NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d'Alene Tribe
Colville Tribe
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Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
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Nez Perce Tribe
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Shoalwater Bay Tribe
Shoshone-Bannock Tribe
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Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Umatilla Tribe
Upper Skagit Tribe
Warm Springs Tribe
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Submitted via Email: Kameron.Matthews@va.gov

January 18, 2019

The Honorable Robert Wilkie
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Room 1000
Washington, DC 20420

RE: Request for Creation of a U.S. Department of Veterans Affairs Tribal Advisory Committee

Dear Secretary Wilkie:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), and Northwest Tribes, I write to request that the U.S. Department of Veterans Affairs (VA) support the establishment of a Tribal Advisory Committee (TAC) to further the unique government-to-government relationship between the federal government and the 573 federally-recognized tribes across the United States. Established in 1972, the NPAIHB is a non-profit, Tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, representing the 43 federally-recognized Indian tribes in Idaho, Oregon, and Washington on healthcare issues. NPAIHB operates a variety of important health programs on behalf of our member tribes, including the Northwest Tribal Epidemiology Center[1], and works closely with the Indian Health Service (IHS Portland Area Office.

AMERICAN INDIAN/ALASKA NATIVE VETERANS

American Indian/Alaska Native (AI/AN) veterans have played a vital role in the United States military for over two hundred years in all of the Nation's wars since the Revolutionary War. In fact, AI/AN veterans have served in several wars before they were even recognized as American citizens. AI/AN veterans have distinctive cultural values that drive them to serve their country. AI/ANs serve in the U.S. Armed Forces at higher rates per capita, are younger as a cohort and have a higher concentration of female servicemembers compared to all other servicemembers, yet they are underrepresented among veterans who access the services and benefits they have earned. In Fiscal Year (FY) 2016, the National Center for Veterans Analysis and Statistics counted for 11,028 AI/AN veterans in the Northwest out of 146,596

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.l. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

AI/AN veterans nationally (not including two or more races). In FY 2016, there were 1,775 AI/AN veterans in Idaho, 3,151 AI/AN veterans in Oregon, and AI/AN veterans 6,102 in Washington (Table 1).[2]

Table 1. Veteran Population By State and Race/Ethnicity in 2016

State	All Veterans	AI/AN Veterans
Idaho	124,123	1,775
Oregon	316,982	3,151
Washington	575,128	6,102
Total	1,016,233	11,028

Source: Race/Ethnicity By States Veteran Population Tables. The National Center for Veterans Analysis and Statistics, 2016.

The VA and the VA Office of Tribal Government Relations (OTGR) released a report in September of 2012 to provide comprehensive statistics on AI/AN veterans through an examination of AI/AN Active Duty, Reserve, and National Guard data with demographic, socioeconomic, and health status statistics for AI/AN veterans. The report reveals that in 2010, the National Center for Veterans Analysis and Statistics identified that approximately half of AI/AN servicemembers were age 24 or younger compared to only 35 percent of all other servicemembers were 24 or younger (Table 2).

Table 2. Active Duty, Reserve, and National Guard Servicemembers by Age and Race

Age Group	AI/AN	Percent	All Other Races	Percent
17 to 24 years	15,230	48.9	773,368	34.6
25 to 34 years	10,997	35.3	826,361	37.1
35 to 44 years	3,790	12.2	456,799	20.4
45 to 54 years	1,006	3.2	156,974	7.0
55 to 64 years	131	0.4	19,900	0.9
65 to 74 years	1	0.0	113	0.0
Unknown	0	0.0	19	0.0
Total	31,155	100.0	2,235,534	100.0

Source: Department of Defense, Active Duty Master Personnel File; Reserve Components Common Personnel Data System (RCCPDS), 2010. Prepared by the National Center for Veterans Analysis and Statistics.

The VA must take into consideration that AI/AN veterans are more likely to lack health insurance and to have a disability, service-connected or otherwise, than veterans of other races. In 2010, the

[2] National Center for Veterans Analysis and Statistics Veteran Population Tables, Fiscal Year 2016.

