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[1] Available at: *https://www.ncai.org/attachments/Resolution_vkouAZmrehTqskEUMrBcxaBCihXkHApCJyGwXAwyjOkhwIcYAGi_ECWS-19-001%20Advance%20Appropriations%20FINAL.pdf*

[2] Available at: *https://www.ncai.org/attachments/Resolution_gvZLHpstyyeGIgbSLNqtMyKClLfloYEDEWdKktjoOvRXjFkXWvg_ANC-14-007.pdf*

[3] Available at: *https://www.govinfo.gov/content/pkg/CHRG-111shrg53369/html/CHRG-111shrg53369.htm*

NCAI stands by this recommendation and urges the continued exploration of alternative options, such as telehealth services, to ensure that all Native veterans are being reached.

Improve Quality of VA Services

Another reason Native veterans use the VA health care system disproportionately less than other veteran groups likely has to do with the lack of service that is often available to patients at VHA facilities. Thirteen years ago in NCAI's testimony, we highlighted that there were "far too many reports of inconsistency in delivery of health care to American Indian and Alaska Native veterans" and discussed concerns related to delays in scheduling appointments as well as the cancellation of appointments without notice by VA hospitals. At that time, NCAI also highlighted the backlog of basic services including dispensing eyeglasses and hearing aids, and noted that many veterans felt their health problems are not being addressed adequately by a system that rushes them through the process without diagnosing all the problems or providing realistic treatment regimens. NCAI's staff continues to hear similar complaints to this day. And, anecdotally, in August of this year, NPR ran a story on Justin Dupree, a Native veteran who did five overseas tours of duty.[4] In that story, Mr. Dupree indicated that it took him six months just to get an appointment scheduled for the therapy he needed. For the men and women who served our country, those kinds of wait times and lack of access to critical health services cannot be tolerated. Whether the solution comes from more funding to VA to improve its capacity, more outreach to tribal communities to improve service delivery, or additional government-to-government consultation to explore innovative ways the VA could partner with Tribal Nations to administer services to veterans, something must be done.

Improve Cultural Competency at the Department of Veterans Affairs

In that same NPR article, Mr. Dupree went on to say that once he finally did get his appointment, his therapist was neither Native nor a veteran and, for those reasons, the session did not go well and Mr. Dupree, ultimately, stopped seeking treatment because he no longer felt comfortable doing so. This story is often repeated through Indian Country and the poor level of cultural competency within the VHA is another barrier to Natives trying to access services.

We are hopeful that the recently created Tribal Advisory Committee within the VA will assist with some of these issues, and applaud the efforts made to both create that entity under law and to fill its seats.

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[4] Quil Lawrence, " One Native veteran's new mission: Fill in the gaps of VA care on his reservation", NPR (August 24, 2022), available at: *https://www.npr.org/2022/08/24/1118761468/native-american-veterans-health-care-military-service*

That said, more needs to be done to address cultural competency. 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, many forms and questionnaires do not address cultural contexts or risks; additionally, as a result of incurring traumatic brain injuries, some Native veterans struggle with second-language retention and require services to be administered in their Native languages instead of English; and finally, there is a dearth of Native professionals and individuals with adequate understanding of tribal communities to truly allow individuals with health concerns to be open, honest, and trusting of the system—something that is essential to achieving positive outcomes for those in need.

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. Similarly, more government-to-government consultation between the VA and Tribal Nations can also generate new methods for improving cultural competency across health services.

Grant a Federal Charter to Native American Indian Veterans, Inc.

And finally, nearly 20 years ago, NCAI passed Resolution #FTV-04-010,[5] "Endorsement of the National American Indian Veterans, Inc. and Requesting the US Congress to Grant NAIV, Inc. a Federal Charter". The National American Indian Veterans (NAIV), Inc. is a strong advocate on behalf of all American Indian, Alaska Native, and Native Hawaiian Veterans without regard to whether they served during times of peace, conflicts and wars and, among other things, will greatly assist in the exchange of information, ideas, and cultural knowledge between Native people and the federal government. NCAI applauds the decision of the U.S. Senate just two weeks ago to pass S.1725, which seeks to grant a Congressional charter for the National American Indian Veterans, Inc. organization, and we now call on the House and the President to take the steps necessary to pass and sign this bill into law.

