S. Hrg. 116–183

RECOGNIZING THE SACRIFICE: HONORING A NATION'S PROMISE TO NATIVE VETERANS TO RECEIVE TESTIMONY ON S. 1001, TRIBAL VETERANS HEALTH CARE ENHANCEMENT ACT AND S. 2365, HEALTH CARE ACCESS FOR URBAN NATIVE VETERANS ACT OF 2019

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

NOVEMBER 20, 2019

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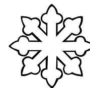

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WEDNESDAY, NOVEMBER 20, 2019

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:38 p.m. in room 628, Dirksen Senate Office Building, Hon. John Hoeven, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. JOHN HOEVEN, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. We will call this hearing to order. We are having a vote right now, so members are working their way back and forth.

We truly appreciate the Secretary joining us. Thank you for being here, Mr. Secretary.

Mr. WILKIE. Yes, sir.

The CHAIRMAN. We are going to get rolling, so that you have time to give your testimony and still some time for Q&A from some of the members before you need to depart.

Again, I call this oversight and legislative hearing to order. In our first panel, the Committee will receive testimony on Recognizing the Sacrifice: Honoring a Nation's Promise to Native Veterans. We will hear from the Honorable Robert Wilkie, Secretary of the U.S. Department of Veterans Affairs. Secretary Wilkie was nominated by President Trump to serve as the tenth Secretary of Veterans Affairs. He was confirmed by the United States Senate on July 23rd, 2018, and sworn in on July 30th, 2018.

Secretary Wilkie is the son of an Army artillery commander, and spent his youth at Fort Bragg. Today, he is a Colonel in the United States Air Force Reserve assigned to the Office of the Chief of Staff.

Before joining the Air Force, he served in the United States Navy Reserve with the Joint Forces Intelligence Command, Naval Special Warfare Group Two, and Office of Naval Intelligence. So you have Army, Air Force, and Navy.

Mr. WILKIE. Yes, sir.

The CHAIRMAN. Still working on the Coast Guard and Marine piece of it?

Mr. WILKIE. Yes, sir.

[Laughter.]

The CHAIRMAN. Secretary Wilkie holds an honors degree from Wake Forest University, a Juris Doctor from Loyola University College of Law in New Orleans, Master of Laws in International and Comparative Law from Georgetown, and a Master's in Strategic Studies from the United States Army War College. Secretary Wilkie is the first sitting VA Secretary to testify in front of the Indian Affairs Committee since the Committee became a permanent committee 35 years ago. For that, we are deeply appreciative.

We are fortunate to have recently hosted Secretary Wilkie in North Dakota, where he was able to see firsthand the good work of our Fargo VA Healthcare Center, which does an excellent job, just an excellent job. You don't have to take my word for it; talk to a veteran from North Dakota or Minnesota, and they will tell you the same thing.

With that, accompanying Sectary Wilkie is Dr. Richard Stone, Executive in Charge for the Veterans Health Administration. With that, Mr. Secretary, again, thank you for being here and we will turn to your testimony.

STATEMENT OF HON. ROBERT L. WILKIE, SECRETARY, VETERANS AFFAIRS, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY: RICHARD STONE, EXECUTIVE IN CHARGE FOR THE VETERANS HEALTH ADMINISTRATION AND DR. KAMERON MATTHEWS, DEPUTY UNDERSECRETARY FOR COMMUNITY CARE

Mr. WILKIE. Mr. Chairman, thank you, and thank you for the honor. It means a great deal to me. I also want to thank Senator Moran and Senator McSally.

I appreciate the fact that I am the first Secretary of this department to appear in front of this distinguished Committee. As you know, in our conversations, I spent a great deal of my childhood on the Great Plains, southwestern Oklahoma, amongst the Great Nations of the southern plains. I learned of traditions and sacrifices.

We were taught as young children the proper protocols when we approached the gravesites of Geronimo and the last of the great scouts, I-See-O. I would watch my father command honor details at the graves of both. And in that part of Oklahoma, we are reminded of the courage of the 45th Infantry Division, the Thunderbirds, comprising 50 tribes up and down the Plains. One of the most decorated units in the history of the United States Army.

I made a commitment when I was asked to come to VA that I would reach out, reach out to rural Native America, the two places in our Country that have the highest per capita rate of service of any groups in America. There are 31,000 Native Americans on active duty and 140,000 are veterans. Per capita, they have the highest rate of award, of the medal of honor. And to this day, serve at all ranks and add testament to a very, very glorious history.

So I wanted to come today and talk about where we are at VA, how we are reaffirming our commitment to the sovereignty of the tribes, the Great Nations of the United States. I have had the pleasure of spending time all the way from Alaska, as you know, to the Dakotas. We will be in Kansas with Senator Moran next week. We will be in Montana with Senator Tester in two weeks, and we will be headed to New Mexico and Arizona at the beginning of next year.

Our pledge at VA is to continue to work with tribal governments to face the unique challenges that accompany life in America's Native communities. We are redefining our partnership with IHS and we are currently in the process of updating that MOU that we have with them to keep up with the changing needs of veterans. And we know the importance of consulting with tribal leaders and the National Indian Health Board as we undertake this project.

I want all Native veterans and their communities to know we are listening to their concerns as we work on this, and that as I said earlier, we have the greatest respect for the sovereignty of their communities.

One counterintuitive fact about Native America is that 53 percent of the population is urban. That still leaves close to half the population in rural areas. We are finding ways to reach them.

One solution that we had pursued is tele-health. VA has its own tele-health facilities in the western States, Alaska, Montana, Oklahoma, and Wyoming. They are helping us to give care to veterans who don't live that short drive away from a VA facility. We are partnering with Wal-Mart to expand this capability even further, as we have found that Wal-Mart locations coincide with the majority of the rural veterans we are trying to reach.

Along those lines, we established the VA–IHS consolidated mail order pharmacy program, which sends prescription medications directly to Native homes. Last year, the program processed 840,000 prescriptions for Native veterans, up 17 percent from the previous year.

The MISSION Act is also helping all veterans access care. As you know, President Trump's PREVENTS initiative aims to bring together governments, faith-based groups, veterans organizations and the private sector who might be struggling with mental health, addiction, or homelessness problems that could pose a heightened risk of the greatest threat to our veteran population, and that is suicide. So much of that work involves getting veterans the help they need in rural areas, either inside VA or in their communities.

As you know, VA is more than just healthcare. Our Benefits Administration is helping Native Americans on issues like job training and housing. And our National Cemetery Administration is a key partner in the Library of Congress' Warrior Spirit project. This is a year-long curriculum development project that honors our Nation's Indian veterans by profiling the sacrifice and patriotism of Native Americans who are memorialized across this Country.

There is always more that can be done. If I might, I would encourage Congress to take two steps that would help VA connect with Native America. First, I would urge you to consider a bipartisan bill in this chamber that will help VA directly fund State and local groups that are in a position to help prevent veteran suicide.

Some of your Committee members are sponsors of the legislation, and it is something that we believe can make an immediate difference in veterans' lives.

Secondly, I would note that VA supports legislation sponsored by Senator Tester to establish a VA advisory committee on tribal and Indian affairs. We believe that this will provide a formal structure and forum for VA to engage with tribal leadership and create many opportunities for collaboration to improve VA services to Native American veterans.

I will leave you with one story that I gave at the groundbreaking for the National Native American Veterans Memorial at the Museum here in Washington. In 1865, as Robert E. Lee was surrendering to General Grant, he was approached by General Grant's most trusted aide, E. Lee Parker, a Seneca War Chief. As he approached General Lee, the Confederate General looked up at Grant and said, finally, we have a real American here, General, to which Colonel Parker snapped to attention and said, General Lee, we are all Americans here.

That is probably the most genuine American response given at any time in our history. As a result of that, it is our mission to ensure that Colonel Parker's admonition in 1865 becomes a reality, and it is our mission to ensure that all Native Americans know that this VA belongs to them as well.

I thank you very much, sir, for your courtesy.

[The prepared statement of Mr. Wilkie follows:]

PREPARED STATEMENT OF HON. ROBERT L. WILKIE, SECRETARY, VETERANS AFFAIRS, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good afternoon, Chairman Hoeven, and Vice Chairman Udall. I appreciate the opportunity to discuss how care at the Department of Veterans Affairs (VA) and our partnership with Indian Health Service (IHS) positively impact our Native Veterans. I am accompanied today by my colleagues Dr. Richard Stone, Executive in Charge for the Veterans Health Administration (VHA); Dr. Kameron Matthews, Deputy Under Secretary for Community Care; and Ms. Stephanie Birdwell, Director for VA's Office of Tribal Government Relations.

Introduction

As I have shared during my engagements with Native Veterans and tribal leaders across the country, our goal at VA is to shorten the distance between people in need of Veterans services. Native Americans have participated in every American conflict dating back to the Revolutionary War, and they serve in the military at a higher per capita rate than any other ethnic group. The importance of Native Servicemembers has only grown in the country over time, and we strive to honor this community with the quality, culturally competent care that they deserve. The American Indian and Alaska Native (AI/AN) populations experience health and other disparities that disproportionally affect their quality of life. VA is working to increase our reach into tribal communities through telehealth, visits from VA representatives, and closer cooperation between VA and IHS.

Five Goals of the MOU between VA and IHS

An MOU, originally signed in 2003 and updated again in 2010, established that IHS and VA can coordinate, collaborate, and share resources between the Departments. Five mutual goals were agreed upon when the MOU was signed:

- Increase access to and improve quality of health care and services to the mutual benefit of both agencies by effectively leveraging the strengths of VA and IHS at the national and local levels to afford the delivery of optimal clinical care;
- Promote patient-centered collaboration and facilitate communication among VA, IHS, AI/AN Veterans, tribal facilities, and Urban Indian Organizations;

- Establish effective partnerships and sharing agreements among VA headquarters and facilities, IHS headquarters, and IHS, tribal, and Urban Indian Organizations in support of AI/AN Veterans;
- Ensure that appropriate resources are identified and available to support programs for AI/AN Veterans; and
- Improve health promotion and disease prevention services to AI/AN to address community-based wellness.

To achieve these goals, VHA has piloted and subsequently adopted several programs. To address access to care, achieve effective partnerships, and ensure the availability of resources, in 2012 VA established a national reimbursement template with IHS which led to 114 Tribal Health Programs (THP) agreements.

In addition to these reimbursement agreements, local VA medical centers have established, where appropriate, several agreements with THPs and IHS facilities to deliver telemental health care to Native Veterans. The program serves tribal communities in Alaska, Montana, Wyoming, and Oklahoma. VA's Office of Rural Health's Veterans Rural Health Resource Center, Salt Lake City (VRHRC SLC) has an active portfolio of innovations in Native Veteran health care, including the creation of a Rural Veteran Tribal Navigator program that will connect Native Veterans with the benefits and care they have earned.

VA Video Connect (VVC) is a pilot program currently being deployed nationwide. VVC will allow rural Native Veterans to access VA health care in their homes or local communities through cellular and wireless capabilities. VRHRC SLC is currently working to tailor this program to Native Veteran communities, creating a model that will weave together the Western medicine, traditional Native Healing, and rural Native communities' strengths through four main components: mental health care, technology, care coordination, and a tailored implementation facilitation strategy. In addition to these programs, VRHRC SLC is piloting programs to establish Tribal-VHA Partnerships in Suicide Prevention and developing Native Veteran Content for the VA Community Provider Toolkit.

One of the great successes in achieving the 2010 MOU goals was the establishment of the VA/IHS Consolidated Mail Order Pharmacy Program (CMOP) that sends prescription medications to Native Veterans' homes. In 2018 alone, CMOP processed 840,000 prescriptions for Native Veterans, up 17 percent from the previous year. Since its inception, CMOP has processed more than 3.6 million prescriptions for AI/AN Veterans served by IHS and THP programs.

In early Fiscal Year 2019, VHA and IHS MOU leadership agreed that the 2010 MOU was no longer meeting the agencies' needs and required modification to create the flexibility needed to move the interagency relationship forward to a new level. The leadership team drafted a new MOU and conducted a first listening session with tribal leaders on May 15, 2019. Tribal input from that session was incorporated into the draft VHA–IHS MOU, and VA and IHS conducted a subsequent consultation session at the National Indian Health Board annual meeting on September 16, 2019. This additional input is now being considered for inclusion in the draft MOU. After the IHS and VA MOU leadership team reaches agreement on the draft MOU, it will enter formal clearance channels for approval by IHS and VA. The approved draft MOU document will be posted in the Federal Register and further tribal consultation for a period of no less than 60 days. Tribal input will be incorporated into the draft document and it will move forward for final approval and signature.

We are confident that the evolution of this MOU will be successful as it is happening in tandem with the MISSION Act. This transformative legislation will entail the most comprehensive change in VA's history. The MISSION Act consolidated community care programs to make it easier for all Veterans, families, community providers, and employees to navigate.

Reimbursement Agreements

Since the Summer of 2012, VA has signed individual reimbursement agreements with THPs to provide direct care services to eligible Native Veterans closer to their homes in a culturally sensitive environment. In December 2012, VA signed a national reimbursement agreement with IHS. Today, the national reimbursement agreement with IHS covers 74 IHS sites. There are also 114 individual reimbursement agreements with THPs of which 26 are in Alaska and cover Native Veterans and Non-Native Veterans.

From August 2012 through September 2019, VA has reimbursed IHS and THPs over $104 million covering approximately 10,645 unique Native Veterans. Of the $103 million, VA has reimbursed approximately $38 million to Alaska THPs for covering an estimated 1,523 unique Native Veterans. Additionally, VA has reimbursed

Alaska THPs approximately $27.9 million for approximately 4,825 unique Non-Native Veterans.

IHS and several THPs have requested that the agreements be expanded to cover reimbursements for purchased referred care under which IHS and THPs can refer Native Veterans to their contracted community care. They feel this will enhance care coordination. VA is also looking to enhance care coordination with IHS and THP facilities. At the request of the Veteran, VA has the primary responsibility for care provided to Veterans and related care coordination. As a result, VA is seeking to develop a standardized care coordination process that will enhance care coordination for Native Veterans. Initial steps include establishing an Advisory Board for care coordination and inviting Tribal Officials to be members on the Board. The Board's main scope will be to implement the standardized care coordination process and to improve care coordination including community referrals between VA and IHS/THP sites for the benefit of Veterans.

Tribal Department of Housing and Urban Development—VA Supportive Housing (HUD–VASH)

Tribal HUD–VASH, is a partnership between VHA, HUD's Office of Native American Programs, and tribes, which provides permanent supportive housing in Indian areas to homeless and at risk of homelessness Native Veterans. The program currently serves 26 tribes with expansion in the next 6 months. VA provides case management and supportive services to promote tenancy in housing supported by HUD grant funding for rental assistance. VA case managers work with local resources and the appropriate VA employment programs to assist Native Veterans to access employment when appropriate for the Veteran.

Housing Programs for Native American Veterans

VA is authorized under the Native American Direct Loan (NADL) program to make loans to eligible Native American Veterans who reside on trust land. The Veteran's tribal or other sovereign governing body must enter into an MOU with VA before VA can offer the program to a Veteran. Once the MOU is in place, the Veteran applies directly to VA for a loan. The Veteran can apply for up to a 30-year fixed-rate loan to purchase, build, or improve a home located on trust land.

The NADL program is a loan and not a grant; therefore, the Veteran must repay it. If eligible, the Veteran can also refinance a previous NADL to lower the interest rate. The NADL program offers many advantages, such as no down payment, no private mortgage insurance, a low fixed interest rate, low closing costs, and the option for multiple uses.

Since 1992, VA has entered into 108 MOUs with Federally Recognized Tribes or Native Hawaiian, Pacific Islander, or Alaska Native communities, and made 1,040 loans to Native Veterans, totaling over $137.9 million. VA staff are required each year to contact all entities that can, or already have, agreed to an MOU. All Federally Recognized Tribes, Villages, Nations, Bands, and Communities, as well as communities of the Hawaiian Homelands, American Samoa, Guam, and the Commonwealth of the Northern Marianas Islands are part of VA's outreach efforts. VA staff also participate in tribal consultations to provide information about the availability of this program and to seek input from tribal leaders on how to improve benefit delivery. VA staff attend stakeholder conferences to discuss Federal housing issues germane to American Indian Veterans. For properties not located on trust land, Native Veterans can use the VA-Guaranteed Home Loan program.