American Community Survey (ACS) highlighted about 19 percent of AI/AN veterans had a service-connected disability rating in 2010, compared with 16 percent of veterans of all other races.

AI/AN veterans have lower incomes, lower educational attainment, and higher unemployment than veterans of other races.[3] In 2010, AI/AN non-Hispanic veterans ($27,129) had the lowest median incomes (Table 3).

Table 3: Median Income by Race

Race	Median Income
Asian	$40,154
Native Hawaiian and Pacific Islander	$37,168
White	$35,786
Hispanic	$35,270
Other	$32,211
Black	$31,806
American Indian/Alaska Native	$27,129

Source: U.S. Census Bureau, American Community Survey, Public Use Microdata Sample, 2010. Prepared by the National Center for Veterans Analysis and Statistics.

NPAIHB recommends that it must be a VA priority to improve AI/AN veteran eligibility for VA services by improving partnerships and addressing the needs of tribal healthcare providers to provide quality and cultural responsive care or refer care for their AI/AN veterans. Furthermore, NPAIHB requests an updated version of the 2012 AI/AN Servicemembers and Veterans Report utilizing 2015 data. There is much more work to be done to align the policies, programs, and systems for billing for VA services in order to ensure that AI/AN veterans have the access to culturally competent benefits they are entitled to receive.

VA TRIBAL CONSULTATION POLICY

The United States has consistently acknowledged the government-to-government relationship with tribes and its special trust responsibility to provide healthcare services to AI/ANs. This unique responsibility and relationship with AI/ANs and tribal governments is the direct result of treaties between the United States and Indian tribes, and has been reaffirmed by judicial decisions, executive orders, memoranda, and Acts of Congress. The issues impacting our AI/AN veterans must be elevated as a priority for the VA.

[3] VA American Indian and Alaska Native Service members and Veterans Report, September 2012.

The VA is required by *Executive Order 13175 on Consultation and Coordination with Indian Tribal Governments* to engage in Tribal consultation. This Order was reaffirmed by both President George Bush and President Barack Obama. Executive Order 13175 establishes regular and meaningful consultation and collaboration with tribes in the development of federal policies, to strengthen the United States government-to-government relationships with tribes and reduces the imposition of unfunded mandates upon tribes.

In 2011, the VA established a tribal consultation policy in order to "enhance the relationship of cooperation, coordination, open communication, good will; to work in good faith to amicably and fairly resolve issues/differences; and to continue to pursue mutually agreeable objectives successful."[4] To comply with this order, it is essential that policy and technical decisions are made with comprehensive knowledge from tribes to the Agency of the impact on access to VA benefits and healthcare for AI/AN veterans. The VA uses the following definition of consultation:

> *"Consultation shall operate as an enhanced form of communication that emphasizes trust and respect. It is a shared responsibility that allows an open and free exchange of information and opinion among parties that, in turn may lead to mutual understanding and comprehension. Consultation with AI/AN Tribes is a unique government-to-government process with two main goals: (1) to reach consensus in decision-making; and (2) whether or not consensus is reached, to afford any party the opportunity to issue a dissenting opinion for the record, and more importantly to have honored each other's sovereignty."*[5]

Tribal consultation is an open and continuous exchange of information that leads to mutual understanding and informed decision making between federal agencies and tribal governments. Tribal consultation should occur at the earliest possible point in the policy formulation process, particularly whenever decisions would impact tribes, would have a substantial compliance or administrative cost, or would result in new or changed policies.

Currently, the VA uses several mechanisms for communications with tribes. These include Dear Tribal Leader letters (DTLLs), comment periods on proposed regulations, a website, and the designation of regional specialists. However, these mechanisms are not utilized often and are insufficient to resolve many issues that are currently impacting Indian healthcare patients and providers. Tribal consultation requires effective communication before, during, and after policy decisions that may affect tribes. To accomplish this, recognized national tribal consultation groups are essential to provide the consensus building processes necessary for the development of federal laws, regulations, and policies that affect all tribes.