Address Other Issues Affecting Veterans

Before I close my remarks, I also want to briefly highlight three other issues impacting Native veterans that NCAI has adopted resolutions on and is advocating be addressed:

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[5] Available at: *https://www.ncai.org/attachments/Resolution_LPJKXXbuNGOuAprOLnkfuRGmVyGwsmTMWozXTzYykZBXmvCbCCU_ftl04-010.pdf*

1. **Address Housing for Veterans**

   Despite the service they provide to our country, homelessness and housing insecurity remains a major concern for our Native veterans. A simple but critically important step to combat this issue is to reauthorize and make permanent the Native American Housing Assistance and Self-Determination Act (NAHASDA). NAHASDA reorganized the system of housing assistance provided to Native Americans through the Department of Housing and Urban Development (HUD) by eliminating several separate programs of assistance and replacing them with a block grant program.This block grant program has successfully been used by Tribal Nations across the country to focus on the specific housing needs in their own communities.

   However, NAHASDA expired nine years ago, and we cannot afford to let this critical legislation go unauthorized any longer. NCAI urges the members of this Committee to support S. 2264: The NAHASDA Reauthorization Act of 2021. This legislation has been reported out of the Senate Committee on Indian Affairs, marking the most progress any NAHASDA Reauthorization bill has made since 2013. Additionally, many of the provisions in S. 2264 are included in the Senate Transportation, and Housing and Urban Development (THUD) Appropriations Bill, and we strongly urge this Committee and other members of Congress to support these efforts.

   Reauthorizing NAHASDA will also help Native veterans struggling with homelessness by improving the HUD-Veterans Affairs Supportive Housing (HUD-VASH) program. The program has been a nationwide success because it combines rental assistance, case management, and clinical services for at-risk and homeless veterans. Unfortunately, this program is not fully available to Native veterans living on tribal lands.

   NCAI has a standing resolution supporting this legislation: Resolution #ECWS-14-001,[6] "Support for Indian Veterans Housing Rental Assistance Demonstration Program in the Native American Housing and Self-Determination Act Reauthorization" and, accordingly, NCAI urges this Committee to pass legislation to address the issues of Native veteran homelessness as soon as possible.

   Also in the housing space, NCAI urges the passage of S. 4505: the VA Native American Direct Loan Improvement (NADL) Act. The VA's NADL program has only provided 190 loans to Native Americans nationwide over the past 10 years. This legislation would help to increase the number of NADL-administered loans by allowing veterans to refinance existing non-VA mortgages utilizing the NADL product, and would also allow veterans

[6] Available at: https://www.ncai.org/attachments/Resolution_rGJmzKMOpmPXCODBFDEimNAVXIDwbXbVyXGHmPeVbMNxlCXSRjF_ECWS-14-001%20resolution.pdf

who have built homes with other sources of construction financing (e.g. a Native CDFI loan) to still use NADL as permanent financing. It also provides grant funding for Native CDFIs, Tribal Nations, Tribally Designated Housing Entities (TDHEs), and nonprofits to assist with outreach, homebuyer education, and other technical assistance to Native veterans seeking homeownership financing.

2. **Collect Data on Native Veteran Suicide**
   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 policy makers have the necessary information to address the suicide crisis among AI/AN veterans.

3. **Restore Pay to Native Veterans**
   For decades, Native service members had state income tax withheld from their military paychecks despite being exempt based on the Soldiers and Sailors Civil Relief Act (Section 514). Nearly twenty years ago, Senator Tom Udall introduced the American Indian Veterans Pay Restoration Act, which would address the 26 states that had illegally taxed service members for as long as 24 years. In 2013, NCAI passed resolution #REN-13-075,[7] "In Support of Legislation to Address the Improper State Taxation of Reservation-Domiciled Service Members" and now, we are once again asking that steps be taken to right this historical wrong. The VA, Department of Justice, Internal Revenue Service, and Congress should work together to remedy this egregious taking of Native service-member pay.

Conclusion

I want to conclude by once again thanking this Committee for both holding this hearing and taking the critical step of discussing Native veteran issues—without dialogue, we all know there can be no change.

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[7] Available at: https://www.ncai.org/attachments/Resolution_uNFXzhlbcGHDDUzPFgAdnhxOdjchQqKmaarlOCoMrxjjKCIFssD_REN-13-075%20final.pdf

I also want to take a moment and acknowledge that when the U.S. government does engage in meaningful dialogue and consultation with Tribal Nations, solutions can be found. We don't need to look any further than the Native American Veteran Parity in Access to Care Today (PACT) Act, which was signed into law nearly two years ago. This piece of legislation has improved accessibility to Veterans Health Administration services by eliminating copayments for our American Indian and Alaska Native veterans; and, we are grateful to Senator Tester for his leadership on getting the Native American Veteran PACT Act passed—it is a valuable demonstration of what can be accomplished for our Native veterans when we all focus and work together.

Our Native veterans—like all veterans—have given up their time, their health, and in many cases their lives to protect this country. For those who have served and are still with us, it is imperative that we give them everything they need to thrive. Thank you again for this opportunity to speak, and I look forward to addressing any questions you may have.