Other VA Services

In addition to these initiatives, VA provides vocational rehabilitation and employment (VR&E) services to Native American Veterans who meet eligibility and entitlement criteria. VR&E's mission is to increase independence in daily living and to assist Veterans with service-connected disabilities prepare for, obtain, and maintain suitable employment. These services are provided by highly trained Vocational Rehabilitation Counselors who recognize the cultural differences and issues impacting the Native American population. VR&E beneficiaries are eligible for any needed health care services, provided by VHA, to help them meet all identified rehabilitation goals. By addressing these specific needs—independence in daily living and employment—the VR&E program is another VA resource available that positively impacts our Native American Veteran population.

Legislation

Mr. Chairman, we know the Committee is also interested in our comments on two pieces of legislation. We offer the following broad comments, and I know our second panel will be ready to talk to them in more detail.

S. 1001 Tribal Veterans Health Care Enhancement Act

S. 1001 would amend the Indian Health Care Improvement Act to authorize IHS to pay the cost of copayments assessed by VA to certain eligible Indian Veterans for covered medical care. Covered medical care would consist of any medical care or service that is authorized for an eligible Indian Veteran (as such term would be defined) under the contract health service and referred by IHS and administered at a VA facility. This would include any services rendered under a contract with a non-VA health care provider.

VA does not support S. 1001 as written. We note that VA business processes related to copayment collections and interagency transfers of funds could present technical challenges, so we look forward to discussing with the Committee the best way to create parity with regard to copayments for eligible Veterans who are referred from IHS to VA for care. We look forward to discussing the bill in more detail with the Committee.

We also note that the Congressional Budget Office concluded that a similar bill from the 115th Congress would cost less than $500,000 over the 5-year period from 2017 through 2021 (letter from the Congressional Budget Office to Chairman John Hoeven regarding S. 304 (115th Congress) dated May 2, 2017, reproduced in Senate Report 115–112 (June 15, 2017)).

S. 2365 Health Care Access for Urban Native Veterans Act of 2019

As background, VHA has entered into reimbursement agreements with IHS and THPs under which VHA reimburses IHS and THP for direct health care services provided in IHS and THP facilities. These reimbursement agreements are authorized by 38 United States Code (U.S.C.) § 8153 and 25 U.S.C. § 1645. The latter authority refers specifically to IHS, Indian tribes, and tribal organizations, and excludes urban Indian organizations.

S. 2365 would amend 25 U.S.C. § 1645 by adding references to urban Indian organizations in subsections (a) and (c), thus authorizing VA to enter into reimbursement agreements with urban Indian organizations.

VA does not object to the bill but would appreciate the opportunity to discuss with the Committee the differences between reimbursement agreements and other methods of procuring health care that are available. VA cannot project costs with specificity for S. 2365, but believes the net cost impact would be minimal, given the number of potentially covered Native Veterans.

Conclusion

The health and well-being of all our nations' Veterans is of the utmost importance. We strive to consistently provide high quality care to all Veterans and continue to make significant strides in enhancing the practice and culture of the Department to be more accessible to our Native American Veterans. Working with many diverse, sovereign tribes is essential to successfully achieve the goals of the MOU between VA and IHS. VA is committed to ensuring that our goals align with IHS and that the needs of our Native American Veterans are met. I want to thank the Committee for hosting this hearing. This concludes my written testimony.

The CHAIRMAN. Thank you, Mr. Secretary. We are deeply appreciative of your being here, and your commitment to all veterans, and of course, being here today, reflecting your commitment to Native American veterans. As you know, Native Americans serve in our military, as a group, at a higher percentage than any other group. It is a remarkable, amazing thing, isn't it?

Mr. WILKIE. It is.

The CHAIRMAN. It really is. Along those lines, right behind you, and you may have had a chance to meet him on the way in, we have not only the Chairman of the Three Affiliated Tribes, Mandan, Hidatsa, and Arikara, Mark Fox, who is a Marine Corps veteran. Semper Fi. We appreciate him being here.

He brought with him Ms. Harriet Good Iron, and she is the matriarch of a Gold Star family. Maybe you could stand up so everybody can see you. Thank you.

[Applause.]

The CHAIRMAN. Her son, Army Colonel Nathan Good Iron, was killed in a firefight 13 years ago in Afghanistan. I was actually

Governor at that time. I remember attending the funeral. It was on the reservation, but it was one of the most amazing funerals, because it combined Native American culture and religion with non-Native culture and religion. It was one of the most moving, amazing funerals that I have ever attended. Of course, it was for one of our heroes, your son, your amazing son. And you and your husband have been such incredible supporters of all of our veterans and all of our events. His spirit lives on. Corporal Good Iron is here with us today in spirit, even as we are here in body.

God bless you, and thank you.

Mr. Secretary, I am going to start with a couple of questions, and then turn things over to the Vice Chairman. Members will be filing back in now, as they have had a chance to vote.

Mr. WILKIE. Senator Tester missed my endorsement of his legislation.

The CHAIRMAN. I know. I can't believe how you raved about him. That will be stricken from the record.

[Laughter.]

The CHAIRMAN. We have already stricken that from the record.

[Laughter.]

The CHAIRMAN. He really did say nice things about you, he is not kidding.

Senator TESTER. I am sorry I missed it.

The CHAIRMAN. We will bold it in the record.

Mr. Secretary, during last month's groundbreaking for the National Native American Memorial at the Smithsonian's National Museum of the American Indian, you spoke about the contributions of Native American service men throughout the history of the U.S. military. I know you are a student of history. So again, I appreciate that commitment to outreach.

Would you highlight the Department's priorities in working with tribal veterans, as well as provide some examples of how the VA is working to help our tribal veterans when they return home from the battlefield?

Mr. WILKIE. I will start with our Veteran Benefits Administration. As you pointed out in many of our conversations, more than half of the budget at VA goes to benefits. It has been my first goal to expand the number of claims clinics that can reach tribal governments across the Country. There were 30 claims events just in this last year, involving 24 tribes and serving well over 1,000 veterans. I want to expand that.

I mentioned expanding tele-health, to cut across the great lengths of the American West. Senator Tester and Senator Murkowski have listened to me talk about the inability of many leaders in this town to comprehend the scale of the places in which you live.

For us, that means two things. One, expanding tele-health, our tele-health budget is now at $1.1 billion. I expect it to grow. The other is getting our mobile facilities out into tribal communities. That is pharmacies, clinics, nutrition vehicles as well as the benefits trucks. And enhancing our relationship with IHS.

I made it a point to the President and to the Secretary of the Interior that without IHS, we can't deliver everything that we need

to our veterans. I am looking at ways that we can further enhance their ability to deliver.

The other thing is memorial. There is no community in the Country that believes more in maintaining the faith with those who have come before. We are expanding the number of grants that we give to tribal communities, not only to preserve, but to create new memorials, new cemeteries. I take that to heart.

In the last year, we have undergone the beginning of 13 new tribal veteran cemeteries across the Country. That is part of a comprehensive program.

Last thing I will say, suicide prevention. Twenty veterans a day take their lives. Sixty percent of those we don't see. In my discussion, particularly in Alaska, and Senator Murkowski was listening remotely last year, I asked the Federation of Natives to help us in doubling the number of tribal VA representatives that they have to get out into the farthest reaches of Alaska, to find those veterans we can't see. I have said the same thing to the leaders of the Southern Plains and in North and South Dakota.

We are opening the aperture in terms of financial support to tribal communities, so that they can be better prepared and they have the resources to go places that we are not. So it is a very comprehensive list of programs, but I think we are in a much better place than we have been in the last few years.

The CHAIRMAN. One of the important programs is the Native American Direct Loan Program that was established in 1992. There has been more than $137 million made in those types of loans.

This really is an opportunity to use that VA loan guarantee on Federal lands. Housing is such an important issue across the board, it is particularly challenging on the reservation. How do we get the word out and get more usage of that program for Native American vets?

Mr. WILKIE. In the past 15 years, there have been 108 MOUs dealing with the National Direct Loan Program. I want to see more. We certainly have had more when it comes to other MOUs on everything from medical services, as I said, to Native cemeteries. The benefit of the Direct Loan Program is that, obviously, no down payment, no PMI, minimal closing costs.

It is my goal that we make sure that every tribal community in the Country has an MOU in place with us, so that we have them making sure that any information that we give on the National Direct Loan Program is sent out to all of its members. Communication is the key. I think we are in a better place than we have been, and it is a vital program.

The CHAIRMAN. Thank you, Mr. Secretary. I will turn to Vice Chairman Udall.

STATEMENT OF HON. TOM UDALL, U.S. SENATOR FROM NEW MEXICO

Senator UDALL. Thank you, Mr. Chairman. Thank you, Mr. Secretary, for being here, and all of your good work on behalf of veterans. I am going to go directly to questions, because I know there are many Senator here who want to question you for the time period that you are here.

We really appreciate your being here. All Federal agencies have a part to play in upholding the United States' trust and treaty responsibilities to Native Americans. You no doubt understand your agency's mission to "provide veterans the world class benefits they have earned." But I want to use this opportunity to ask you about your role as trustee, in the role of executing the trust responsibility to Native Americans.

What is your understanding of the Federal trust and treaty responsibilities to Native Americans, and what is the VA's role in fulfilling it?

Mr. WILKIE. Senator Udall, while you were voting, I talked about my upbringing in southwestern Oklahoma. You and I have actually had this discussion in your office, and I have said this publicly in Alaska. Coming from the world I come from, I always affirm the tribal sovereignties, sovereignty of all the Nations and Tribes of the United States. It is a government to government relationship. I am dealing with sovereign entities.

My job is in honoring that relationship to not only provide as many resources as I can, but also to ensure that there is a free flow of information, which is why I mentioned Senator Tester's legislation earlier. It is long past time that we have a VA tribal council that is on a day to day basis feeding us information on what is going on in those sovereign lands.

Senator UDALL. Thank you. Secretary Wilkie, our shared trust and treaty responsibilities to tribes and their members exists with equal force both on the reservation and off the reservation. In a report accompanying the first reauthorization of the Indian Health Care Improvement Act in 1988, this Committee stated very directly, "The responsibility for the provision of healthcare arising from treaties and laws does not end at the borders of the Indian reservation." This is still the policy of the United States Government.

Is the VA committed to working with this Committee and the Indian Health Service to ensure our shared trust and treaty responsibilities to all Native American veterans, including those who live on or off the reservation, are fulfilled?

Mr. WILKIE. Yes, sir, absolutely. What is hard for many in this town to comprehend is that 53 percent of Native Americans live in urban centers. That relationship should be as robust as the relationship we have with Native peoples in rural areas. So absolutely.

Senator UDALL. Thank you very much for that answer and for that commitment.

I would just note here, my bill, S. 2365, would correct a legislative oversight and would ensure that the VA is able to administer its IHS reimbursement program consistently for all Native veterans, in alignment with the principles of Federal Indian Health policy.

Mr. WILKIE. And I support that legislation as it pertains to urban Indian organizations, sir. I do.

Senator UDALL. [Presiding.] Thank you, Mr. Secretary.

Senator Murkowski, I recognize you.

Senator MURKOWSKI. I think it is Senator McSally.

Senator UDALL. Senator McSally, pardon me. She gave me a note, as always, it is the Senator that screws up, it is the staff that gets it right. Go ahead.

STATEMENT OF HON. MARTHA MCSALLY, U.S. SENATOR FROM ARIZONA

Senator MCSALLY. It is all good. Thank you so much, Senator Udall.

Secretary Wilkie, it is great to see you again. Arizona has a proud history of Native Americans serving in our military. One of the most amazing is the Code Talkers, Navajo and Hopi. I will tell you, one of the highlights of my life was this summer being out on the Navajo Nation and meeting four of the five remaining Code Talkers for National Navajo Code Talker Day. I will tell you, there was not a dry eye in the place as one of them stood up and broke out in the Marine Corps song in Navajo. It was just an extraordinary experience.

And they are passing this on to the next generation, to continue to serve. It is just amazing. We have 22 federally recognized tribes in Arizona. But they are in very rural areas across Arizona, major land masses, over 26,000 veterans, according to the 2017 Census.

So access is a significant issue, as you talked about. But broadband and connectivity is also an issue. That is something this Committee has been focusing on, and we are really attuned to. So tele-medicine just may not be an option for many of them. And taking long trips into where there may be health care or VA, other facilities, or even using the VA MISSION Act into the rural community, they just may not have the specialties that they need.

So what are the options? I would really like to explore more in Arizona of bringing services to them, with mobile units and specialties and mental health providers. Because tele-medicine just isn't going to work until we fix the broadband and connectivity issue.

Dr. STONE. Senator, you are exactly correct. We have a program called VA Video Connect, which uses telephonic transmission rather than the broadband transmission. Even then, it is not adequate, and therefore, the need to use—we have just placed in Montana a mobile unit from Phillips in a VFW hall, and we look forward to expanding that. Literally, it is a remote clinic that we provide the infrastructure to. We will be expanding that dramatically, we hope, in the near future. That is a pilot program in an effort to reach these remote areas.

Our mobile units, it is so geographically dispersed that even our mobile units are not enough, and therefore we think that these kinds of partnerships with the VFW and Phillips is one we must go to. We had about 19,000 remote visits through VA Video Connect in our tele-health program in the Native American communities in both the lower 48 and Alaska last year. But it must expand dramatically. We will need your help to get the infrastructure built to do that.

Senator MCSALLY. Absolutely. I would love to partner with you on this specifically in Arizona.

Other partnerships, I remember getting briefed by one of the private sector health organizations who received a grant and is doing more on some of the Native American communities. Are you also

partnering with them to see where others are already getting out there with educational programs and other things to figure out how you can partner with them and not reinvent the wheel? It is such a challenging access issue. We don't need to be duplicating efforts.

Dr. STONE. That is correct. In fact, this year, we funded a Rural Native American Navigator Program that we are engaging individual tribes in, and members who will act as navigators for other veterans to bring them into the system and to help them understand what is available to them.

Senator MCSALLY. Great, thanks.

Mr. WILKIE. I would add one other thing, Senator. We are looking to expand the number of MOUs with Indian Health. One of the focuses that I have is making sure that our mail order pharmacy service is robust and is serving the needs of Native communities in a way that it sometimes has not in the past.

Senator MCSALLY. Thanks. I know recently in my office we met with representatives from Navajo. My understanding is that the VA is exploring, studying the possibility of bringing a community-based outpatient clinic there. I don't know if you can answer now or for the record what the status of that is. There are 10,000 veterans on the Navajo Nation. So it is a pretty big deal.

Dr. STONE. We will take that for the record, and come back to you. I can't answer that right now for you.

Senator MCSALLY. Great, thank you.

And then one last thing. I appreciate, Secretary Wilkie, your focus on veteran suicide. This is just unacceptable. We deploy, and those who took their oath of office, we are willing to put our lives on the line. Then they are coming home, surviving battle, and taking their own lives. More has to be done. Business as usual, more of the same, insanity is doing the same thing over and over again and expecting a different result.

Specifically for Native Americans, though, my understanding is that even in the data collection they are listed as "other." So we don't even understand what the scope of the problem is specifically for Native American veterans who are at risk of suicide or committed suicide. So if you just want to follow up on updating and even how we got any data, if we don't know what the problem is, we don't know how to fix the problem.

Mr. WILKIE. Mr. Chairman, may I beg your indulgence?

Senator UDALL. Yes, please.

Senator MCSALLY. Yes, I know, we are over.

Senator UDALL. We need to ask questions to you.

Mr. WILKIE. This is a number one clinical priority. I come from a military family. My formative experiences were watching the aftereffects of Vietnam. A father, senior officer in the 82 Airborne Division, couldn't wear his uniform off post. The majority of veterans who take their lives are from Vietnam. Lyndon Johnson left Washington, D.C. 50 years ago in January. That is how long some of these have been germinating.

The other tragedy, this involves the American west, is that the Department of War started taking statistics on veteran suicide in 1892. We have never had a national conversation about suicide, particularly amongst veterans. So we do have the first national task force. We just are supporting legislation that some on this

Committee are supporting that opens the aperture, so that we get resources to tribal governments, so that they can find those 50, those 60 percent that we don't see.

Senator MCSALLY. Right.

Mr. WILKIE. That is the biggest hurdle for us. Finally, finally we are addressing it, finally we are having a conversation about mental health that is long overdue.

Senator MCSALLY. Thank you. Thank you, Mr. Chairman.

Senator UDALL. Senator Tester is recognized.

STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Ranking Member. I want to echo Senator McSally's statement on high speed internet being necessary for tele-medicine in Indian Country. As the Senate and the House, we need to step up and make sure that infrastructure is there and if you are going to be able to deliver it in areas. I always point out the fact that I don't have very good internet in my area, but if you go 25, 30 miles east of me on Rocky Boy Indian Reservation, they have none. So it is really, really important.