Tribal consultation is an evolving process and must include an ongoing strategy between the VA and tribal nations. To continue this process, the VA should immediately implement a VA TAC comprised of Agency representatives and tribal representatives from each IHS Area to engage in

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[4] Department of Veterans Affairs Tribal Consultation Policy (2011)
[5] *Id.*

consultation on the mechanisms for national consultation. There is much more work to be done to align the policies, programs, and systems for billing for VA services in order to ensure that AI/AN veterans have access to culturally competent benefits they are entitled to receive.

NPAIHB recommends that the VA Tribal Consultation Policy be reviewed with the VA TAC, once established, to update the policy with tribal input and provide for the development of more efficient procedures within the Agency to operate policies impacting AI/AN veterans and tribes.

VA TRIBAL ADVISORY COMMITTEE

The creation of a VA TAC is critical to ensuring that the VA in partnership with tribes provide comprehensive care and benefits to our AI/AN veterans. Tribes have treaty rights that guarantee access of AI/AN veterans to healthcare which precedes any VA services that they are entitled to receive. However, it is incumbent upon the VA to provide care to this group of veterans that have traditionally enlisted in wartime at a greater per capita rate than other populations.

Currently, the VA has an Advisory Committee on Minority Veterans (ACMV), which consists of veterans who represent respective minority groups and are recognized authorities in fields pertinent to their needs. However, it is not sufficient for meaningful tribal consultation and deliberation on issues that pertain to the complex and varying infrastructure of tribal healthcare facilities for the 573 federally-recognized tribes in the United States.[6] For the VA to better serve AI/AN veterans after their service, the VA must create a TAC to address inequities of AI/AN veterans and fulfill the federal trust responsibility. The creation of a VA TAC is critical to ensuring that the VA in partnership with tribes provides comprehensive culturally responsive care and benefits to our AI/AN veterans who not only have treaty rights to care, but have also fought in every war, beginning with the American Revolution, at higher rates than any other race in this country. The scope of the VA TAC should largely be focused on healthcare, and then on benefits, housing, education, transportation, burial, and memorial benefits. Additionally, subcommittees will be necessary to enhance the work of the TAC on the various issues. NPAIHB recommends that VA TAC meet quarterly, as frequently as the U.S. Department of Health and Human Services (HHS) Secretary's Tribal Advisory Committee (STAC) as well as hold monthly conference calls or webinars as necessary.

The VA TAC is needed to:

- Have on-going communications with the leadership of the VA regarding broad policy decisions.
- Ensure that effective collaboration and informed decision-making with tribes occurs before, during, and after VA policy decisions are made.
- Identification of individuals within VA who are responsible for developing and implementing programs that affect tribes.
- Establish a process to identify the VA programs that impact tribes.

[6] Veterans' Benefits Improvements Act of 1994

- Promote communication between the VA and tribes.
- Promotes positive government-to-government relations between VA and tribes

Current VA TAC Legislation

NPAIHB and our member tribes are supportive of the *Department of Veterans Affairs Tribal Advisory Committee Act of 2018, S. 3269* introduced by Senator Jon Tester (D-MT) in the 115th Congress. The Act directs the Secretary of the VA to establish an advisory committee to provide advice and guidance to the Secretary on matters relating to Indian tribes, tribal organizations, and AI/AN veterans.[7] Establishing a VA TAC through legislation ensures that AI/AN veterans from each Area will have a seat at the table to discuss, analyze, and provide feedback on VA program and service to improve access to VA care and benefits.

On October 17, 2018 our Board adopted Resolution # 19-01-01, *Support for Legislation that Establishes a Department of Veterans Affairs' (VA) Tribal Advisory Committee (TAC).*[8] The Resolution specifies that the VA TAC is needed to ensure that effective collaboration and informed decision-making with tribes occurs before, during, and after VA policy decisions are made. NPAIHB recommends in the Resolution that the VA TAC should be comprised of designated tribal representatives to ensure-ongoing communications with the leadership of the VA regarding broad policy decisions that significantly impact the healthcare and well-being of AI/AN veterans. NPAIHB believes that there is national tribal support for the creation of a VA TAC and it will be endorsed by national tribal organizations, tribes, and Congress