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
NICKOLAUS LEWIS, VICE CHAIRPERSON AND
PORTLAND AREA REPRESENTATIVE
NOVEMBER 30, 2022

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.

National Indian Health Board

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;

National Indian Health Board

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.

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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.**

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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.

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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.

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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]

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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

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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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NATIONAL COUNCIL of URBAN INDIAN HEALTH

November 30, 2022
Written Testimony of Sonya Tetnowski (NCUIH)
Senate Committee on Veterans Affairs

My name is Sonya Tetnowski, I am an enrolled member of the Makah Tribe and a Veteran of the United States Army. During my time serving the United States on Active Duty and in the Reserves, I deployed in support of Operations Desert Shield and Desert Storm and Operation Uphold Democracy. I currently serve as the President of the National Council of Urban Indian Health (NCUIH) and Chief Executive Officer of the Indian Health Center of Santa Clara Valley. I also have the honor of serving as the Co-Chair of the health subcommittee within the Department of Veterans Affairs (VA) first-ever Advisory Committee on Tribal and Indian Affairs. As a noncommissioned officer, I took an oath to place the needs of my Soldiers above my own, an oath I continue to strive to fulfill in my advocacy on behalf of Native veterans. Today, I am here on behalf of NCUIH, the national advocate for health care for the over 70% of American Indians and Alaska Natives (AI/ANs) living off-reservation, and the 41 Urban Indian Organizations (UIOs) that serve these populations. I would like to thank Chairman Tester, Ranking Member Moran, and members of the Senate Committee on Veterans Affairs for the opportunity to testify today on the vital topic of Native veterans.

We want to acknowledge the recent strides that the Department of Veterans Affairs (VA) has made in addressing its shortcomings in serving Native veterans. I have seen firsthand the drive and commitment of VA staff, like Stephanie Birdwell and Clay Ward in the Office of Tribal Government Relations, to better serve Native Veterans. NCUIH commends the VA for the creation of the Office of Tribal Health – an office we think has the potential to significantly improve health outcomes for Native veterans including those who do not live on reservations. Finally, we should recognize the recent revisions to the Veterans Health Administration (VHA) – Indian Health Service (IHS) Memorandum of Understanding (MOU) and associated Operational Plan, both of which commit the VHA and IHS to concrete steps to improve the quality of health care and services for Native veterans.

However, Native veterans continue to experience significant barriers to accessing the benefits and services they earned through their military service. This is all the more critical given the disparities Native veterans experience compared to other veterans in areas like health, employment status, and educational attainment. Accordingly, we respectfully request the following:

- Improve access to care for Native veterans at their provider of choice within the Indian healthcare or veterans' healthcare systems
- Advance appropriations for the Indian Health Service
- Increase outreach and technical assistance regarding the VA Reimbursement Program for UIOs

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- Ensure the VA utilizes self-attestation in determining Native identity for VA copayment purposes
- Establish an Urban Confer Policy with the VA

Living Off of Reservation Land: Background on Urban Native Veterans

AI/ANs have a long history of distinguished service to this country. AI/ANs have historically served in the U.S. military at a higher rate than any other population and have served in all the nation's wars since the Revolutionary War.[1] Time and time again, Native service members have answered this Nation's call, fighting and dying for the United States even while being subjected to forced removal from their homelands, denial of citizenship, and treatment as second-class citizens when we returned home from war. In return for this service and our willingness to make the ultimate sacrifice for our Country, the United States promises Native veterans, like all veterans, world-class benefits and services.

NCUIH estimates that about 67 percent of the Native veteran population lives in metropolitan areas and we earned the same benefits to which all veterans are entitled. Urban Native Veterans experience the same poor physical and mental health outcomes as Native veterans in rural areas.[2] In fact, urban Native Veterans generally have lower incomes, higher unemployment, lower education attainment, higher VA-service-connected disability ratings, and generally live in poorer housing conditions than non-Native veterans also living in urban areas.[3] For example, 12.5 percent of Native veterans living in urban areas have a VA service-connected disability rating of 70 percent or higher, compared to 7.7 percent of non-AI/AN veterans in urban areas.[4]

Native Veterans and Urban Indian Organizations

Native veterans are entitled to receive healthcare through both the veterans' healthcare system and the Indian healthcare system. The Indian healthcare system consists of IHS, Tribal organizations, and UIOs, and is colloquially referred to as the I/T/U System. A study published in the Military Medicine Journal confirmed that more than 50 percent of Native Veterans use the I/T/U system for their health needs.[5] Many Native veterans who preferred using Indian healthcare services reported that