First of all, I want to thank you both for being here. For the folks that aren't familiar with the VA, it is the second largest agency within the government. Secretary Wilkie and Dr. Stone do a great job. I would tell you that if everything went perfect, I could still find something wrong. So thank you very much for what you are doing.

I just want to give you a little bit of advice, and it makes my life a lot simpler, if you do this. Manchin is not a crazy guy. He is not. And there are some people that died or were murdered in that VA facility. We have to figure it out. Joe is not doing anything that any of the others of us wouldn't do. If something had happened in Montana, we would be asking for answers.

Quite frankly, since it happened in a VA facility, we have to get answers from the VA to make sure that we know what happened, and make sure that it doesn't happen again. You don't have to answer to that. What I am saying is that if we are going to keep that committee together and not blow it up, this is a big one, guys. Joe has to be responded to in a very, very professional, civil way.

You go ahead, Secretary.

Mr. WILKIE. I will respond. I agree with your sentiment. I also make the point that this investigation began before I was Secretary.

Senator TESTER. Absolutely. I am not pointing fingers at anybody.

Mr. WILKIE. Because of the nature of those investigations, I am precluded from even knowing what happened. But Dr. Stone has been with Senator Manchin, he has been to West Virginia. We are doing everything we can within the parameters of the law. But you are absolutely right, we have to keep the confidence of our veterans. I am committed to that.

Senator TESTER. That is just important. Joe talks to me every time I see him, and I think there is good reason for it.

I just want to ask you one question, then I will let somebody else go. Secretary Wilkie, you talked about suicide being a big problem,

and it is. Sixty percent of the folks you never see, that commit suicide.

In Indian Country, especially in large land-based tribes, it is a long way between houses. Are you doing some things specifically for Indian Country when it comes to outreach? Let me just give you an example. Campaigns are a fine example. If we are going to go out and try to influence Native Americans, I can't have a bunch of white folks with me to get that done. I need to have folks with that tribe to come in, and then you can make some influences.

So the question is, what are you doing to make that outreach happen? Because it is different there than in Big Sandy, Montana, or somewhere else.

Mr. WILKIE. Absolutely, sir. Before Dr. Stone answers, I testified in front of the House Veterans Committee today. This was the subject. You are absolutely right. Me showing up is no good. That is why I have to get resources, to the tribal governments, to make sure that they are the ones on the tip of the spear.

Senator TESTER. And you are doing that.

Mr. WILKIE. And that is what we are doing with our new budget. That is what the PREVENTS Act will do, the PREVENTS task force, I know that is what they will recommend. So you are absolutely right. Cultural sensitivity, for me, has been incredibly important in my time at VA.

Senator TESTER. Okay.

Dr. STONE. Senator, we have funded, in the last number of years, a rural health tribal effort in order to embed suicide culturally climatized individuals with the tribes, trying to bring more veterans in. It is the same as your colleague's questions earlier, the remoteness of this, as we try to approach it.

That said, we know, since you have graciously funded, through your effort, tremendous expansion of our behavioral health providers, from 10,000 a few years ago to 25,000 today. Much of the problems are facing is not mental health. It is isolation. It is loneliness. It is separation. It is grief. It is financial problems. Therefore, the effort that we have going, that you are well aware of on the Senate side and on the House side, we are strongly in support those, our ability to give grants to communities that would engage a community us effectively.

Mr. WILKIE. That is why I said that your legislation is long overdue, because it can be the foundation for the expansion of what Dr. Stone is talking about.

Senator TESTER. Thank you.

Senator UDALL. Senator Murkowski is recognized.

STATEMENT OF HON. LISA MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman. Gentlemen, thank you. Mr. Secretary, I want to truly thank you for the efforts that you have made in the State of Alaska, your visits, just the engagement that you have had with us, whether it is the Alaska Native Veterans Allotment Act, your support on the VA MISSION Act, to make sure that the Alaska-specific provisions in there that kind of move us away from this one size fits all approach to health care, that they work.

I think we are seeing some very significant gains on the ground, the ability to just recruit, to retain physicians at the CBOCs there in and around the State. More than 100 new employees within the Alaska VA healthcare system dealing with the issue that we had, the appointment referrals, and basically getting them back to the local VA.

So we are seeing some real gains on the ground. It has to be heartwarming for you, because it certainly is for me, when I am hearing from our veterans who are saying, you know, I have never really been very happy with the care of the service, but things are turning around, and they are seeing the difference. I truly believe that you are helping to facilitate in that effort.

Mr. WILKIE. Thank you.

Senator MURKOWSKI. But we are also seeing the partnership with the tribes benefit as well. I think we are seeing some of the previous barriers kind of be pushed back, the delays in enrollment that we have, the denial of care, the lack of access to VA services. I do think these partnerships are yielding the benefits.

I too want to focus on the mental health, the behavioral health side of this, because with the issues related to suicide, and particularly with our Native people, this is significant for us. The high rates of suicide amongst Natives generally, but then you bring into it the mix with our veterans.

Senator McSally addressed this, and you really didn't speak to it, but with the published report that the VA puts out every year on suicide data, it does just put our veterans, our Native veterans into a "other" category. I think what we are learning is, that lack of data being able to differentiate that makes it more challenging than to develop policy responses. Later this afternoon here, we are going to be moving out two bills, Savanna's Act, and Not Invisible, that are focused on diving into the actual data as it relates to murdered and missing indigenous women, murdered and missing trafficked women. But until we know the numbers, we are not able to better define the solution sets.

Will the Bureau work with us to be publish the Native veteran suicide data to help us? Because it seems to me, if we can get a better handle on that, it might help us in our initiatives.

Dr. STONE. Senator, we certainly pledge to you to pull that data out. As you know, we obtain from the National Death Index, the Traumatic Index, from the CDC.

Senator MURKOWSKI. Right.

Dr. STONE. It takes us about a year to separate out the overarching veteran numbers. It took us, in preparation for this study, a fair length of time to separate Native American data out. I think you identify a real weakness in the way we have approached this. If we are going to identify subpopulations, which clearly this is one, it appears that the Native American population has a suicide death rate of over 44 per 100,000, some of the highest in the Nation. There is a dramatic difference in the female Native American veteran.

We would be happy to go through that with you, and we pledge our participation with you.

Senator MURKOWSKI. I appreciate that. I think it is something that we need to be really drilling down a little bit more into. Be-

cause it is within the Department of Justice as well. Senator Cortez Masto and I have learned this, that if we don't collect the data this way, it is tough for us, when we ask you the question, and you are not able to give it to us, not because you don't want to, but because we haven't differentiated it that way. So I think it is something that we need to work on.

Mr. Secretary, you mentioned the doubling of the VA reps, our Native VA reps around the State. I so thank you for that. I so appreciate it. I do think it will make a difference. But we also know that in a State like mine, where 80 percent of our communities are not connected by roads, these are small, small isolated villages. You have to have the travel budget that goes with it.

This is not a nice, cushy vacation for anybody. This is getting to work. So being able to provide for those resources is so appreciated.

Mr. WILKIE. Senator Murkowski, you are absolutely right. Two things. I will work on that categorization.

Senator MURKOWSKI. Thank you.

Mr. WILKIE. I agree with you about the word "other."

Second, there is legislation that Senator Boozman and Senator Warner have, it is Bergman and Houlahan in the House, it is bipartisan, that will do what you described. It will allow us to take grant money and get that money out into those communities, into those tribal representatives, so that they are funded to do those outreach efforts.

It is absolutely essential, because it is community based, and it is people who know their fellow citizens.

Senator MURKOWSKI. That is so important, I so appreciate it. I know that Senator Tester, coming from a big State like Montana, it is going to make a difference to them as well. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. [Presiding.] Senator Smith.

STATEMENT OF HON. TINA SMITH, U.S. SENATOR FROM MINNESOTA

Senator SMITH. Thank you, Chair Hoeven, and Vice Chair Udall, for holding this hearing today, and thank you very much. I appreciate your being here.

Mr. WILKIE. Thank you.

Senator SMITH. I also want to just note, I am really pleased that we are joined here today by White Earth Secretary Treasurer, Alan Roy, who is a U.S. Army Veteran and here in the audience with us today. Thank you, Secretary Treasurer, for being with us today.

The CHAIRMAN. This will have to be the last question, because the Secretary does have to go.

Senator SMITH. Absolutely. I have one question. And that has to do with the issue that Senator McSally raised, which has to do, I have heard it from Secretary Roy as well, which is now Native American veterans can access their benefits. We have talked a little bit about this, the billion dollars, and Federal funding to expand veterans access to healthcare through tele-health. I would like to hear a little bit more, understanding you have challenges with broadband, how that billion dollars is being used on tribal lands to serve Native veterans.

Dr. STONE. I talked a little bit about our Phillips partnership and trying to reach that and taking areas where the infrastructure is built. Our other options are to bring in mobile units with satellite transmission, which we have a large number for our emergency operations work around the Country. We can bring in and use that to create connectivity.

But it is about connecting very rare, difficult to recruit, mental health services. Now, this is where the beauty of our Indian Health Service relationship goes to, and where we are so pleased at what the IHS and the Public Health Service brings to us, as well as our relationships with the other tribal health programs. We have 114 relationships with tribal health programs. We are working on an additional 40 in order to reach individually.

But still, it is about taking difficult to recruit, remote services, and getting them into remote areas when there is not much infrastructure.

Senator SMITH. Thank you. Thank you, Mr. Chair.

The CHAIRMAN. It is my understanding that Dr. Stone can stay and answer some additional questions, is that correct?

Dr. STONE. Yes.

The CHAIRMAN. With that, Mr. Secretary, thank you so much for being here and for extending. We understood earlier you had to leave at 3:00, so we greatly appreciate the additional time.

Mr. WILKIE. Thank you. Thank you very much for what you do, and thank you for the honor of being first.

The CHAIRMAN. It is great to have you here. Thank you, sir.

Senator UDALL. Thank you very much.

The CHAIRMAN. Senator Smith, do you have any other questions for Dr. Stone? Okay.

I think next in the queue is Senator Daines.

STATEMENT OF HON. STEVE DAINES, U.S. SENATOR FROM MONTANA

Senator DAINES. Dr. Stone, thank you for being here today.

It pains me to talk about an issue that we are dealing with when it comes to our veterans today. Unfortunately, our veterans have become targets by scam artists and criminals who are looking to swindle their pensions. Unfortunately, even if these criminals hurting our veterans are caught, there is no penalty.

This sad reality was brought to my attention by a widow in Montana who was getting a fraction of her pension. That is why I introduced the Free Veterans Act. This will ensure that people who scam our veterans, of which I am a son of a U.S. Marine, will serve time in jail or pay a fine or better yet, both.

Dr. Stone, as you might recall, there was a recent GAO report that indicated that VA could be doing more to assist the Department of Justice and the Federal Trade Commission, stopping these scams and these criminals. I was pleased to see this report come out literally just as I was introducing my bill. And everything described in that IG report is laid out in the bill that I have introduced.

So my question is this. Are you committed to working with me, along with the Secretary, to combat this pension poaching that is plaguing our veterans?

Dr. STONE. Sir, as a veteran, as the son of a veteran, absolutely we are committed. My dad just turned 101, and I will tell you, the frequency of this type of poaching on our elderly veterans and our vulnerable veterans, we need to do a better job of protecting them from this.

These are bright individuals who have served with honor. But their information has to be protected. We are absolutely committed to working alongside of you.

I am familiar with the GAO report. It is a complex report, I am not going to tell you we agree with every piece of it. But it does highlight a number of things that are in your bill. We look forward to working with you.

Senator DAINES. Dr. Stone, I couldn't ask for a better response. Thank you, and I look forward to working together to protect our veterans and their benefits.

I want to shift gears here about Montana, about our Native populations. We have a legacy that is incredible as it relates to service to our Country. In fact, we have one of the highest population of veterans per capita in the Nation. That includes our Native American veterans who bravely serve in uniform so we get to live in a free country.

Many people don't know this. We know that back in Montana, though, leading up to 9–11, Native American veterans served at a higher percentage compared to veterans of all other races. While many of our tribal veterans have gone on to lead extraordinary lives after their service, there are many who are left struggling with issues that can be unique to Indian Country.

One issue impacting our tribal communities and veterans is combating Mexican cartels and their illegal meth distribution. In fact, Attorney General Barr will be in Montana Friday with me to talk about this very issue. Dr. Stone, as you know, serious physiological distress and mental health issues have been linked to substance abuse for our veterans. What outreach and programs has the VA offered to tribal veterans to guard against our veterans turning to drugs like meth?

Dr. STONE. You portrayed the problem very well, Senator. We know in the American population about 9 percent of the American population has substance use disorder. Amongst the Native American population, it is at 13 percent, fully 45 percent higher, than the rest of the American population.

Reaching that population is what we have been talking about with a number of your colleagues. Reaching them using tele-medicine, our relationships with the Indian Health Services, our relationships with tribal health programs, with the Alaska Native health programs, are what we are looking for to expand relationships to reach into this population.

But part of fixing that substance use disorder problem is also ensuring that we take care of the other health problems, including dramatically higher rates of PTSD, higher rates of diabetes, higher economic challenges because of unemployment rates, all contribute to fixing this problem of substance use disorder and those who prey on this population.

Senator DAINES. Dr. Stone, I appreciate your looking into the root cause, from what drives folks to move to meth. Years ago, in

Montana, it was homemade meth with about a 25 percent purity. Today, this Mexican cartel is 95 percent pure. Very addictive, the price has gone down, distribution is widespread. Indian Country is getting hit particularly hard by this. I think getting back to the core issues of mental health is one good place to provide assistance.

Thank you for your testimony. There is a lot more to talk about, but I appreciate your good answers, and happy birthday to your father.

Dr. STONE. Thank you, sir.

The CHAIRMAN. Senator Cortez Masto.

STATEMENT OF HON. CATHERINE CORTEZ MASTO, U.S. SENATOR FROM NEVADA

Senator CORTEZ MASTO. Thank you. And I will be quick, because a lot of my colleagues have echoed similar concerns for the State of Nevada and our rural communities and our 28 tribes. Tele-medicine is great. We are glad that you have the funding for that. But if we don't have broadband, we can't get it into the communities. I know in Nevada, there are over 4,500 Native American vets, and they are in all rural parts of our communities.

So I look forward to working with you and reaching out and making sure that we are addressing those issues. Nevada also has, unfortunately, a similar concern with mental health and a high suicide rate.

So let me ask you this. As we talk with our tribes around the State, they are often unable to receive the VA training to become accredited veteran service officers. So it is something we are looking into in Nevada. I am curious, is there a way for the VA to provide grants to help tribes cover expenses associated with these VSO? Is there something the VA is exploring?

Dr. STONE. Senator, I cannot answer that question, and I would ask the second panel to approach it. If they can't, we will take it for the record and come back to you, on how we certify those. All through our rural health program, which for the Native American community we run out of Salt Lake City, we have a number of programs trying to reach into the tribes to help. But how we certify those action officers, I cannot answer the question. If the second panel can't do it, we will make sure that we get that for the record.

Senator CORTEZ MASTO. I appreciate that, thank you. And of all the concerns that we have talked about, besides the mental health piece of it, there is in general the poor health that we have seen from overweight, or obesity, diabetes, cardiovascular disease. Much of the information that I have seen is anecdotal. There is not a lot of data. And I know Senator Murkowski talked about data is key.

But what I am curious about is whether or not you have data on really the delta between eligible service members and those who are actually using their coverage. Let me add one more thing that I am interested in. Do you have data on the dual eligibility of Native service members for other health programs, like Medicare and Medicaid?

Dr. STONE. Yes, we do. That data breaks down, and I will give you a very high-level view, and we will be happy to give you a deeper breakdown.

Senator CORTEZ MASTO. Thank you.

Dr. STONE. We know that there are 145,000 Native American veterans. A little over 62,000 are enrolled in health care. About 19,000 receive their health care directly from a VA facility. About 10,000 are receiving health care through the IHS and a tribal health program.

The delta between that 60 some thousand that are enrolled and the 30,000 I just gave you is what we are struggling with. Where are they, how are they using, are they going to IHS directly? Are they in urban areas and we can't see them because we aren't engaged with the urban tribal health clinics? That is what we are trying to get to.

We do know that about 85 percent of that population have other health insurance. They may not be identifying themselves as Native Americans as they come through the program. Therefore, we can't see them.