NPAIHB VA TAC Recommendations

NPAIHB generally recommends that the scope of the VA TAC should largely be focused on healthcare, and then on benefits, housing, education, transportation, burial, and memorial benefits. NPAIHB also makes the following specific recommendations:

Structure and Frequency of Meetings

The VA TAC should be structured like the HHS STAC to elevate the voice and needs of our people. HHS established its STAC in 2010 to provide advice and input to HHS leadership on policy and program issues impacting AI/ANs served by varying HHS programs. Although not a substitute for formal consultation with tribal leaders, STAC enhances the government-to-government relationship, improves communication, and increases understanding between HHS agencies and Tribes. The VA TAC will also need to establish subcommittees to enhance the work of the TAC on the various issues.

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[7] Department of Veterans Affairs Tribal Advisory Committee Act of 2018, S.3269
[8] Northwest Portland Area Indian Health Board Resolution 19-01-0, Support for Legislation that Establishes a Department of Veterans Affairs' (VA) Tribal Advisory Committee (TAC). October 27, 2018. (Attachment A).

NPAIHB recommends that the VA TAC meet quarterly, as frequently as the HHS STAC as well as hold monthly conference calls or webinars as necessary.

Membership, Selection Process, and Term

We recommend that the membership be representative of the tribal communities and their AI/AN veterans, similar to the structure of most federal HHS tribal advisory committees. As such, the VA TAC should have at least 12 Area representative members, one from each IHS Area as well as an alternate member from each Area. Additional tribal representative members, often called members at large, should also be included to assure that a full range of information is presented in the decision-making process. We recommend there should be representation from IHS and national organizations. Additionally, each tribal representative must be able to identify technical advisors to assure that subject specific expertise is available.

Tribal leaders in each area should have the authority to select their own area representatives to participate on a VA TAC. These representatives would be accountable to the Areas that select them.

NPAIHB believes that there should not be term limitations, providing continuity and expertise growth. There should be a mechanism for automatically removing people from the committees if they fail to attend a specified number of consecutive meetings.

Role of TAC

NPAIHB recommends that the VA create a working model specifically for TAC meetings involving routine consultation on policy changes. It will be the duty of the TAC to analyze, discuss, and assist in implementation of potential policy and programmatic changes. We request that the TAC be utilized to ascertain that there is a high degree of national consensus on VA issues. The TAC would not replace the formal requirements of tribal consultation with tribes nationally. Further, that the TAC members go back to the tribes in their Area to inform them about issues and to poll tribes informally or use a formal resolution process for Area positions, returning to the VA TAC for a national consensus position. The TAC would also have the authority to request that VA hold formal consultations with Tribes at the regional and national levels.

Initial TAC Agenda

NPAIHB recommends that initial tasks of the TAC include: review of the VA Tribal Consultation Policy implementation, outreach and education to VA Departments in the Indian healthcare system and tribal infrastructure, as well as setting an agenda for additional issues to be addressed by the TAC. Of particular interest in the consultation process is the structure of the TAC and how this committee should function.

NORTHWEST AI/AN VETERAN ISSUES

In the Portland Area, 75% of the total IHS funding is compacted or contracted and includes 6 federally operated service units, 17 Title I Tribes, 26 Title V Tribes, 3 urban Indian facilities, and 3

treatment centers. There are also no IHS or tribal hospitals. When hospital care and specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded Purchased and Referred Care (PRC) program. PRC funds are very limited and get exhausted often before the fiscal year is over. This results in the Portland Area tribes being PRC dependent. The PRC program is one of the most important health services for tribes and tribal clinics in the Portland IHS Area as it allows AI/AN to access critical specialty care services.

In the Northwest, 19 out of 43 federally recognized tribes have reimbursement agreements with the VA pursuant to Section 405(c) of the Indian Health Care Improvement Act (IHCIA).[9] Essentially, if a veteran receives care directly from IHS or Tribal Healthcare Providers (THPs), the VA reimburses. However, if a referral is needed for specialty care (or other services not directly provided by IHS/THPs), the VA only pays for the specialty service if the veteran goes back to the VA health system and gets another referral by a VA provider. The current process often leads to tribes utilizing PRC dollars to pay for the specialist care of AI/AN veterans. The IHS/VA Memorandum of Understanding (MOU) does not currently provide for reimbursement of PRC for specialty care services at IHS or Tribal healthcare facilities.