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[1] Proclamation on National Native American Heritage Month, 86 C.F.R. § 60545 (2021), available at https://www.whitehouse.gov/briefing-room/presidential-actions/2021/10/29/a-proclamation-on-national-native-american-heritage-month-2021/.
[2] Kimberly Huyser, Sofia Locklear, Connor Sheehan, Brenda Moore & John Butler, Consistent Honor, Persistent Disadvantage: American Indian and Alaska Native Veteran Health in the National Survey of Veterans, 33(7-8S) J. of Aging and Health 68S-81S, 70S (2021), https://journals.sagepub.com/doi/pdf/10.1177/0898264321101403 4
[3] U.S. Census Bureau, 2015-2019 American Community Survey 5-year Public Use Microdata Samples (2020), retrieved from https://usa.ipums.org/usa/sda/. Urban Veterans are defined as respondents who 1. Reside in a Public Use Microdata Areas (PUMA) which lies fully or partially within a Metropolitan Area with a population of 50,000 or more; 2.Were formerly in the armed forces or are currently in the armed forces. CODEBOOK for Variable Descriptions: https://sda.usa.ipums.org/sdaweb/docs/us2019c/DOC/nes.htm
[4] *Id.*
[5] Harada ND, Villa VM, Reifel N, Bayhylle R. Exploring veteran identity and health services use among Native American veterans. Mil Med. 2005 Sep;170(9):782-6. doi: 10.7205/milmed.170.9.782. PMID: 16261984.

this was because of its increased accessibility, including location and shorter waiting times.[6] UIOs are a vital branch of the I/T/U system, and many offer a variety of health services, including cultural services, to our urban Native veterans. UIOs are especially critical to VHA and IHS' mission to improve care and access to services for Native veterans because of their deep ties to the Native community in urban areas. The 41 UIOs currently operate over 77 facilities, in 38 areas[7], and provide a wide range of services including primary care, behavioral health services, social & community services, and traditional medicine. UIOs currently serve seven of the ten metropolitan areas with the largest Native veteran populations, including Los Angeles, Phoenix, Dallas, Seattle, New York, Oklahoma City, and Chicago. In cities like Dallas, Chicago, or New York City UIOs are the only provider within the Indian health care system available to Native veterans. As providers of culturally competent care, UIOs are perfectly situated to further VHA and IHS's mission to improve the health care available to veterans.

It wasn't until December 2020, after tireless advocacy from NCUIH, that the *Health Care Access for Urban Native Veterans Act* (S. 2365) was included in the Consolidated Appropriations Act of 2021, which provided authority for UIO reimbursement from VA for these critical services to AI/AN veterans. We are grateful for the VA's commitment to working with UIOs and expanding care to urban Native veterans who defend our country.

Benefits and Access to Care at IHS Facilities

As I have already mentioned, Native veterans are eligible to receive health services at IHS and VHA facilities. This is because the United States owes Native veterans health care twice over: once because of the United States' trust responsibility to provide health services to Native people and once because of the United States' promise to provide health care to veterans. As this body set forth in the Indian Health Care Improvement Act, "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."[8] Similarly, President Lincoln laid down the charge for the country "[t]o care for him who shall have borne the battle, and for his widow, and his orphan." This dual responsibility should lead to our Native veterans receiving the highest quality of care.

It is important to recognize the need for Native veterans to have the flexibility to seek care from the I/T/U system and the VHA as needed. Native veterans may prioritize receiving their care at a certain facility depending on the challenges they are facing. As such, coordination between these two agencies is critical to best serve Native veterans. Native veterans deserve the right to choose to receive care at their preferred facilities, especially given the fact that many important cultural services are not

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[6] *Id.*
[7] Harada ND, Villa VM, Reifel N, Bayhylle R. Exploring veteran identity and health services use among Native American veterans. Mil Med. 2005 Sep;170(9):782-6. doi: 10.7205/milmed.170.9.782. PMID: 16261984.
[8] 25 U.S.C. § 1601.

available at VA facilities. We owe it to our Native veterans to have broader access to the benefits they are entitled to, especially their choice of where to receive care.

We request that Congress increase the oversight on the coordination between the VA and IHS, including requesting submissions of regular reports on the Memorandum of Understanding implementation and service delivery to Native veterans.

UIO Eligibility as Covered Facilities Under the VA PPGMER

Related to the right to choose care is the VA Pilot Program on Graduate Medical Education and Residency (PPGMER) Program. In the MISSION Act of 2018, Congress intended to expand veterans' access to medical care and enable them to seek quality health care outside the VA. As part of its strategy, Congress directed the VA to expand its existing medical residency program to underserved non-VA facilities and support the provision of healthcare that provides high-quality, culturally sensitive healthcare options for Native veterans. The PPGMER is the VA's efforts to meet the requirements of the MISSION Act.[9] However, VA's proposed implementing regulations only explicitly lists two of the three branches of the I/T/U healthcare system as eligible for placement of residents: Tribes or Tribal organizations, and facilities operated by IHS. UIOs are not listed, despite being the third branch of the I/T/U system.