Senator CORTEZ MASTO. So there is an attempt, though, to try to identify them through outreach, education, more opportunity to engage?

Dr. STONE. Yes. And there is a request to the sovereign nations that when people come in that they do identify themselves as Native Americans, so that we can help identify the exact needs.

We do know there is a massive problem, over a quarter of the population has diabetes. We are working on a number of studies across the entire veteran population to take unique approaches to diabetes and obesity. As we approach this risk group, it would be great if we could identify more effectively. We look forward to a partnership with you in order to figure out ways to approach this community more effectively.

Senator CORTEZ MASTO. I do, too. Thank you. Thank you for all the good work, Doctor. We appreciate your being here.

The CHAIRMAN. Thank you, Dr. Stone, for being here, and answering questions. We appreciate you and appreciate what you do.

At this point, we are going to gavel out of this hearing and then have a business meeting, then we will come back into this hearing session for our second panel.

[Whereupon, at 3:32 p.m., the Committee was recessed, to reconvene following a business meeting.]

[4:00 p.m.]

The CHAIRMAN. We will now reconvene our earlier hearing and proceed to our second panel.

According to the Veterans Administration, Native Americans continue to serve in the Armed Services at a higher per capita rate than any other ethnic group in the United States. In 2010, the United State Census identified over 150,000 American Indian and Alaska Native veterans in the United States.

Today's oversight hearing coincides with recognizing Native American Heritage Month. I, along with Vice Chairman Udall and 30 co-sponsors, introduced Senate Resolution 414, which recognizes November as the month when the Nation celebrates the heritage, culture, and contributions of Native Americans, including the service of our Native American veterans.

The hearing today will examine how the United States can fulfill its promise to Native American veterans for the sacrifice they made in defense of our Country. The many contributions Native Ameri-

cans have played in the Country are historic. As of 2010, there have been 3,469 medals of honor awarded to combat veterans, 29 of which have been awarded to Native Americans.

In 2016, the VA held a series of tribal consultations to identify the priorities of Native American veterans. The top priorities identified by the Native American veterans were homelessness and housing, access to healthcare, and job training and employment. We need to address these issues.

That is why on January 29th, 2019, I, along with Senators Udall, Isakson, and Tester, introduced S. 257, the Tribal HUD–VASH Act of 2019. S. 257 would, among other things, make the Tribal HUD–VASH program permanent. S. 257 would also improve case management services and provide housing for eligible Native American veterans who are homeless or at risk of homelessness. This is accomplished by ensuring that Federal agencies work in a cooperative manner and that these programs are accountable to those they serve, Congress and the taxpayers.

On June 27th, 2019, the Senate passed S. 257 by voice vote and the bill is currently awaiting action in the House. We hope that today's hearing will help to further raise awareness of Native American veterans' issues.

Before I turn to our witnesses from the second panel, I will ask Senator Udall for his opening comments.

Senator UDALL. Thank you so much, Chairman Hoeven, for calling today's hearing. American Indians, Alaska Natives, and Native Hawaiians have shown a profound dedication to protecting our freedom and national security through their military service. After working with many tribal leaders in New Mexico who are veterans, I know firsthand when duty calls, Indian Country always answers.

Native veterans have earned nearly every service award and decoration our Nation offers. They count among their ranks recipients of the Purple Heart, Service Cross medals and the Medal of Honor. Without question, they deserve our gratitude, our Country's recognition and full access to the programs and resources we promise veterans.

That is why I have worked hard on behalf of Native veterans for the last 20 years I have been in the Congress. One of my first projects here in Washington was working with Senator Bingaman to recognize the Navajo Code Talkers with Congressional Gold Medals. From there, I made sure the Department of Defense corrected its over-taxation of Native veterans in the Service Member Civil Relief Act of 2003, and introduced legislation to give tribes resources to establish veterans cemeteries on trust lands.

As Vice Chairman of this Committee, I am continuing those efforts, working across the aisle and across Senate committees to put forward Native veterans legislation. Senator Tester is both the current ranking member of the Veterans Affairs Committee and former chairman of this Committee and has been a true partner in helping me elevate this work in the Senate. Together, we have introduced four Native veteran-focused bills, including the Veterans Benefits and Transition Act, which became public law last year, and S. 524, the VA Tribal Advisory Committee Act.

We have also worked with Chairman Hoeven and the Veterans Affairs Committee Chairman Isakson on S. 247, the Tribal HUD–

VASH Act. Most recently, we have worked with Senator Moran on one of the bills up for consideration today, S. 2365, the Health Care Access for Urban Native Veterans Act.

We developed each of these bills in concert with Native veterans, tribes and organizations, including the National Congress of American Indians, National Indian Health Board, National Council of Urban Indian Health, to make sure these bills address the needs of all Native veterans over 150,000 strong, whether they are living on the reservation or off the reservation or in a city.

My thanks go out to everyone who has guided our work to ensure it is grounded in the principle of tribal consultation and lives up to Congress' trust and treaty responsibilities. I also want to take a moment to thank and to recognize our two tribal witnesses for their service in the Marine Corps and the Army. Like many Native veterans, Chairman Fox's and Councilman Dupree's service did not end when they retired from the military. They returned home and continued to dedicate themselves to their communities. Thank you to both. It is an honor to have you both here today.

I am also glad that we have had Secretary Wilkie here today. He made some really strong commitments to me and to the Committee and to other members that questioned him.

So with that, Mr. Chairman, thank you again for this hearing. I yield back.

The CHAIRMAN. Thank you, Vice Chairman Udall.

I want to welcome our witnesses, and I will introduce them and turn to Senator Tester then for purposes of an introduction as well. Thank you, Dr. Kameron Matthews, for being here, Deputy Undersecretary for Community Care, U.S. Department of Veterans Affairs here in Washington, D.C. Also Rear Admiral Chris Buchanan, Deputy Director, Indian Health Service, U.S. Department of Health and Human Services, Rockville, Maryland.

The Honorable Mark Fox, Chairman, Mandan, Hidatsa, and Arikara Nation, New Town, North Dakota, Marine Corp veteran, someone I have known for many years. I have known his family for many years. And he has done an amazing job of leading the reservation, which is now absolutely, if not the leading energy producing reservation, it has to be the leading energy producing reservation in the Nation. If it were a State, it would be in the top ten energy producing States all by itself. Just his reservation. So he has brought amazing leadership to the Three Affiliated Tribes, and we appreciate you very much being here. And we appreciate your service as a Marine Corps veteran.

Then I will turn to Senator Tester for an introduction of the Honorable Jestin Dupree, Councilman from Fort Peck.

Senator TESTER. Thank you, Mr. Chairman. You will have to correct me, Jestin, if I say anything that is wrong. Jestin is a 68-and-a-half-year veteran of the Army. He serves on the Tribal Council in Fort Peck. He serves on the school board. He has every important job there is to do at the local level, and I might say very difficult ones, too.

He is a consumer of VA health care, and he is on the council of one of the largest frontier land-based tribal reservations out there. He will give us a perspective on the Chair. really want to thank him for making the trek out from Poplar and say it is good to see

you here. Hopefully we will see you here many more times in the future. Thank you.

Again, I want to thank and acknowledge Harriett Good Iron for being here, Goldstar Mother. Really a bright, bright light in her son Nathan, who is one of our heroes, and will always be with us. He will never be forgotten. Thank you for being here. We appreciate it.

With that, we will turn to Dr. Kameron Matthews.

Dr. MATTHEWS. Sir, I would actually defer my opening statement. Mr. Wilkie definitely spoke on VA's behalf, so I would definitely be open to questions.

The CHAIRMAN. That would be fine.

Rear Admiral Buchanan.

STATEMENT OF REAR ADMIRAL CHRIS BUCHANAN, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICE

Mr. BUCHANAN. Good afternoon, Chairman Hoeven, Ranking Member Udall, and members of the Committee. I am Chris Buchanan, the Deputy Director of the Indian Health Service.

Thank you for the opportunity to discuss S. 2365, the Health Care Access for Urban Native Veterans Act of 2019, and S. 1001, Tribal Veterans Health Care Enhancement Act. In the late 1980s, the IHS and the Department of Veterans Affairs began to explore the feasibility of entering into an arrangement for sharing of medical facilities and services as required by the Indian Health Care Improvement Act. The Patient Protection and Affordable Care Act of 2010 permanently reauthorized the Indian Health Care Improvement Act, authorizing IHS to enter into arrangements for the sharing of medical facilities and services between IHS, Indian tribes, and tribal organizations and the Department of Veterans Affairs and the Department of Defense.

The law also directs the VA or the DOD to reimburse the IHS, Indian tribes or tribal organizations for the services provided to eligible beneficiaries of either department in the respective facility. While the law clearly extends this authority to IHS and the Indian tribes and tribal organizations, it does not mention urban Indian organizations.

Since implementing the reimbursement agreements to date, VA has reimbursed IHS and tribal health programs over $94 million for direct care services covering over 10,000 eligible American Indians and Alaska Native veterans. Approximately 71 percent of American Indians and Alaska Native populations now live in urban areas. The IHS funded urban Indian organizations expressed the need for developing sharing arrangements for sharing of health care services with other departments, such as the VA and DOD, for American Indian and Alaska Native populations in urban settings.

S. 2365, if passed by Congress, would authorize reimbursement to urban Indian organizations by the VA or DOD for services provided to eligible American Indian and Alaska Native beneficiaries under an arrangement between the urban Indian organizations and VA and DOD.

S. 1001 proposes to amend the Indian Health Care Improvement Act by adding a new provision regarding the liability for payment

to allow IHS to cover the cost of copayments assessed by the VA to eligible Indian veterans for covered medical care under the PRC program. In addition, S. 1001 would amend Title IV of the Indian Health Care Improvement Act to require IHS, VA, and impacted tribal health programs to enter into a memorandum of understanding on a national or regional basis for the IHS or tribal health programs to pay copayments owed to the VA by eligible Indian veterans for covered medical care.

Currently, the Indian Health Care Improvement Act prohibits a tribal veteran from being charged a copayment when they seek treatment at an IHS facility. When seeking treatment at a VA medical center, tribal veterans currently are charged a copayment that the individual pays. Current law does not permit a provider, including VA, to impose financial liability on a patient pursuant to an authorized IHS PRC referral. As a payor of last resort, IHS would only pay for cost sharing when there are no alternative resources and all of the other PRC requirements have been met.

Currently, cost sharing is waived for PRC referrals and Medicaid, as well as referrals when a patient is covered by insurance obtained through the individual marketplace. IHS has the lowest per capita spending for Federal health programs. The proposed legislation would redirect funds away from direct services and may reduce services at IHS. It would change the way certain services are funded and result in disparate treatment for IHS beneficiaries.

These changes could impose serious challenges to IHS's ability to provide quality care to its beneficiaries. This is not only problematic for IHS, but also concerning, given the Federal Government's legal responsibility to provide health care for American Indians and Alaska Natives.

IHS is prepared to provide the Committee technical assistance on the legislation. We will remain formally committed to improving the quality, safety, and access to health care for American Indians and Alaska Natives. In collaboration with our sister Federal agencies, we appreciate all your efforts in helping us provide the best health care services to people we serve.

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

[The prepared statement of Admiral Buchanan follows:]

PREPARED STATEMENT OF REAR ADMIRAL CHRIS BUCHANAN, DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICE

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

The IHS mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. As an agency within the Department of Health and Human Services (Department), the IHS provides federal health services to approximately 2.6 million American Indians and Alaska Natives from 573 federally recognized tribes in 37 states, through a network of over 605 health care facilities, including hospitals, clinics, health stations, and other facility types. The IHS also enters into agreements with 41 Urban Indian Organizations (UIOs). These 41 UIOs are 501(c)(3) non-profit organizations that provide culturally appropriate and quality health care and referral services for Urban Indians throughout the United States in 22 states.

S. 2365

In the late 1980s, the IHS and the Department of Veterans Affairs began to explore the feasibility of entering into an arrangement for sharing of medical facilities and services, as required by the Indian Health Care Improvement Act (IHCIA).[1] The Patient Protection and Affordable Care Act of 2010 permanently reauthorized the IHCIA, authorizing IHS to enter into (or expand) arrangements for the sharing of medical facilities and services between IHS, Indian Tribes, and Tribal Organizations and the Department of Veterans Affairs (VA) and the Department of Defense (DOD).[2] The law also directs the VA or the DOD (as the case may be) to reimburse the IHS, Indian Tribe, or Tribal Organization for the services provided to eligible beneficiaries of either Department in the respective facility. While the law clearly extends this authority to IHS, Indian Tribes and Tribal Organizations, it does not mention UIOs. In March 2012, as Federal agencies worked to implement this new authority, IHS and VA jointly engaged in Tribal consultation on a draft national agreement for VA to reimburse IHS for direct healthcare services provided to eligible American Indian and Alaska Native Veterans at IHS federally-operated facilities.

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

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

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

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

S. 1001

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

Currently, the IHCIA prohibits a tribal veteran from being charged a copayment when they seek treatment at an IHS facility. When seeking treatment at a VA medical center, tribal veterans currently are charged a copayment that the individual pays. Current law (25 U.S.C. § 1621u) does not permit a provider, including VA, to impose financial liability on a patient pursuant to an authorized IHS PRC referral.

[1] 25 U.S.C. § 1680f, Indian Health Service and Department of Veterans Affairs health facilities and services sharing.
[2] 25 U.S.C. § 1645, Sharing arrangements with Federal agencies.
[3] Treatment of certain demonstration projects—Tulsa Clinic and Oklahoma City Clinic (25 U.S.C. § 1660b).

As a payer of last resort, IHS would only pay for cost-sharing when there are no alternative resources and all of the other PRC requirements have been met. Under IHS's current payment structure and policy, cost-sharing is the responsibility of the patient when a Tribal Veteran elects to seek treatment without a PRC referral. Currently, cost sharing is waived for PRC referrals in Medicaid, as well as referrals when a patient is covered by insurance obtained through the individual market place.

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

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

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

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

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

The CHAIRMAN. Thank you, Admiral.
Chairman FOX.

STATEMENT OF HON. MARK FOX, CHAIRMAN, MANDAN, HIDATSA, AND ARIKARA NATION

Mr. FOX. Thank you, Chairman Hoeven. I appreciate this opportunity today as well as the other honorable members of the Committee. It is a pleasure and an honor for me to be able to share with you today. I thank you for this privilege.

I introduced myself as Mark Fox, I am the Chairman of the Mandan, Hidatsa, and Arikara Nation. My name in Hidatsa is [phrase in Native tongue], in Arikara it is pronounced [phrase in Native tongue], which means Sage Man.

I proudly represent my nation, Fort Berthold Indian Reservation, the Mandan, Hidatsa, and Arikara Nation. I have with me, as you have introduced, and thankfully so, Chairman, and in recognizing Harriett Good Iron, who has accompanied me this day, as well as other staff.

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

MHA Nation has a proud and prestigious history of military service. I always proudly proclaim and will until the day I die, whether chairman or not, that nowhere else in the world does a people recognize and honor its veterans more so than we do at Fort Berthold. Everything there we do surrounds itself around the reverence for Native Americans that serve in our military. That is whether it is at funerals, at our ceremonies, at our pow wow celebrations, everything, at the lead is our respect and honor of our veterans who bring in the flags and the colors, in everything that we do.

This was never more so stark and noticeable than, for example, during the Vietnam War. In the Vietnam War, when many of the service men returned home to people spitting on them and hitting them with signs and things of that nature, at Fort Berthold, we welcomed them back with open arms. We celebrated their courage; we celebrated every single one of them. We have never turned out back in that way, never have, never will. And that has been a tradition, we will remain that way.

We can go back, our traditions, actually, the first time that the United States Government declared war against a tribe west of the Mississippi, it was the Arikara War of 1823. That resulted in, in 1825, a peace treaty. Since that time, since 1825, and subsequent treaties at Laramie, our three nations, all three tribes that came together have always honored that bond, have always honored that alliance. We have served the military of the United States ever since that time.

So we have this proud tradition that we are very proud of, myself, my own family, my grandfather. One of my grandfathers served in World War I, and yet he was not yet a U.S. citizen. My father, World War II veteran, along with his two brothers, all three brothers served in World War II, became veterans. My brother served in the Vietnam era, and myself, a United States Marine, I served as well.

So I come before you to really talk about when we are sitting as Native American veterans, when we come home, and we can talk day in and day out about all the good things.