Although the reimbursement agreements have demonstrated success in facilitating patient care for AI/AN veterans, we recommend that the reimbursement agreements include reimbursement for PRC. The legal authority that authorizes this provision of care already exists. Section 405(c) of the IHCIA, as amended and enacted by the Affordable Care Act (ACA), requires the VA to reimburse the IHS or tribal healthcare facilities for services provided to beneficiaries.[10]

NPAIHB recommends that the VA improve and strengthen the reimbursement agreements with THPs. Consideration must be made for smaller tribal healthcare facilities who do not serve a significant number of veterans and who are only Medicaid certified, not Medicare certified. The following barriers have been identified by Northwest tribes who do not have reimbursement agreements with the VA: long negotiation process, lack of training, limited personnel, minimal resources to support program, and small tribes with a small number of veterans do not receive as many benefits. For numerous tribes, it is a barrier to constantly refer patients back to the VA because it is time consuming and, ultimately delays services.

AI/AN veterans are forced to maneuver through a complex healthcare system and an elaborate administrative process usually requiring multiple referrals to address their healthcare needs. This overly-burdensome duplicative referral process is counterproductive and impedes timely and efficient access to care for AI/AN veterans. NPAIHB recommends the need for improvements in identification of AI/AN veterans, and make them eligible and trustful of the VA to receive culturally competent and comprehensive healthcare services.

With the VA transition from to the Cerner Electronic Health Record (EHR) system, we are unsure if AI/AN veteran patients will experience barriers to their continuum of care from the tribal facility to the VA facility. Spokane and Seattle have been identified as pilot sites for the 2020 phase-in, yet

[9] Indian Health Care Improvement Act. Public Law 94-437; Approved September 30, 1976; 25 U.S.C. 1601 et seq. As Amended Through P.L. 1115-91, Enacted December 12, 2017.
[10] Indian Health Care Improvement Act. Public Law 94-437; Approved September 30, 1976; 25 U.S.C. 1601 et seq. As Amended Through P.L. 1115-91, Enacted December 12, 2017.

tribes have not been nationally or regionally consulted or involved in discussions between IHS and VA. Many tribes in the Northwest still utilize the Resource Patient Management System (RPMS) as well as a significant number of commercial off-the shelf (COTS) EHR systems. NPAIHB requests a regional and national consultation on the Cerner transition.

CONCLUSION

We appreciate the VA's commitment to the important goals of improving the lives of our AI/AN veterans. NPAIHB and Northwest tribes look forward to working with the VA to ensure that our recommendations and VA priorities take into account the unique needs of AI/AN veterans. We invite you to visit the IHS Portland Area to further understand the needs of our tribes and AI/AN veterans. If you have questions or would like more information about our request for a VA TAC and recommendations discussed above, please contact Laura Platero, Government Affairs/Policy Director at (503) 407-4082 or by email to lplatero@npaihb.org and Sarah Sullivan, Health Policy Analyst (703) 203-6460 or by email to ssullivan@npaihb.org.

Sincerely,

Andy C. Joseph, Jr.
NPAIHB Chairperson
Colville Tribal Council Member

Cc: Dr. Kameron Matthews, Deputy Under Secretary for Health, VHA Office of Community Care
Kristin Cunningham, Executive Officer, VHA Office of Community Care
Majed Ibrahim, Program Manager, VHA Office of Community Care
Stephanie Birdwell, Director, VA Office of Tribal Government Relations
Terry Bentley, Specialist, VA Office of Tribal Government Relations

ATTACHMENT A: Northwest Portland Area Indian Health Board Resolution # 19-01-01, *Support for Legislation that Establishes a Department of Veterans Affairs' (VA) Tribal Advisory Committee (TAC).*