Listing UIOs as covered facilities will help the VA ensure that it carries out Congress' intent to expand veterans' access to medical care and enable veterans to seek quality health care outside of VA. As mentioned before, access to culturally sensitive healthcare options can be difficult for Native veterans living in urban areas due to a lack of training in VA facilities and long distances to IHS and Tribal facilities, making UIOs ideal service providers to meet this need. Native veterans living in urban areas earn the same benefits to which all veterans are entitled to, which is why this expansion of eligibility to UIOs is critical.

Tribal Representation Expansion Project Expansion to UIOs

The need to better serve Native veterans goes beyond access to healthcare. For example, a recent VA initiative, the Tribal Representation Expansion Project (T.REP), strives to ensure that Native veterans have access to responsible, qualified representation in the preparation, presentation, and prosecution of their benefits claims before the VA by expanding certification for employees of Tribal governments to represent Native veterans. However, this program does not include any expansion of accreditation opportunities for representatives of Native veterans living in urban areas[10]

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[9] NCUIH. Federal Comments to Deputy Chief Greenberg. RE: RIN 2900-AR01—VA Pilot Program on Graduate Medical Education and Residency. [PDF]. Available at: https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:f62a2395-030c-33be-b3f1-31c817ade4f0.
[10] National Council of Urban Indian Health (NCUIH). Federal Comments to Secretary McDonough. RE: The Tribal Representation Expansion Project. [PDF]. Available at: https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:62f567aa-26bf-3fe4-a999-e847a4290392.

Like AI/AN veterans living on Tribal trust land, AI/AN veterans living in urban areas face significant barriers to accessing representation on VA benefit claims based on their location. For example, according to VA's Accreditation Search tool, there are no accredited attorneys, claims agents, or Veterans Services Organizations (VSO) in the city of Flagstaff, AZ. There is just one accredited VSO representative.[11] Similarly in Helena, MT there is just one accredited attorney, no accredited agents or VSO representatives, and a single VSO.[12] Butte, MT has no accredited attorneys or agents, and just two VSO representatives.[13] There are just two accredited attorneys in the city of Santa Barbara, CA, no accredited agents, and a single VSO representative.[14] Manteca, CA is served by a single VSO representative.[15] Each of these cities is currently served by a UIO which, if included in T. REP, could provide access to accredited representatives for AI/AN veterans as well as the broader veteran population in these cities.

AI/AN individuals living in urban areas have maintained strong, vibrant, and distinct cultures and communities despite the federal government's attempts to force them to assimilate into mainstream culture through its Relocation and Termination policies.[16] In fact, UIOs "are an important support to Native families and individuals seeking to maintain their values and ties with each other and with their culture," which exist to provide "a wide range of culturally sensitive programs to a diverse clientele."[17] Even in cities which have significant numbers of accredited representatives, there is no guarantee that these representatives will be culturally competent. Further, like AI/AN veterans living in rural areas, AI/AN veterans may also lack trust in the federal or state government. As a result, UIOs are uniquely placed to help AI/AN veterans living in urban areas overcome cultural barriers in accessing representation in VA benefit claims.

NCUIH recommends that VA expand T. REP to allow UIOs to designate members of their staff as authorized to prepare, present, and prosecute VA benefit claims. Doing so will further VA's stated goal "to further facilitate access to culturally competent representation for Native American Veterans,"[18] by providing AI/AN veterans living in urban areas, not just those living on Tribal trust lands, access to culturally competent representation on their VA benefit claims. Alternatively, NCUIH requests that VA establish a similar expansion project for UIOs. VA states that its goal is "to ensure that Native American Veterans have access to responsible, qualified representation in the preparation, presentation, and prosecution of their benefit claims before VA."[19]

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[11] Department of Veterans Affairs, *Accreditation Search*, https://www.va.gov/ogc/apps/accreditation/index.asp (last visited Mar. 29, 2022).
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *E.g.*, Jennifer Bereskin, *Maintaining Traditions and Identity as Urban Indians*, FIRESTEEL (Oct. 5, 2021), https://www.ywcaworks.org/blogs/firesteel/tue-10052021-0942/maintaining-traditions-and-identity-urban-indians; National Urban Indian Family Coalition, *Urban Indian America: The Status of American Indian & Alaska Native Children & Families Today* (2008), https://assets.aecf.org/m/resourcedoc/AECF-UrbanIndianAmerica-2008-Full.pdf
[17] National Urban Indian Family Coalition, *supra* note 21 at 12.
[18] Department of Veterans Affairs, *supra* note 2.
[19] *Id.*

When this program was first announced, myself and NCUIH staff engaged on several occasions with VA officials to explain the need for a similar program for Native veterans living in urban areas, but so far they have been unwilling to expand this program. AI/AN veterans living in urban areas must not be left behind by VA. We urge the VA to either include UIOs in T. REP or establish an alternative expansion project so that it truly fulfills its goals and responsibilities to AI/AN veterans.