But what I want to focus now on, in the last few minutes here, is to really talk about what happens when veterans come home. When veterans come home, we have a great difficulty, especially those that are on the reservation. When they come home, PTSD, as well as other attributable ailments that come from the military, are very prevalent. This often leads to self-medication, drug abuse, things of that nature. And so we built ourselves a facility. The United States Government needs to help us step up and build more facilities for treatment.

It is just a matter of helping our people through, especially our veterans. We treat a large number of veterans at our facilities today. So we need help with that. Our own tribe has built a drug treatment facility in Bismarck, North Dakota. We also have provided other services and members of the Committee, as well as Chairman Hoeven, of course, I have a letter here, I would like to invite you on December 19th, we will have a grand opening of our brand-new veterans center at Fort Berthold. We spent a lot of money, but we think it is worth the time to do that.

So we invite you all, if you have a chance, to come up and celebrate with us. Because again, our reverence for Native veterans that we have to maintain is very important to us as well.

So that all being stated, the other things that occur, as our veterans come home, is our health care services. In North Dakota alone, if you want to get some type of minimal services, you have to travel for a couple of hours. If you want to get the full breadth of services, you have to, both ways, round trip, travel about six hours.

So it puts great difficulty on many of our veterans. We have a phrase called toughing it out. Our veterans often tough it out, instead of seeking medical attention and things that they need. They often, as veterans, sit back and say, ah, that is okay, I am all right, and they don't take the precautionary services they need and things of that that nature.

So those are some of the things. In regard to the bill itself, the two bills that are before us, S. 1001 and S. 2365, our basic position is this. Anything we can do to help our service men in any area, be it copays or expanding services, is very important and we should do that. But I would also remind that if we are going to do that, make sure that we don't diminish current services, make sure that we have enough resources, so that everybody gets the services that they need. We can't simply provide more services and slice up that pie even thinner.

So I would encourage that as well, on both fronts. Thank you.

[The prepared statement of Mr. Fox follows:]

PREPARED STATEMENT OF HON. MARK FOX, CHAIRMAN, MANDAN, HIDATSA, AND ARIKARA NATION

Introduction

Chairman Hoeven, Vice Chairman Udall and Honorable Members of the Senate Committee on Indian Affairs, the Mandan, Hidatsa and Arikara (MHA) Nation appreciates the opportunity to provide this testimony for the Committee's Oversight Hearing on "Recognizing the Sacrifice: Honoring A Nation's Promise to Native Veterans." My name is Mark Fox and I am the Chairman of our Tribal Business Council. The homeland of the MHA Nation, also known as the Three Affiliated Tribes, is located along the Missouri River in the west-central part of North Dakota on the Fort Berthold Indian Reservation. We have over 16,000 members with about 7,000 living on our Reservation. With me today is Harriet Good Iron. Ms. Good Iron is the mother of Army Corporal Nathan Good Iron, who gallantly sacrificed his life defending our country on November 23, 2006, in Afghanistan. Ms. Good Iron was the 2018 North Dakota Gold Star Mother of the Year.

I. Tribal Military Service and Recognition

I want to provide you with a short overview of the MHA Nation's history and military service. Before we were federally designated as the Three Affiliated Tribes, each of our tribal nations signed individual peace treaties in 1825 with the United States. Since that time, the Tribes have gone beyond the treaties call to act as an ally of the United States. By enlistment and special detail, the MHA Nation historically has served in support of the United States military. The MHA Nation's commitment to service would continue from the 19th into the 20th century including World Wars I and II, Korea, Vietnam, Desert Storm, and other major conflicts. A renowned military commander once stated that he "found tribal soldiers to be of great courage, initiative, and intelligence.and they were always volunteers for the most dangerous missions; brave to the point of recklessness; and prove themselves to be soldiers of the highest type."

During the Second World War the MHA Nation sent over half of our adult male population to Europe, North Africa, and the Pacific. Tribes as a whole served in record numbers between 1941 and 1945. In that time span over 44,000 Native Americans would serve. At the time there were less than 350,000 Native Americans

in the United States. A portion of our membership served as Code Talkers. Though not as well recognized as our Hopi, Navajo, and Lakota brethren the "Ree Talkers" saved countless lives through the use of our language to communicate orders, strategies, and commands.

The exceptionally high service rates of Native Americans in the United States military continues to this day. According to the Department of Veterans Affairs in 2012 there were over 30,000 tribal members in the US military and it is a fact that tribal members serve at a higher rate than any other race or ethnicity.

The MHA Nation takes exceptional pride in recognizing and revering our veterans. Our tribal nation has specific military cemeteries that provide burial grounds and educate on the heroic deeds of our veterans. Reverence for veterans is not only reserved for those who have passed or those who returned home from combat, but for those whose service remains recognized throughout their lives. For example, as many communities throughout the United States shamed, attacked, or ignored military members returning from the Vietnam War, but the MHA Nation welcomed home its members with appreciation and honor. That same recognition and reverence continues to this day with military members and veterans being honored at tribal meetings, community events, and traditional ceremonies and celebrations.

Tribal recognition and support of veterans goes beyond just words and honorariums. To date, the MHA Nation has spent over seven million dollars for the construction of a Veteran's Affairs Building. The Tribe has also expended more than five million of its own dollars since 2006 on programs specifically for veterans.

II. Difficulties of Veterans Returning Home

Veterans returning home from military service continue to struggle daily. Many suffer from alcohol and drug abuse, inadequate health care, a lack of education, and limited job opportunities. Though the Tribe has expended significant funds and manpower in assisting its veterans we desperately need additional federal assistance. Providing cost effective, modernized, and accessible healthcare to our veterans is one of the most important issues facing the MHA Nation today. The bills before this Committee represent a small, but important, step in assisting the MHA Nation in supporting and assisting our veterans.

Native American Veterans face unique challenges after exiting military service. Upon returning home Native veterans face high unemployment and severely limited economic opportunities. A 2010 U.S. Census Bureau report found that Native American veterans held the lowest median income of all veterans. That median income at just over $27,000 is almost half of the highest median income. The lower poor median income is a reflection of the extreme socio-economic poverty in Indian Country. The unemployment rate on reservations is more than twice the national average of 4.9 percent. Some reservations face unemployment that is greater than 60 percent.

The lack of jobs and economic security does more than just effect the financial welfare of native veterans. It is well accepted that economic insecurity and economic stressors have a direct effect on alcohol and drug use rates. Combined with Post-Traumatic Stress Disorder (PTSD) and other military conditions our native veterans suffer extreme rates of alcohol and drug disease. These all combine to cause Native Americans to have less access to affordable and quality treatment options.

The lack of economic opportunities is compounded by the difficulty that MHA Nation veterans face in securing even basic health services from a Veterans Administration (VA) facility. While the Tribe has a small veterans assistance program on the Reservation it is drastically understaffed and underfunded. This program can only provide minimal essential services. To reach a more robust VA facility requires a 4-hour drive. Harsh winter weather conditions make even the shortest drives treacherous from November to April in North Dakota.

The impact of unemployment, underemployment, and travel distances for health care services on Native veterans cannot be understated. Veterans are often forced to choose between dangerous and expensive travel for health services and paying for basic necessities. As a result, many tribal veterans choose to "tough it out." This choice to simply forego treatment due to either distance, time, or cost only compounds the mental and physical ailments of our veterans.

III. Specific Bill Testimony

The bills before this Committee are good steps in assisting native veterans. However, they are simply first steps and additional proposed legislation is necessary. The MHA Nation faces significant underfunding for our Veterans programs. We can only fund two employees and our Tribe requires a significant increase in funding for an expansion of services available to veterans from other health providers including the Indian Health Services.

To that end Senate Bill 1001, the Tribal Veteran Heal Care Enhancement Act, is a positive step toward assisting tribes in its pursuit of better outcomes for veterans. The ability to cover certain copays is important as it will relieve some economic stress on our veterans. However, I would urge you to greatly expand this bill. The MHA Nation needs additional clinical and administrative staff on our Reservation. Saving veterans time and money on travel by providing services on the Reservation is paramount. These men and women served our Country. We must be able to give them the services they deserve.

I also stand in support of Senate Bill 2365. The bill will help our members who are located in urban centers who we cannot reach or assist. However, that will amount to an additional cost that the VA cannot fully fund as of today. It is vitally important that you increase the total funding available to Tribes.

Conclusion

In conclusion, I encourage this Committee to honor the commitments of the MHA Nation veterans. The Tribe has honored its commitment to peace and to act as an ally of the United States. Recommending the passage of the two bills before this Committee is necessary. However, the appropriate step for this Committee to recommend is a significant expansion of the VA programs and VA funding available to Tribes. The geographical and economic limitations of the Tribes require unique and forward-thinking solutions. Providing additional funding to Tribes to oversee on-Reservation programs is an important part of honoring Native veteran's service and the trust responsibility of the United States.

I would like to thank you for your time and look forward to working with the Committee to finding the appropriate solutions to the problems facing our military members and veterans.

The CHAIRMAN. Thank you, Chairman Fox. We appreciate it.

Councilman Dupree.

STATEMENT OF HON. JESTIN DUPREE, COUNCILMAN, FORT PECK ASSINIBOINE AND SIOUX TRIBES

Mr. DUPREE. Mr. Chairman, members of the Committee, good afternoon. My name is Jestin Dupree. I am a council member for the Fort Peck Tribes, which is located in northeastern Montana. I am also a veteran of the U.S. Army, where I served as a senior non-commissioned officer. I was deployed five times overseas, once to Bosnia, once to Afghanistan, and three times to Iraq. Starting in 2001 to 2010, I was deployed every other year as an infantryman.

There are more than 600 veterans residing on the Fort Peck reservation that have served in various conflicts. Unfortunately, we are not honoring their service. Native American veterans earn less than half of the income of others in Montana, and their life span is 20 years less.

I know firsthand what it is like to get out of the military and want to move home to better my community. But unfortunately, I was met with barrier after barrier. Thankfully, I was able to overcome those barriers. But one of the issues that lies out there is, for a lot of our veterans, that doesn't happen.

It is hard to prioritize what is more important, a place to live, adequate health care or do I want to get a job. What I found out is in order to have one, you must have the others. Unfortunately, when a veteran seeks help, they are often met with the terms stop, no, and don't. I believe these are unacceptable responses. I believe the answer, when a veteran asks for help, should be, please, come in, and how can I help you.

Before I talk about these barriers to honoring our veterans, I want to talk about what the military could do to address some of these changes that our Native veterans are facing. The military of-

fers a place to learn discipline and leadership. For many of us, this is also a place where we find structure, because we were lacking that in our personal lives.

The structure and discipline that was learned allows many people to suppress the trauma from their own lives, and realize they were meant for a higher purpose. When a veteran's service is up, they are often left alone to seek help. The military does not adequately prepare a person for reentry into the civilian world. The military owes it to service members that when their contract is up, they then go back into a normal life with as much as their mind, body, and spirit as possible. Currently, this is not happening.

At Fort Peck, the biggest barrier to our veterans receiving health care is how far the VA facilities are from our reservation. Currently, I personally used to go to the Mile City VA Hospital, which is a two-and-a-half-hour trip, 325 miles round trip. But then without any notice, I was told that I could only be paid to go to the nearest VA facility, which is in Glasgow, Montana, which is one hour to Glasgow and one hour back. It is 145 miles round trip.

If a veteran was receiving care and built trust with a provider, it is a letdown to start off at a new facility due to some guidance from the VA. Personally, this is frustrating and a lot of our veterans will result to alcohol and drug use.

A veteran who may not have a job and was forced to live with family members struggles. What little money they have will be used to assure their family, if they have children, have the basic necessities.

I think the VA should consider a mobile health unit that would come to our reservations, like Fort Peck, on a regular basis, and be part of the community to built trust with our veterans. This mobile unit should be equipped to treat physical and mental health concerns.

Moving on from health care, finding secure and affordable housing is extremely challenging. Like many reservations, we have a long waiting list for housing. This is challenging, because prior to this Bakken oil boom, which took place over in the Williston, North Dakota, area, this had a cause and effect issue of our reservation, because of rent. It went extremely high. What happens is a veteran will move in with their family members, oftentimes in crowded situations. There is simply not enough housing.

I recognize that there is a VA loan program for veterans, but I am not sure if this is working at Fort Peck, as only one individual has used this program. I do not know the historical data from this, but I know and suspect that numbers are low.

Finally, a foundational challenge facing our veterans is employment. The biggest barrier for many of our veterans is chemical dependency. One of our first priorities to a veteran should be to assure that they are physically and mentally capable of doing their job.

I think one of our greatest resources that we have is our tribal community colleges. Congress should create a program to utilize our tribal colleges to retrain our veterans for jobs that are needed in our areas.

In addition, the BIA and IHS must do a better job hiring veterans. Tribal veterans should not have to resort to being homeless

or begging and living on the streets. We truly need to honor their sacrifice by removing the barriers to health care, housing, and employment.

Again, my name is Jestin Dupree. Thank you for your attention and your efforts to address these important issues. Have a nice day.

[The prepared statement of Mr. Dupree follows:]

PREPARED STATEMENT OF HON. JESTIN DUPREE, COUNCILMAN, FORT PECK ASSINIBOINE AND SIOUX TRIBES

I would like to thank the Committee, Senator Tester and Senator Daines for inviting me to testify before the Committee today. I am Jestin Dupree and I am a Tribal Executive Board member for the Assiniboine and Sioux Tribes of the Fort Peck Reservation.

I am a veteran of the United States Army where I honorably served as a Senior Non-Commissioned Officer and was deployed overseas on five tours of duty as an Infantryman. From 2001 to 2010, I was deployed every other year and my tours of duty lasted from ten to fifteen months. While deployed I served our country in Bosnia, Afghanistan, and Iraq three times.

I am honored to provide this testimony on behalf of our native veterans and provide some insight on the issues tribal Veterans face in accessing housing, employment and health care when they return home from service. There are more than six hundred veterans residing on the Fort Peck Reservation. The majority of our veterans are veterans of the Gulf Wars, the Vietnam War and the ongoing wars in Afghanistan and Iraq. We are blessed to still have seven Korean War Veterans, including our former Chairman Rusty Stafne, and two World War II Veterans. The Fort Peck Tribal Members who served during World War II were part of the widely heralded Sioux Code Talkers. Thus, Fort Peck tribal members have a long and decorated history of serving this country and I am proud be included with these great men and women. Unfortunately, we as a Nation are not honoring these great men and women. According to my Tribe's Health Director, Native American Veterans have less than half the income of others in the state of Montana and their lifespan is twenty years less than non-tribal members in the state.

Now my duty of service has taken on another form. I am for better or worse a politician, who has been selected by my people to serve their needs. I think that my service in the military laid a strong foundation to enable me to weather the storms of politics to serve my Tribe. As a member of Tribal government, it is my is responsibility to work for all tribal members, but I hold a special responsibility toward Veterans.

I know firsthand what it is like to get out of active duty and to want to return home with all of the knowledge and experience that I was taught and gained in the military and to use this knowledge and experience to better my community. But I was met with barrier after barrier. Thankfully, with a little luck and resiliency I was able to overcome these barriers, but for many Veterans returning home to Fort Peck this is not the case.

It is hard to prioritize which is more important: does a Veteran need a place to live, an informed healthcare provider, or a job the most? What I have found, is that in order to have one you often times must have the other. You cannot obtain housing without employment. You can't obtain employment because you are struggling with mental, behavioral or physical health challenges. You cannot obtain health care because you have no vehicle or a support system to ensure you can get to a VA health care facility. Unfortunately, many times when a Veteran seeks help, he or she is told no; wait in line; or stop asking for help. I believe these are unacceptable responses. I believe the answer when a Veteran asks for help should be yes, come through this door and let me answer your questions and help you.

Before I talk about these barriers to honoring our Veterans, I want to talk about what the Department of Defense could do to help address what may be at the root of some of the challenges in serving native veterans. The military offers a place to learn discipline, to learn leadership, and to learn a skill. For many of us, it is also a place where we were able find a structure that was lacking in our personal homes and families. The structure and the discipline that the military offered also allows many people to compartmentalize the trauma from their home life and know that their life was meant for a higher purpose. However, when a person is separated from the military, in many cases the trauma that was suppressed by the military structure will return to the surface and often times this trauma is compounded by

a person's experiences in the military. Unfortunately, the military does not prepare a person for reentry into the civilian world. The Department of Defense owes all service members to ensure that when they end their service, they are going into the civilian world with as much of their mind, body and spirit intact as possible. Right now, I believe the DOD is failing at this, and the VA is left to account for this failure.