Advance Appropriations

As many Native veterans choose to use the I/T/U system to for their health care needs, a critical issue for their care is advance appropriations for IHS. Congress has provided advance appropriations for VHA since 2009. This gives the VHA budget certainty for two years at a time and means the healthcare which Veterans receive through VHA is protected from government shutdowns and stopgap funding.

Unfortunately, healthcare provided to Native people, including Native veterans, through IHS, Tribal facilities, or Urban Indian Organizations, is not similarly secure. In fact, the Indian Health Service is the only major federal healthcare program that is not protected. Whenever there is a gap or disruption in IHS funding, either as a result of a shutdown or continuing resolution, Tribes and Urban Indian Organizations are often forced to reduce or sometimes even cease healthcare services entirely. For some Native veterans, a Tribal or UIO facility is their only accessible provider of healthcare. As a result, even though VHA may continue operations during a shutdown, many Native veterans will still experience gaps in coverage when Tribal and UIO facilities are forced to reduce or shut down services due to a lack of funding.

Disruptions in federal funding quite literally put Native lives at risk. For example, during the 35-day government shutdown at the start of Fiscal Year 2019, 5 patients died and UIOs were forced to take drastic measures by laying off staff, slashing hours, reducing services, and even closing their doors due to lack of funding. My clinic also had to support an Urban Indian health clinic that needed assistance to stay open due to the funding delays. I urge this committee to help secure stable healthcare funding for all Native veterans, no matter where they live, by supporting advance appropriations for IHS.

Increasing Outreach to UIOs on the VA Reimbursement Program

NCUIH advocated for years, and I testified multiple times before Congress, for the vital inclusion of urban Indian organizations in the VA reimbursement program. We are grateful to Chairman Tester, Ranking Member Moran, and members of this Committee for fixing a parity issue that was impacting the health care delivery for Native veterans. Unfortunately, many UIOs noted they are having difficulties enrolling in the VA reimbursement program, and so far, only one of 41 are currently enrolled. This is not because UIOs do not have the desire to enroll in the program. In fact, many UIOs like mine expressed direct interest in enrolling. Instead, many UIOs reported that they are unaware of whom to contact to begin the process of enrolling. It would

be valuable if the VA could increase its outreach to help educate and assist UIOs in this process. With additional outreach and technical assistance from the VA, more UIOs would enroll in this program, amplifying their capacity to provide more robust health services to the Native veterans they serve.

Co-payments & Benefits Identification

It has been more than two years since NCUIH worked with Chairman Tester and Ranking Member on the PACT Act to remove copayments for Native veterans receiving healthcare and extend that to those who meet the statutory definition of the term 'Indian' or 'Urban Indian' set forth in the Indian Health Care Improvement Act, which encompasses a broad range of individuals. Yet, this has not been implemented since its passage.[20] It is our understanding that the VA is currently developing a regulation to implement this prohibition, and during his address at the National Indian Health Board's conference, Secretary McDonough promised that it will be issued by the end of the year. This Committee should encourage VA to require self-attestation or certification that a Veteran meets the definition of "Indian" or "Urban Indian" in implementing the copayment prohibition.

In a Federal Register notice concerning this issue, VA suggested that it is considering requiring Native veterans to show a Tribal identification card or a Certificate of Degree of Indian Blood. Doing so would potentially exclude many eligible Native veterans and subvert Congress' will to exempt all Native veterans meeting the definition of the term "Indian" or "Urban Indian" from VA copayments. For example, a Native veteran who is unhoused or low-income in an urban area may not have the ability to travel back to their Tribe to receive an identification card. That Native veteran might also have significant difficulty obtaining the required certified copy of a birth certificate needed to apply for a CDIB. In addition, in some cases, the Indian Health Care Improvement Act defines Indians and Urban Indians as descendants of Tribal citizens. Native veterans meeting that definition would not have the Tribal identification VA proposes to require.

Ultimately, there is a significant portion of the Native veteran population who would not benefit from this identification statute. It is critical that VA utilizes self-attestation in determining Native identity for VA copayment purposes. Without self-attestation, Native veterans may be denied exemption from VA's copayment rules, which is directly contrary to Congress' intent to increase access to care and resources Native veterans have earned by reducing out-of-pocket costs and eliminating a disparity for Native veterans who receive health care at VA rather than IHS.

Urban Confer

[20] Public Law 94-437. Indian Health Care Improvement Act.

An Urban Confer is an open and free exchange of information and opinions that leads to mutual understanding and comprehension and emphasizes trust, respect, and shared responsibility.[21] Urban Confer is an established mechanism for dialogue between federal agencies and UIOs. They are a response to decades of deliberate federal efforts (forced assimilation, termination, relocation) that have resulted in 70% of Native people living outside of Tribal jurisdictions. This has made Urban Confer integral to addressing the care needs of most Native people. Establishing an Urban Confer policy is consistent with the federal government's trust responsibility. Congress has declared "that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities."

Failure to communicate about policies impacting urban Natives is not only inconsistent with the government's trust responsibility, but it is contrary to sound public health policy. A VA Urban Confer Policy is especially important given that an estimated 67 percent of Native veterans live in urban areas.

Currently, Congress has only directed IHS to confer with UIOs.[22] Unfortunately, many agencies have interpreted this to mean that IHS alone has the requirement to confer with UIOs. NCUIH has heard from several agencies that they cannot confer with UIOs without legislative authority. While we disagree with this interpretation, we urge Congress to help us overcome this barrier to serving Native veterans and pass legislation establishing an Urban Confer policy with the VA. For example, during the rollout of COVID-19 vaccines, some of our clinics, unfortunately, didn't receive as many vaccines and in Montana, some veterans who went to the VA to receive vaccines were told to go back to the "Indian clinic". This shows the need for greater coordination among these entities serving our veterans. An Urban Confer policy would establish the necessary procedures for more direct and clear communication so that both the VA and UIOs can better serve the Native veteran population.

NCUIH supports the government-to-government relationship between Tribes and the United States and a robust Tribal Consultation process. It is important to note that Urban Confer policies do not supplant or otherwise impact Tribal consultation and the government-to-government relationship between Tribes and the United States. We simply seek to increase avenues of communication between the federal government and UIOs so that we can work together to better fulfill the trust responsibility and our duties to Native veterans no matter where they live.

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[21] 25 U.S.C. § 1660d.
[22] NCUIH. Federal Comments to Acting Deputy to the Assistant Under Secretary for Health Julianne Flynn. RE: VA Updated Reimbursement Agreement Template. [PDF]. Available at: https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:582ce9a4-3459-34fc-9c75-296af5a48967.

In June, the Health Equity and Accountability Act was introduced with the first-ever legislative text establishing an urban confer policy with the VA. We would love to see this Committee include that language in future packages on Native health care and we can provide the text.

Conclusion

Thank you to the committee for allowing me to speak on the critical issues impacting our Native veterans. We owe it to our Native Veterans – including those of us who do not reside on reservations - to remedy these issues so they have greater access to the care they rightfully earned.

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Questions for the Record

Questions for the Record
Senate Veterans' Affairs Committee
Native American Veterans
Sen. Cramer
12/07/22

Questions for Roselyn Tso, Director, Indian Health Service

Ms. Tso, as you know, American Indians serve in the armed forces at a much higher rate than any other group, and in North Dakota, we see this firsthand as the state continually delivers one of the highest rates of military service per capita. As our Native American Veterans seek care, we must ensure IHS facilities are equipped to deliver the quality health care our veterans have earned. I recently visited the Standing Rock Sioux Reservation in my state. Unfortunately, this IHS facility is facing severe structural and staffing challenges impacting their ability to adequately deliver health care services. In addition, they have encountered numerous roadblocks in securing IHS funding for facility improvements. What can be done to improve this facility and empower the delivery of health care services for veterans and members of the tribe?

Response: Thank you for the question. The Indian Health Service (IHS) is committed to maximizing resources for the provision of safe, quality healthcare. This includes, but is not limited to, use of: IHS maintenance and improvement funds to support facility upkeep and improvements; recruitment and retention incentives, and special provider pay rates, to bolster staffing levels; and the Purchased/Referred Care program to provide access to health services not available directly at the health care facility. In addition, the IHS works collaboratively with the U.S. Department of Veterans Affairs (VA) to improve the health status of American Indian and Alaska Native veterans. For example, the IHS and VA consulted with tribes and conferred with Urban Indian Organizations to develop an annual operating plan that outlines objectives and metrics for improving care coordination, expanding reimbursed services, collaborating on shared services, and many additional projects and initiatives designed to improve health care services for American Indian and Alaska Native veterans.