Again, Veterans returning home from service face significant barriers upon reentry. As I said, it is difficult to prioritize which barrier is the most significant, but I will begin with health care, because in my discussions with the many Fort Peck Tribal departments tasked with serving Veterans it was the one constant that is lacking—ensuring that our Veterans are able to contribute to our Reservation in a positive and constructive way.

At Fort Peck, the biggest barrier to our Veterans receiving care is how far the VA facilities are from the Reservation. This distance is compounded by the VA's changing rules and bureaucracy. For example, while the VA reported that a Veteran could report to any VA health care facility, they changed the rules and the VA will now only pay costs for travel to the closest VA facility. For Fort Peck that would be the Glasgow health care facility. However, the majority of our Veterans receive care at the Miles City VA hospital. This change in travel policy was imposed on our Veterans without notice or consultation.

Thus, a tribal Veteran who has no resources to travel to the VA in Miles City, must now switch from a provider he had a relationship with to another one in Glasgow. I have to tell you this is not likely to happen. For a Veteran to ask for money to go to Miles City so that he can seek help from a behavioral specialist, and then to build a relationship of trust that allows for the provider to treat him is probably one of the hardest things that this Veteran has ever done. For the VA to tell this Veteran that it will no longer support his travel to the provider in Miles City and that he has to step into a new facility in Glasgow and rebuild trust with a new provider. the VA might as well send this Veteran back to Iraq.

I know some of you might say that the Veteran should not have to depend on the VA for the gas money to get to Miles City. Again, this is a man who may not have a job, whose family may be living with other family members and what little money he does have he may be using to ensure his children have food, heat and clothes on their back. He is not going to use the $40 in gas money that it takes to get back and forth to Miles City for himself. He is going to use it for his family. Because the VA will not pay $40 for this Veteran to receive care with the provider that he has built a relationship with, he will be left untreated, or worse, he will self-medicate with drugs or alcohol.

I do appreciate that Fort Peck Veterans can access health care in Glasgow, which is anywhere from 30 to 100 miles to travel to depending on which tribal community the Veteran lives in or in Miles City, which again is at least 160 miles from our Reservation. If a Veteran needs more sophisticated care, like an MRI, that Veteran will have to travel to Sheridan, WY or Helena, MT. Both are about a nine-hour drive in good weather. With our lovely Montana winters this trip can be ten hours or more. I know a great deal of focus has been given to VA wait times, I can tell you that at the facilities in Montana, at least in N.E. Montana, this is still a problem reported by our Veterans.

There are some legislative bills on today's agenda. I want to testify on S.1001, which would require the Indian Health Service to use limited IHS Purchased and Referred Care dollars to pay the VA for a native veteran's copays that are charged for treatment at the VA. This is inconsistent with the federal government's trust responsibility to provide Indian people with health care, and also the VA's responsibility to provide care to Veterans. As I see it, I have already paid twice, my ancestors paid when they signed the treaty, and I paid when I served five tours of duty. I do not think my elder who needs gallbladder surgery that would be denied because PRC money was paid to the VA should have to pay too. This bill should instead waive all copays for Indian Veterans. It is absurd that an Indian Veteran getting treatment at a federal facility is charged a copay for that health care.

Again, I cannot over emphasize the need to secure health care that is targeted towards Veterans, especially mental health and behavioral health care. Over and over again, in my discussions with the Tribes' Program Directors they identified chemical dependency as the primary impediment to a Veteran obtaining a job, obtaining housing and improving the quality of their overall physical health.

I think the VA should consider a mobile health unit that would travel to rural places like Fort Peck on a regular basis and be a part of the community to build trust and confidence with the Veterans. This mobile unit should be equipped to treat physical and mental health issues. I know from my many conversations, the hardest thing for a Veteran to do is to ask for help from anyone, but from a stranger

it is almost impossible. But if this mobile unit became a regular part of our community and our Veterans could become familiar with the services and providers, that would remove a substantial impediment to access to care.

Moving from health care, securing affordable housing on the Fort Peck Reservation is actually more challenging than accessing quality health care. At Fort Peck, like many Reservations, we have a long waiting list for Tribal housing. Accordingly, a Veteran returning home must put his name on that list and wait. At Fort Peck, a Veteran seeking an apartment is faced with high rental rates due to the Bakken Oil Boom. As a result, many Veterans and their families are forced to live with other family members, many times in overcrowded situations. There is simply not enough housing support for Veterans. It is tragic that HUD has not been able to fully implement the Tribal Veteran Affairs Supportive Housing Program, supporting housing for Indian Veterans. Congress must authorize this program and continue to fund it and ensure that HUD eliminates the bureaucracy that is impeding its implementation.

I recognize that there is the VA Native American Veteran Direct loan program. I am not certain this Program is working as well as it could work. The Fort Peck Tribes have a Memorandum of Agreement with the VA for this program, but only one person on the Reservation is now receiving a loan from this program and is having a home built. I do not know the historical numbers of people who have participated in this program at Fort Peck, but I suspect they are very low.

One of the barriers to applying to this program is that it is handled out of Denver and not locally. The VA should send a loan officer to the Reservation on a regular basis to explain the program and provide direct face to face service to Veterans. This should be part of the Memorandum of Agreement with the Tribes.

Another problem with this program, is that the application process itself is too cumbersome, with the VA again having no one locally to provide assistance to potential applicants. In this regard, the VA should do a better job at outreach and, in some cases, waiving some of the requirements that may be prohibiting tribal veterans from participating. For example, if a person is in school or in a training program, the VA could waive the requirement for two paystubs.

Finally, a foundational challenge facing Veterans returning home is employment. As I said the biggest barrier for many of our Veterans to gaining employment is chemical dependency. Chemical dependency can make it virtually impossible for a Veteran to hold a job successfully. The negative pattern of not being able to keep a job can lead to a lifetime of bouncing around from job to job. Thus, priority one is treating the Veteran's physical and mental health so that he or she can hold a job in the civilian world.

However, even if a person is not battling physical and mental health challenges, we are not readily equipped to translate the skills and knowledge that a Veteran obtained from the military into a civilian job. A Veteran knows how to show up to work on time, he or she knows how to follow orders, he or she knows how to solve problems, and he or she knows how to operate under pressure. All of these skills are basic to any job and there is no reason they cannot be translated to many jobs such as law enforcement, health care, or teaching.

I think one of the greatest resources we have in Indian country are our tribal colleges. I think that Congress should create a program at tribal colleges that is focused on retraining Veterans for needed civilian jobs in our communities. In addition, the Bureau of Indian Affairs and Indian Health Service must do better at hiring Veterans and providing education or training for them to do jobs in the area of law enforcement, education or health care. I served in Iraq, Bosnia and Afghanistan, and I simply do not believe the Bureau of Indian Affairs or the Indian Health Service cannot find qualified people to be police officers, social workers, nurses, physician assistants, or teachers because of the remote and isolated nature of many of the tribal communities. The BIA and the IHS simply must do a better job creating and supporting training opportunities for Veterans.

Tribal Veterans should not have to resort to being homeless, living on the streets, or begging for change. We need to truly honor their sacrifice by removing barriers to health care, housing and employment.

Thank you for your time.

The CHAIRMAN. Thank you, Councilman.

We will now turn to five-minute rounds of questioning.

Dr. Matthews, Senate Bill 1001 was introduced by Senators Thune and Rounds. The purpose of the bill is to amend the Indian Health Care Improvement Act to authorize the Indian Health Serv-

ice to cover the cost of copayments for American Indian or Alaska Native veterans receiving medical care or services from Department of Veterans Affairs upon authorized referral from IHS.

What recommendations do you have in regard to that legislation?

Dr. MATTHEWS. Senator, thank you for the question. I think VA is very interested in working with the Committee, as well as IHS, to figure out how best to address the actual purpose of the bill, which is to remove the copayment.

The way it is currently structured, it does place some administrative as well as financial burden on IHS. We would like to consider perhaps additional ways to address those issues with our sister agency. But overall, we do support the intent behind the legislation.

The CHAIRMAN. Admiral Buchanan.

Mr. BUCHANAN. Yes, we definitely want to work with VA and Congress to address the challenges. The way the bill is written, there are several technical issues that we definitely need to work out. We have some Indian health care authority activities as it relates to our PRC program that, it basically says that anybody that is referred by a PRC program shouldn't be billed, whether it is copays or any of those activities.

So that is the challenge that we are facing. We have veterans that may access VA and that doesn't come through the IHS system. They are being charged copays. So there is that disparate treatment between IHS PRC referrals in how a veteran access the VA system.

The CHAIRMAN. I would ask you both to work with Senator Thune to see if you can't come up with some ideas to address it.

Dr. MATTHEWS. Definitely.

Mr. BUCHANAN. Yes, sir.

The CHAIRMAN. Thank you.

For Chairman Fox, I have introduced the HUD–VASH Act, along with Senator Udall, Senator Isakson, and Senator Tester. We have passed that through the Senate. Now it is in the House.

As you know, essentially it would make permanent a program whereby Native American veterans would get vouchers for housing. We think this is just an incredibly important program that we get passed. We are very hopeful, and we are pushing to get it through the House and hope to get it through the House and passed into law.

I guess the question is, are programs like Tribal HUD–VASH, where Congress empowers veterans to make their own decisions in choosing what works best for their housing and their health care needs, is that a good way to address some of the challenges you have for both housing and health care for veterans on the reservation?

Mr. FOX. Absolutely. I definitely stressed the importance of that housing, very critical, housing and jobs, very critical. Anything that you can do to promote opportunities for veterans when they return home, or enlisted men, when they return home. So definitely, we need those areas.

When you reference health care, of course, the physical ailments that we tend to suffer are very important. But what we are coming to find more so, and I heard reference to that earlier in previous

discussions, is the mental health portion, addictions, the abuses that occur of alcohol and drugs or meth or what have you. We have been forced to build a drug treatment facility simply because of that.

We truly believe that even including our veterans, in particular, we can help them find their way back, so to speak, that we can get them into good homes. If we can give them an opportunity to work, that is all they really want.

But when they return home, those don't exist. It is very difficult for a service man who gets up at 5:00 a.m. and commits years and years of service at a work level, and then returns home and does not have that before them, an opportunity to do that, you are just begging for them to turn the wrong way. There is too much direction that they learn and acquire, and they no longer have that.

So when we create these opportunities to work for that, then you are going to see the benefit of doing that, no doubt.

The CHAIRMAN. Councilman Dupree, the same question, the value of the HUD–VASH program, both housing vouchers as well as health care services from VA, making that permanently authorized for Native American vets on the reservation.

Mr. DUPREE. Mr. Chairman, thank you for that question. As I stated earlier, I want to echo what Chairman Fox said, that there is a huge request for help for mental health in our remote areas. There is a big difference from the urban areas, in terms of reservation, compared to our rural area. We are very rural. In terms of rural, I always tell this story, but we actually have to go 85 miles into North Dakota to go to Wal-Mart, and then drive that 85 miles back.

We do have a huge demand. Again, I appreciate your efforts with the veterans issues. But we do have some tough issues, and these are tough questions to sit here and think about these. Anything that can help with funding, and issues to housing, employment, and health care, would be greatly appreciated. I know I could sit here and speak for Fort Peck all day and probably sound selfish. But you guys have to make these decisions to help everybody out. Again, I thank you for allowing us some time to come up here and address these very serious issues. Thank you.

The CHAIRMAN. Thank you, Councilman. We will turn to Vice Chairman Udall.

Senator UDALL. Thank you, Mr. Chairman.

Rear Admiral Buchanan and Dr. Matthews, I have spoken to IHS a number of times regarding my concerns with the IT coordination issues faced by the VA, the Indian Health Service, tribes, and urban Indian health programs. I am deeply concerned about the impacts these IT shortfalls can have on care coordination for native veterans.

The National Indian Health Board just testified about this very issue in the House of Representatives last month. They said, and I agree, "It is shameful that Native veterans are put in a position where they have to find their own solutions to these ITS problems." I have been told that sometimes that means they are having to hand carry their health records from the Indian Health Service over to the VHA provider.

Dr. Matthews and Admiral Buchanan, how are your two agencies working together to address this inter-operability issue?

Mr. BUCHANAN. Thank you for the question. IHS has initiated the Health Information Exchange, a utility referred to as the direct secure messaging part of the 2014 certification. Both VA and IHS are participants in the sharing of medical information through this secure exchange of information.

There are still some challenges that need to be worked out, for sure. We are basically only able to transfer a limited amount of information at this time. Currently, we are working on the HIT, or Health Information Technology modernization project, which will actually look at some of these activities and hopefully enhance that capability going forward.

Senator UDALL. When should that be up and running?

Mr. BUCHANAN. Currently, it is in the design phase. We just recently completed the HIT modernization project. We are currently, as of today, talking to tribes and tribal organizations and urban organizations to talk about the next steps. So I don't have a date for you on that for sure.

Senator UDALL. Dr. Matthews?

Dr. MATTHEWS. Sir, it is such an important question. Care coordination is critical. I am a family medicine doctor. I completely understand and agree that this is something that we need to work through. The Health Information Exchange that the Admiral raised, of course, is a critical piece. But as we were talking about in the first panel, broadband access, things of that nature, obviously affect the ability for that communication to be successful. So we do need to address all of the above when we are talking about electronic coordination.

The other piece that we have definitely committed to in VA is moving forward with an advisory board on consultation about how better to bring about care coordination between not only IHS facilities and VA but also the tribal health programs that Dr. Stone mentioned, that we have reimbursement agreements as well, that that care coordination should go beyond the electronic means. But how best to do that, and how to keep it as veteran centric as possible, we are fully committed to that.

It is also worth acknowledging that VA is moving into a new realm in the next 10 years, with our electronic health record modernization. We are definitely open, my leadership is committed to opening up discussions about how that can best serve our needs from an interoperability standpoint, working together to make sure IHS is a partner with us.

Senator UDALL. Thank you very much.

The National Council of Urban Indian Health recently testified in the House of Representatives, "The Health Care Access for Urban Native Veterans Act is a necessary and critical piece of legislation, one that will make a real, meaningful difference." Councilman Dupree, Montana has the second highest number of urban Indian Health programs in the Country. So while we don't have an Urban Indian Health Program director with us for today's hearing, I trust you can speak to the important work urban Indian clinics do for Native veterans in your home State.

Do you agree that the VA and the IHS should do more to support urban Indian health programs that provide culturally competent care for Native veterans living in our urban areas?

Mr. DUPREE. Mr. Chairman, Senator Udall, that question is kind of the discussion we had about urban and rural. But it doesn't matter if you are a veteran or tribal veteran or non-tribal veteran, you should be able to receive adequate health care. You should not have to live in an urban area and come all the way back to a reservation to receive adequate care. I think that this needs to be addressed. I hope I answered your question. Thank you.

Senator UDALL. Yes, you have. Thank you very much.

I yield back, Mr. Chair.

The CHAIRMAN. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman. I want to thank you all for being here today.

This first question is for you, Dr. Matthews. In Councilman Dupree's opening remarks, he talked about mobile health centers and how they could work very well in tribes that are remotely located. Many in the west are. There are a couple of mobile units in Montana, and I am sure we are not the only State to have some.

Are they fully staffed up; do you know?

Dr. MATTHEWS. I apologize, sir, I will have to take that for the record. I am not sure.

Senator TESTER. That would be great. And do you know if they put priority, and I am not talking just Native American tribe, but to go out to the more frontier areas, which would, by the way, include every tribe in Montana, but it also includes some other areas, too. Do you guys prioritize that?

Dr. MATTHEWS. I would need to look at what the actual prioritization ranking would be. I know that we also use it for emergency management. They have been deployed to hurricane zones and the like.

But I can definitely get you that information.

Senator TESTER. I think that information would be very, very helpful. I think he makes a very good point. In lieu of having a facility right there, that is good.

I do want to add on to the point that he talked about, wanting to go to Mile City and the VA only going to offer him mileage reimbursement for Glasgow. What really complicates this is Glasgow didn't have a doc or a nurse practitioner for five or six years. Now they have a nurse practitioner. He has a relationship with a doc in Miles City. And now we are saying, we are not going to pay if you go to Miles City anymore. You have to change your home doctor and go to—we have to make some allowances for that.

If you could take that down, if there are things that we need to do in the Senate to do that. Because I think home health is really important. If you have a doctor you like, we had this debate during the ACA. We had this debate in the VA. If you have a doctor you like in IHS, you should be able to keep them.

So I want to go over to both Councilman Dupree and Board Member Fox. Do you feel like there is an avenue in Indian Country to give information back to the VA, not IHS, but VA, if they are not meeting the needs of your veterans in your specific reservations? Is there an avenue to give input back?