For additional background, the Fort Yates Hospital, on the Standing Rock Sioux Reservation at Fort Yates, North Dakota, is not on the current Healthcare Facilities Construction Priority System (HFCPS) list. Per statute, IHS has to fund and complete projects on the HFCPS list prior to funding any other projects. The HFCPS was established in 1991, and ten (10) projects remain on that list. The ten projects that remain on the HFCPS list have all received some funding through the Congressional appropriations process and are in planning, design, or construction phase.

After the remaining projects from the 1991 list are fully funded, potentially as early as 2025, IHS will work with Tribes to identify and fund health care facility needs. The revised HFCPS list will utilize information from the 12 IHS Area's Health Services and Facilities Master Plans.

I would also like to invite you to visit North Dakota with me and see firsthand the Standing Rock IHS facility and severe challenges on the ground. Will you commit to visiting the Standing Rock IHS facility in North Dakota with me? If schedules cannot be aligned, will you commit to visiting the facility in the near future?

Response: Thank you for the invitation, and yes, I will commit to visiting the Standing Rock IHS facility in North Dakota. I am happy to work with you on scheduling. If our schedules do not align, you have my commitment to visit the Standing Rock facility in the near future.

Sen. Moran
Questions for the Record
Senate Veterans' Affairs Committee
Native American Veterans: Ensuring Access to VA Health Care and Benefits
12/5/22

Questions for Leo Pollock, Administrator, Blackfeet Veterans Alliance

1. What concerns do you have with regard to the VA's partnerships with tribes to make certain native veterans have access to culturally competent and geographically accessible burial options? What could the Department do to improve these partnerships?

Thank you, Ranking Member Moran, for taking the time to follow up as well as reading my response. With over 574 Federally recognized tribes in the United States, this isn't an easy question to answer. Visiting with fellow veterans, the majority of the Amskapi Pikuni bury their deceased within family plots. I have served on Funeral Details where a family plot is often miles off the beaten path and a four wheel drive vehicle is sometimes needed to reach these plots.

Now in the sense of creating a Veterans Cemetery, I believe it would be very beneficial if each tribe was able to have their own. I understand that this is no easy task as some tribes may not have the land available to establish a Veterans cemetery. On behalf of our tribe, we have our Blackfeet Tribal Business Council, an Honorary Elders Council, as well as Cultural Advisers. It would be beneficial to gather input from all parties to ensure that whatever location was being considered, so that we can indeed meet the culturally competent and geographically accessible location.

I firmly believe that to improve on these partnerships would be to continue to keep liaisons in contact with the tribes. This does not always have to be in person. A phone call here and there, email, or the occasional in-person meeting is very much appreciated. To establish that contact, it allows an open flow of communication between the Tribal, State and Federal levels that is crucial in improving a partnership across all levels.

Sen. Moran
Questions for the Record
Senate Veterans' Affairs Committee
Native American Veterans: Ensuring Access to VA Health Care and Benefits
11/30/22

Questions for Larry Wright Jr., Executive Director, National Congress of American Indians

1. What concerns do you have with regard to the VA's partnerships with tribes to make certain native veterans have access to culturally competent and geographically accessible burial options? What could the Department do to improve these partnerships?

    a. Thank you for the question, Senator Moran. First, it is important to note that the question is based on the premise that Veterans Affairs is interested in working with Tribal Nations to ensure that Native Veterans have access to culturally competent and geographically accessible burial options. This is a significant starting point because despite the quantity of Native Veterans serving in the military, for many, many decades, there was no interest in ensuring Native Veterans were buried in a manner that respected their culture. In that sense, the question itself is meaningful if the goal is to be more culturally sensitive to the needs of Native American Veterans.

    With respect to concerns about VA's partnerships with Tribal Nations, more than anything, it is simply important to note that Tribal Nations are not uniform in their beliefs, customs, and practices related to death. There are 574 federally recognized Tribal Nations, which means there are hundreds of variations on: what role death plays in any given Native culture; what significance a burial has in a given Native culture; how long ceremonies related to death last in a given culture; and what roles friends, family, and community members play in a given ceremony. Due to this great variety in cultures and practices, my primary concern with VA's partnerships efforts is being too rigid in its procedures and not taking the time to listen to each Tribal Nation and each Native person about what must be done for the burial to be meaningful, honorific, and respectful of Native culture.

    In order to improve these partnerships, the VA should continue to gain information from Tribal Nations and Native service members about what they see as necessary for burial options to be both culturally competent and geographically accessible. It might be worthwhile for VA to engage in formal

government-to-government consultation on this issue. At the very least, VA should continue to engage with Tribal Nations and Native Veterans on this issue and ensure that any individuals involved in burials of Native Veterans have gone through significant cultural competency training and are prepared to handle the different needs that the families and communities of Native Veterans may ask for.

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