Mr. FOX. Thank you. I appreciate it very much. I believe there are avenues, but I don't think at this point in time they are effectively workable avenues as we sit today. It is obvious by the lack of services that still remain out there in Indian Country.

But I do I think it is going to improve? I truly do. Based upon what I have heard just yesterday and today, whether it is the meeting at the White House that we had, and now of course, today, that there is deliberate effort to expand those services and get them out there. That is really what we need. But we are missing too many people right now.

Senator TESTER. How about you, Councilman Dupree? What is your perspective?

Mr. DUPREE. Mr. Chairman, Senator Tester, thank you. In terms of communication, effective communication with the VA, we have your office in Montana that we do effectively communicate quite often with. But in terms of the VA, I am not tracking any person that really comes out and says, hey, what can we fix, how can we fix it. From the VA headquarters office, we are about eight and a half, nine hours away in good driving weather.

Senator TESTER. So that is good enough. So I bring this back to the question that I asked Secretary Wilkie and Dr. Stone, and that is, if there is not an avenue to give information back to the VA, it is pretty hard to think that there is an avenue to reach that 60 percent that never go to VA facilities.

My guess is, it is probably not much different in Indian Country than it is anywhere else in this Country, that there are 60 percent of the people that either aren't aware of the services that are out there for them that have served, or they just have a different opinion of the VA than what really exists today. So if you could take some of that back, Doctor, and pass it along. It would really be helpful.

I want to talk about HUD and VA just for a second. I sit on the Banking Committee. We deal with HUD on the Banking Committee. Do you guys know what the homeless, how many homeless vets you have on your reservation? Any idea? Is it a hundred? Is it 500? Is it a thousand?

Mr. FOX. I wouldn't know the specific numbers on our particular reservation. I see homeless individuals that we have out there, and of course, you are from Montana. When we address homelessness at home in Fort Berthold, there are two ways to look at it. There is winter and non-wintertime. We are occupying our time trying to provide shelter, trying to make sure that they are safe and that they don't freeze to death when they are homeless. In the winter, it below minus 20.

But at the same time, I know we are working hard to try to record data on how many of them are actually veterans and how many are not.

Senator TESTER. How about you, Councilman?

Mr. DUPREE. Senator Tester, thank you for that question. This is really a hard number to track down, because you have some veterans that, if they move home, there is no adequate housing, they are going to move in with their family members. A lot of the numbers are extremely unreported.

So to knock on a door and ask hey, how many people are living in your home, you are not going to get an accurate number.

Senator TESTER. That is exactly the point. You have people who are homeless, then you have people who are living generations in the same house. If there wasn't that culture to bring people in, they would be homeless, too.

I would just say that I know it is not in the purview of this Committee, but the HUD–VASH vouchers are really, really important. I bet you if we double them from what you get now, you would probably utilize every damned one of them and then a bunch more.

I want to thank you all for being here. I didn't get a chance to talk to you and IHS, but we will, don't worry about that. I want to thank you very much for what you guys do every day, and I look forward to working with you to improve the situation. Thank you.

The CHAIRMAN. All right, if there are no more questions for our panel, I would like to thank all of you for being here, particularly for our tribal chairman. Again, thank you, Harriett, thank you for being here. God bless you. And Councilman Dupree, thank you as well. We truly appreciate your joining us, as well as, of course, Dr. Matthews and Admiral Buchanan.

The hearing record will be open for two weeks. I want to again thank you. With that, we are adjourned.

[Whereupon, at 4:42 p.m., the hearing was adjourned.]

A P P E N D I X

Prepared Statement of Sonya Tetnowski, Vice-President, National Council of Urban Indian Health

My name is Sonya Tetnowski, I am a member of the Makah tribe, a U.S. Army Paratrooper Veteran, and the Chief Executive Officer of the Indian Health Center of Santa Clara Valley in California. I'm also the Vice President of the National Council of Urban Indian Health (NCUIH), which represents 41 Title V Urban Indian Health Organizations (UIOs) across the nation, as well as the President of the California Consortium for Urban Indian Health (CCUIH). UIOs provide high-quality, culturally competent care to urban Indian populations, which constitute more than 78 percent of all American Indians and Alaska Natives (AIANs). I would like to thank Chairman Hoeven, Vice-Chairman Udall, and other distinguished members of the committee for holding this important hearing. The testimony submitted will concentrate on S. 2365, the Health Care Access for Urban Native Veterans Act.

S. 2365 is a necessary and critical piece of legislation, one that will make a real meaningful difference in the funding for health care services provided by UIOs across the United States. Over the last few months the National Council of Urban Indian Health were invited to provide in person testimony on this very issue before the House Indigenous Peoples of the United States Subcommittee Legislative Hearing held on September 25, 2019 and House Committee on Veterans' Affairs, Subcommittee on Health, Oversight Hearing held on October 30, 2019 to voice our support on H.R. 4153 introduced this past August by Representative Khanna. H.R. 4153 is an identical and companion bill to S. 2365.

I cannot express more urgently, that the single most important thing the Department of Veterans Affairs (VA) can do to improve healthcare to AI/AN Veterans, is to fully implement the VA and Indian Health Services' Memorandum of Understanding (VA–IHS MOU) and Reimbursement Agreement for Direct Health Care Services. This would allow UIOs to be reimbursed for providing culturally competent care to AI/AN Veterans residing in urban areas. Despite an embattled history between tribal people and the United States government, and as an inherited responsibility to safeguard the lands of their ancestors, AI/ANs serve this country at a higher rate than any other group in the nation. A significant number of these Veterans live in urban areas and seek out the high-quality, culturally competent care at their local UIO.

UIOs were formally recognized by Congress following the end of the Termination Era in 1976 under the Indian Health Care Improvement Act to fulfill the federal government's health care-related trust responsibility to Indians who live off the reservations. Each UIO is led by a Board of Directors that must be majority Indian. They are collectively represented by the National Council of Urban Indian Health (NCUIH), which is a 501(c)(3), member-based organization devoted to the development of quality, accessible, and culturally sensitive healthcare programs for AIANs living in urban communities. UIOs are a critical part of the Indian Health Service (IHS), which uses a three-prong approach to provide health care: Indian Health Services, Tribal Programs, and Urban Indian Organizations commonly referred to as the I/T/U.

VA–IHS MOU Historical Background

In February 2003, the VA and IHS signed a Memorandum of Understanding (MOU) and updated this MOU in October 2010. The very first paragraph of the MOU states:

> "the intent of this MOU (is) to facilitate collaboration between IHS and VA, and not limit initiatives, projects, or interactions between the agencies in any way. The MOU recognizes the importance of a coordinated and cohesive effort on a national scope, while also acknowledging that the implementation of such efforts requires local adaptation to meet the needs of individual tribes, villages,

islands, and communities, as well as local VA, IHS, Tribal, and Urban Indian health programs."

In December 2012, the two agencies signed a reimbursement agreement allowing the VA to financially compensate IHS for health care provided to AIANs that are part of the VA's system of patient enrollment. While this MOU has been implemented for IHS and Tribal providers, it has not been implemented for UIOs, despite the fact that UIOs are explicitly mentioned in the original language of the 2010 MOU, and provide healthcare within IHS's own I/T/U system. Leaving out UIOs is a violation of the MOU since the agencies agreed to "not limit initiatives, projects, or interactions between the agencies in any way." Not reimbursing UIOs for services provided to Native Veterans is limiting this vulnerable, underserved population from the healthcare they need and deserve. NCUIH and UIO leaders have been testifying before Congress for years that the MOU is not being recognized for UIOs. Members have said this is an "easy fix," and "an oversight," so we are happy to see that there is now a bill to address this issue once and for all. We maintain that as part of the I/T/U, the VA already has the authority to reimburse title V UIOs, but we are happy Congress is taking the next step to address this important issue. Between 2012 and 2015, the VA reimbursed over $16.1 million for direct services provided by IHS and Tribal Health Programs covering 5,000 eligible Veterans under the IHS–VA MOU. In spite of the federal trust responsibility to AIANs, the VA had decided to deem UIOs ineligible to enter into the reimbursement agreement under the IHS–VA MOU. For context, UIOs are already extremely underfunded and receive less than $400 per patient from IHS, versus national health expenditure rates of almost $10,000 per patient. In 2018, UIOs received a total of $51.3 million to support 41 programs, and that is before IHS's administrative costs are removed. UIOs only receive one line-item appropriation in the IHS budget- the urban Indian health line item. UIOs don't receive purchase and referred care dollars, Federal Tort Claims Act coverage, 100 percent FMAP, or facilities funding. In fact, a few UIOs temporary closed during the shutdown due to the lack of parity within the IHS system. VA reimbursement, even half of the $16.1 million, would drastically help our facilities. It is time to fix this issue for good.

The VA's position is that UIOs are not identified in 25 U.S.C. § 1645(c) as one of the organizations it may reimburse. However, it is important to note that two UIOs are covered under the IHS–VA MOU because VA officials report that those programs function as a service unit as defined in 25 U.S.C. § 1603(20).

There have been several Government Accountability Office (GAO) reports conducted on the VA–IHS MOU—two reports on VA and IHS implementation and oversight of the MOU were released in 2013 and 2014. In March 2019, the GAO released a study entitled *"VA AND INDIAN HEALTH SERVICE Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans"*. The GAO was asked to provide updated information related to the agencies' MOU oversight. This report examines (1) VA and IHS oversight of MOU implementation since 2014, (2) the use of reimbursement agreements to pay for AI/AN veterans' care since 2014, and (3) key issues identified by selected VA, IHS, and tribal health program facilities related to coordinating AI/AN veterans' care. In this report the GAO report makes the recommendation to both the VA Secretary and IHS Director to ensure measureable targets to track and measure performance, and has jump started efforts by VA to conduct consultation and confer. The VA is currently working with IHS to revise the MOU, stating their goals for this revision: increase access and quality of care for AI/AN veterans, improve health promotion and disease prevention, encourage patient centered collaboration and communication, consult with Tribes at the regional and local levels, ensure appropriate resources for services for AI/AN Veterans. Furthermore, the VA in a 2018 report to Congress stated themselves that UIOs under IHCIA are "eligible, capable, and are entitled to receive reimbursement for healthcare services they provide to AI/AN veterans from any payer" as part of the IHS I/T/U system. They also acknowledge that they have no current legal authority to allow for expanding existing reimbursement agreements to include UIOs. If the goal is to increase access to care for AI/AN veterans, then now is the time for the VA to finally recognize that UIOs are a critical part of the Indian Health Service (IHS), acknowledge the needs of the significant amounts of AI/AN veterans who live in urban areas and expand the reimbursement agreement to include UIOs.

Both the legislative and executive branches strongly support efforts to increase timely access of healthcare for Veterans. Recognition of the MOU for UIOs and urban Indian Veterans would be highly consistent with those efforts. NCUIH has worked closely with the National Congress of American Indians who recently passed

a resolution in support of our efforts to ensure parity for UIOs. This resolution is being submitted as a part of my testimony today.

In Conclusion

We strongly recommend that the VA reimburses UIOs for services rendered to Native Veterans. These reimbursements must be companied by outreach and advocacy resources to ensure that Native Vets are aware of all the health care options available to them in their communities. The VA is known for its challenging wait times, yet we all agree access to care for Veterans is a priority. UIOs can provide excellent, culturally competent primary care, dental, and behavioral health services to Veterans, while reducing the burden on the VA and allowing it to focus on the specialty services it provides best.

Our national interest of serving Veterans will be best carried out when we extend the collaborative arrangements already agreed to by the VA and IHS to include the bulk of our nation's Native American Veterans—who either are or could be served by a UIO.

NCUIH strongly recommends, pursuant to Section 405(c) of the Indian Health Care Improvement Act, that the VA–IHS MOU be expanded to include reimbursement for care provided by the UIOs. Thank you for holding this hearing today and for the Committee's support of urban Indian healthcare issues. We strongly support S. 2365 and look forward to working with Congress to serve as an expert resource regarding this legislation and other good work regarding urban Indian health care and the overall health of Indian Country.

PREPARED STATEMENT OF THE NATIONAL INDIAN HEALTH BOARD (NIHB)

Chairman Hoeven, Vice Chairman Udall, and Members of the Committee, thank you for holding this important hearing on health care access for Native Veterans. On behalf of the National Indian Health Board (NIHB) and the 573 federally-recognized sovereign Tribal Nations we serve, I submit this testimony for the record. The federal government's trust responsibility to provide quality and comprehensive health services for all American Indian and Alaska Native (AI/AN) Peoples extends to every federal agency and department, including the Department of Veterans Affairs (VA).

By current estimates from the VA, there are roughly 146,000 AI/AN Veterans, with Native Servicemembers enlisting at higher rates than any other ethnicity nationwide. Indeed, the Department of Defense continues to acknowledge the indispensable role of AI/AN Servicemembers throughout American history. Native Veterans are highly respected throughout Indian Country, in recognition of what they have sacrificed to protect Tribal communities and the United States. Yet despite the bravery, sacrifice, and steadfast commitment to protecting the sovereignty of Tribal Nations and the entire United States, Native Veterans continue to experience among the worst health outcomes, and among the greatest challenges in receiving quality health services.

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 the Tribes. The terms codified in those Treaties—including for provisions of quality and comprehensive health resources and services—have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even presidential executive orders. These federal promises have no expiration date, and collectively form the basis for what we now refer to as the federal trust responsibility. Moreover, the United States has a dual responsibility to Native Veterans—one obligation specific to their political status as members of federally-recognized Tribes, and one obligation specific to their service in the Armed Services of the United States.

In 1955, Congress established the Indian Health Service (IHS) in partial fulfillment of its constitutional obligations for health services to all AI/ANs. The IHS is charged with a similar mission as the VHA as it relates to administering quality health services, with the exception of the following differences: (1) the federal government has Treaty and Trust obligations to provide health care for all American Indians and Alaska Natives; (2) IHS is severely and chronically underfunded in comparison to the VHA, with per capita medical expenditures within IHS at $4,078 in Fiscal Year (FY) 2017 compared to $10,692 in VHA per capita medical spending

that same year[1]; and (3) unlike IHS, the VHA has been protected from government shutdowns and continuing resolutions (CRs) because Congress enacted advance appropriations for the VHA a decade ago.[2]

Health Outcomes among Native Veterans and AI/ANs Overall

Destructive federal Indian policies and unresponsive human service systems have left Native Veterans and their communities with unresolved historical and intergenerational trauma. From 2001 to 2015, suicide rates among Native Veterans increased by 62 percent (50 in 2001 to 128 in 2015).[3] In FY 2014, the Office of Health Equity within 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 percent vs. 11.6 percent), depression symptoms (18.7 percent vs. 15.2 percent), and major depressive disorder (7.9 percent vs. 5.8 percent).[4]

Native Veterans are 1.9 times more likely to be uninsured than non-Hispanic White Veterans, and are significantly more likely to delay accessing care due to lack of timely appointments and transportation issues.[5] Among all Veterans, Native Veterans are more likely to have a disability, service-connected or otherwise.[6] Native Veterans are exponentially more likely to be homeless, with some studies showing that 26 percent of low-income Native Veterans experienced homelessness at some point compared to 13 percent of all low-income Veterans.[7] 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 IHS and Tribes to create more resources specifically for Native Veterans.

According to IHS, AI/ANs born today have a life expectancy that is on average 5.5 years less than the national average.[8] In states like South Dakota, however, life expectancy for AI/ANs is as much as two decades lower than for Whites. Health outcomes among AI/ANs have either remained stagnant or become as AI/AN communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. According to the Centers for Disease Control and Prevention, in 2016, AI/ANs had the second highest age-adjusted mortality rate of any demographic nationwide at 800.3 deaths per 100,000 people.

In addition, AI/ANs have the highest uninsured rates (25.4 percent); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50 percent higher). AI/ANs also have the highest Hepatitis C mortality rates nationwide (10.8 per 100,000); and higher rates of chronic liver disease and cirrhosis deaths (2.3 times that of Whites). Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for AI/ANs. For instance, from 1999 to 2015 AI/ANs encountered a 519 percent increase in drug overdose deaths—the highest rate increase of any demographic nationwide.[9] All of these health determinants of health and poor health status could be dramatically improved with adequate investment into the health, public health and health delivery systems operating in Indian Country.

The VA's Veteran Outreach Toolkit lists AI/ANs as an "at-risk" population, citing this troubling suicide rate. Additionally, AI/ANs grapple with complex behavioral health issues at higher rates than any other population-for children of AI/AN vet-

[1] The full IHS Tribal Budget Formulation Workgroup Recommendations are available at *https://www.nihb.org/docs/04242019/307871__NIHB%20IHS%20Budget%20Book__WEB.PDF*

[2] *See* 38 U.S.C. 117; P.L. 111–81.

[3] VA, Veteran Suicide by Race/Ethnicity: Assessments Among All Veterans and Veterans Receiving VHA Health Services, 2001–2014 (Aug. 2017) (citing CDC statistics).

[4] Lauren Korshak, MS, RCEP, Office of Health Equity and Donna L. Washington, MD, MPH, Health Equity-QUERI National Partnered Evaluation Center, and Stephanie Birdwell, M.S.W., Office of Tribal Government Relations.

[5] Johnson, P. J., Carlson, K. F., & Hearst, M. O. (2010). Healthcare disparities for American Indian veterans in the United States: a population-based study. Medical care, 48(6), 563–569. doi:10.1097/MLR.0b013e3181d5f9e1.

[6] U.S. Department of Veterans Affairs. (2015a). American Indian and Alaska Native Veterans: 2013 American Community Survey. Retrieved from *https://www.va.gov/vetdata/docs/SpecialReports/AIANReport2015.pdf*

[7] U.S. Department of Housing and Urban Development, U.S. Department of Veterans Affairs, National Center on Homelessness Among Veterans. Veteran Homelessness: A Supplemental Report to the 2010 Annual Homeless Assessment Report to Congress. Washington, D.C.2011:56.

[8] Indian Health Service. 2018. Indian Health Disparities. Retrieved from *https://www.ihs.gov/newsroom/includes/themes/responsive2017/display__objects/documents/factsheets/Disparities.pdf*

[9] Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas—United States. MMWR Surveill Summ 2017;66(No. SS–19):1–12. DOI: *http://dx.doi.org/10.15585/mmwr.ss6619a1*

erans, this is compounded by the return of a parent who may suffer from post-traumatic stress disorder (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.

Funding Levels for IHS versus VHA: The Need for Advance Appropriations

1. Tribes and NIHB strongly urge Congress to pass bipartisan legislation that would enact advance appropriations for Indian programs

By the most recent estimates, federally-operated IHS facilities, Tribally-operated health facilities and programs, and urban Indian health programs collectively serve roughly 2.6 million AI/ANs nationwide. In comparison, the VHA serves roughly 6.9 million Veterans through 18 regional networks. In FY 2019 discretionary appropriations for IHS equaled roughly $5.8 billion; in comparison, spending within the VHA totaled over $76 billion. In effect, this means that while the VHA service population is roughly only three times the size of the Indian health system, its discretionary appropriations are approximately thirteen times higher than for IHS.

According to the IHS Tribal Budget Formulation Workgroup, IHS appropriations must reach nearly $38 billion—phased in over twelve years—in order to fully meet current health needs. In other words, even if today IHS were fully funded at the level of need identified by sovereign Tribal Nations, it would only equal half the total FY 2019 discretionary appropriation for the VHA. Indeed, the federal government's continued abrogation of its trust responsibility for health services for AI/ANs is clearly exemplified by the gravity of the divide in health funding for the VHA versus IHS.

Although the IHS budget has nominally increased by 2–3 percent each year, these increases are barely sufficient to keep up with rising medical and non-medical inflation, population growth, facility maintenance costs, and other expenses. According to a 2018 report by the Government Accountability Office (GAO–19–74R), from 2013 to 2017, IHS annual spending increased by roughly 18 percent and per capita spending increased by roughly 12 percent; in comparison, annual spending under the VHA increased by 32 percent and per capita spending increased by 25 percent during the same time period.[10] The widening gap in funding levels between IHS and the VHA only serves to perpetuate the disproportionately higher levels of health disparities experienced by Native Veterans and AI/ANs overall.

Unequivocally, the U.S. federal government has a moral and ethical obligation to ensure all U.S. Veterans can access quality health services—and it must continue to honor this responsibility. But the U.S. also has a Trust obligation to ensure all AI/ANs, including Native Veterans, can receive quality health services, that it continuously fails to honor. It is long past due for the federal government to make good on its constitutional obligation to Native Veterans an all AI/AN Peoples.

The discrepancies do not end with chronic underfunding of IHS. Of the four major federal healthcare entities, IHS is the only one subject to the devastating impacts of government shutdowns and continuing resolutions (CRs). This is because Medicare and Medicaid receive mandatory appropriations, and the VHA was authorized by Congress to receive advance appropriations nearly a decade ago. As a result, the VHA has been insulated from every government shutdown, CR, and discretionary sequestration over the past decade. While it is true that no sector of government is fully spared by the repercussions of endless shutdowns and CRs, those repercussions are neither equal nor generalizable across all entities. In fact, the worst consequences are levied on Indian Country.

For instance, during the 2013 federal budget sequester, the IHS budget was slashed by 5.1%—or $221 million—levied on top of the damage elicited by that year's government shutdown. In fact, IHS was the only federally funded healthcare entity that was subject to full sequestration because Congress had already exempted the VHA when it authorized it to receive advance appropriations. Once again, during the most recent 35-day government shutdown—the nation's longest and most economically disastrous—IHS was the only federal healthcare entity to be shut down. While direct care services remained non-exempt, providers were not receiving pay. Administrative and technical support staff—responsible for scheduling patient visits, conducting referrals, and processing health records—were furloughed. Contracts with private entities for sanitation services and facilities upgrades went

[10] Government Accountability Office. 2018. Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs. Retrieved from *https://www.gao.gov/assets/700/695871.pdf*

weeks without payments, prompting many Tribes to exhaust alternative resources to stay current on bills.

Several Tribes shared that they lost physicians to hospitals and clinics not impacted by the shutdown. Some Tribal leaders even shared how administrative staff volunteered to go unpaid so that the Tribe had resources to keep physicians on the payroll. These are just a few examples of the everyday sacrifices and ongoing struggles that widen the chasm between the health services afforded to AI/ANs and those afforded to the nation at large. While it is impossible to measure the full scope of adversity brought on by the 35-day government shutdown, one reality remains clear—Indian Country was both unequivocally and disproportionately impacted.

In 2018, GAO released a report examining the benefits of authorizing advance appropriations for the IHS and thus establishing parity between IHS and the VHA (GAO–18–652). The report outlined how Congress has been forced to use short-term or full-year CRs in all but four of the last 40 years. In fact, only once in the past two decades—in FY 2006—has Congress successfully passed the Interior, Environment, and Related Agencies appropriations package (which funds IHS) before the end of the fiscal year. As a result, year after year, the Indian health system is curtailed from making meaningful improvements towards the availability and quality of health services and programs, further restraining efforts to advance quality of life and health outcomes for AI/ANs.

While a CR is always preferable to a government shutdown, they are not devoid of obstacles that directly impact patient care. Because of budget authority constraints under a CR, IHS is prohibited from initiating any new activities or projects that were not expressly authorized or appropriated in the previous fiscal year. In addition, under a CR, IHS must exercise significant precaution over expenditures, and is generally limited to simply maintain operations as opposed to improve them. When you compound the impact of chronic underfunding and endless use of CRs, the inevitable result are the chronic and pervasive health disparities seen across Indian Country. As such, Tribal Nations and NIHB strongly urge the Senate to pass S.229—Indian Programs Advance Appropriations Act and S. 2541—Indian Health Service Advance Appropriations Act of 2019 that would authorize advance appropriations for Indian programs.

Lack of IHS and VHA Care Coordination and Reimbursement Agreements

1. Congress should pass legislation exempting Native Veterans from copays and deductibles

Section 222 of IHCIA prohibits cost sharing of AI/ANs in cases where an AI/AN receives a referral from IHS or a Tribal Health Program (THP) under the Purchased/Referred Care (PRC) program. Like IHS and the Marketplace, the VHA is another means by which the federal government must uphold its trust responsibility to AI/ANs. As such, it is imperative that Congress enact legislation that requires the VHA to similarly exempt AI/AN Veterans from copays and deductibles in the VA system in recognition of the federal trust responsibility.

Tribal Nations and NIHB appreciate the intent of S. 1001—*Tribal Veterans Health Care Enhancement Act* and its goal of holding all Native Veterans harmless from copays and deductibles. However, Tribes and NIHB strongly believe that copay costs should not be shifted to IHS or Tribal governments. The VHA must absorb these costs on behalf of AI/AN Veterans in recognition of their Trust and Treaty obligations to AI/AN Peoples. Shifting costs to IHS would also be in violation of Section 405 of IHCIA which established IHS as the payer of last resort. As such, Tribes and NIHB strongly urge that S. 1001 be amended to require the VHA to cover the full cost of copays for AI/AN Veterans, and ensure that IHS, Tribes, and Native Veterans are held harmless of these costs.

2. Congress should clarify statutory language under section 405(c) of the Indian Health Care Improvement Act and make explicit the VHA's requirement to reimburse IHS and Tribes for services under Purchased/Referred Care (PRC)

By law, an AI/AN Veteran is eligible for services under both the VHA and IHS. A 2011 report showed that approximately one-quarter of IHS-enrolled Veterans use the VHA for health care, commonly receiving treatment for diabetes mellitus, hypertension or cardiovascular disease from both federal entities.[11] According to the VA, more than 2,800 AI/AN Veterans are served at IHS facilities.[12] In instances where an AI/AN veteran is eligible for a particular health care service from both the VA

[11] Kramer, BJ, Wang M, Jouldjian S, Lee ML, Finke B, Saliba D. Healthcare for American Indian and Alaska native veterans: The roles of the veterans health administration and the Indian Health Service. Medical Care.

[12] VA/IHS listening session held on May 15, 2019

and IHS, the VA is the primary payer. Under section 2901(b) of the Patient Protection and Affordable Care Act (ACA), health programs operated by the IHS, Tribes and Tribal organizations, and urban Indian organizations (collectively referred to as the "I/T/U" system) are payers of last resort regardless of whether or not a specific agreement for reimbursement is in place.

Section 407(a)(2) of the Indian Health Care Improvement Act (IHCIA) reaffirms the goals of the 2003 Memorandum of Understanding (MOU) between the VHA and IHS established to improve care coordination for Native Veterans. In addition, during permanent reauthorization of IHCIA, section 405(c) was amended to require the VHA to reimburse IHS and Tribes for health services provided under the PRC program. In 2010, the VHA and IHS modernized their 2003 MOU to further improve care coordination for Native Veterans by bolstering health facility and provider resource sharing; strengthening interoperability of electronic health records (EHRs); engaging in joint credentialing and staff training to help Native Veterans better navigate IHS and VHA eligibility requirements; simplifying referral processes; and increasing coordination of specialty services such as for mental and behavioral health.

According to a 2019 GAO report (GAO–19–291), since implementation of the 2010 MOU, the VHA has reported entering into 114 signed agreements with Tribal Health Programs (THPs), along with 77 implementation agreements to strengthen care coordination. While a single national reimbursement agreement exists between federally-operated IHS facilities and the VHA, THPs continue to exercise their sovereignty by entering into individual agreements with the VHA. From 2014 to 2018, those reimbursement agreements with THPs alone increased by 113 percent.

VA reimbursements to IHS and THPs overall during that same time period increased by 75 percent, reaching $84.3 million in total. Yet these increased reimbursements still represent just a fraction of one percent of the VA's annual budget. While recent increases in the quantity of agreements and reimbursements demonstrates a positive trend, there continue to be significant challenges in care coordination between the VHA and IHS. The 2019 GAO report highlighted three overarching challenges related to care coordination: ongoing issues in patient referrals between I/T/U facilities and the VHA; significant problems in EHR interoperability; and high staff turnover within both VHA and IHS. These complications continue to stifle Native Veterans' access to health care, erodes patient trust in both IHS and VHA health systems, and obstructs efforts to improve health outcomes.

These issues are exacerbated by VHA claims that no statutory obligation exists for reimbursement of specialty and referral services provided through IHS or THPs. To clarify, the VHA currently reimburses IHS and THPs for care that they provide directly under the MOU. Despite repeated requests from Tribes, the VA has not provided reimbursement for PRC specialty and referral care provided through IHS/THPs. This is highly problematic, as AI/AN Veterans should have the freedom to obtain care from either the VA or an Indian health program. If a Veteran chooses an Indian health program, that program should be reimbursed even if the service could have been provided by a VA facility or program in the same community.

But because that doesn't happen, it creates greater care coordination issues and burdensome requirements for Native Veterans. For example, if a Native veteran goes to an IHS or THP for service and needs a referral, the same patient must be seen within the VA system before a referral can be secured. This means the VHA is paying for the same services twice, first for those primary care services provided to the Veteran in the IHS or THP facility, and then again when the patient goes back to the VHA for the same primary care service to then receive a VHA referral. This is neither a good use of federal funding, nor is it navigable for veterans. In order to provide the care that Native Veterans need, many THPs are treating Veterans or referring them out for specialty care and paying for it themselves so that they can be treated in a timely and competent manner. For those Veterans that do go back to the VHA for referrals, there is often delayed treatment and a significantly different standard of care provided.

As a step toward mitigating the confusion surrounding reimbursement for care provided by the VHA, NIHB recommends the VHA include PRC in future IHS/THP reimbursement agreements, so that there is no further rationing of health care provided by IHS and THPs to Native Veterans and other eligible AI/ANs. Ultimately, however, NIHB recommends that Congress clarify the statutory language under section 405(c) of IHCIA and make explicit VHA's requirement to reimburse under PRC.

3. NIHB strongly supports the GAO recommendation that the VHA work with IHS to create written policy or guidelines to clarify how referrals from IHS and THP facilities to VHA facilities for specialty care should be managed, and to establish specific targets for measuring action on MOU performance measures

The GAO report cited how, for example, facilities reported conflicting information about the processes for referring Native Veterans from IHS or Tribal facilities to VHA, and VA headquarters officials confirmed that there is no national policy or guide on this topic. One of the leading collaboration practices identified by 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 consistent understanding of the options available for referral of Native Veterans for specialty care.

As is currently the case, the result is duplicative care for AI/AN Veteran and duplicative costs for the federal government. NIHB has heard that some AI/AN Veterans prefer to simply hand carry their EHR records from their IHS provider to their VHA provider to avoid having to receive the same care twice. In short, lack of written policy perpetuates this burdensome, pointless, and complicated process that only serves to frustrate patients, worsen administrative red tape, and increase expenditures.

For numerous Tribes, and especially for the Veterans themselves, it is an undue barrier to constantly have to refer patients back and forth to the VA that ultimately wastes time and delays access to care. The GAO identified that IHS and VA lack sufficient measures for quantifiable assessments of progress towards MOU goals and objectives. Although the VHA and IHS have created fifteen performance measures, no specific targets or indicators have been established that allow Tribes to measure progress towards achieving the goals and objectives of the MOU.

4. Tribes and NIHB have strongly recommended that the VHA consult with Tribes and work through their MOU with IHS to create and publish a living list of available Veterans Liaisons/Tribal Veterans Representatives across all IHS and VHA regions

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 AI/AN Veterans also sends the message that care for AI/AN Veterans is not a priority. But despite repeated Tribal demands, the agency has yet to implement this request.

A closely related issue is the fact that Native Veterans are still charged copays and deductibles when receiving services under the VHA. The federal government's trust responsibility for health services extends to all Native Veterans. In recognition of this, AI/ANs do not have copays or deductibles for services received at an I/T/U facility. Additionally, the ACA further affirmed the trust responsibility when it included language at Section 1402 to exempt all AI/ANs under 300 percent of the federal poverty level from co-pays and deductibles on plans purchased on the health insurance Marketplace.

5. Congress should pass the bipartisan S. 524—Department of Veterans Affairs Tribal Advisory Committee Act of 2019

Tribal Nations and NIHB have also strongly advocated for the seating of a Tribal Advisory Committee (TAC) within the Office of the Secretary at the VA. Establishing a Veteran TAC is essential for strengthening the government-to-government relationship, and improving VA accountability to AI/AN Veteran health needs. Through the seating of a TAC, top VA officials would have the ability to hear directly from Tribal leaders about the unique health priorities and challenges that impact Native Veterans. In addition, it would help prevent the development of new rules or policies that would adversely affect care for AI/AN Veterans. As such, Tribes and NIHB strongly support the bipartisan S. 524, introduced by Senator Tester, and urges the Senate VA Committee to pass this significant legislation.

EHR Interoperability and Health Information Technology (IT) Modernization

1. Congress must ensure parity between the VA and IHS in appropriations and technical assistance for health IT modernization

The Resource and Patient Management System (RPMS)—which is the primary health IT system used across the Indian health system—was developed in close partnership with the VHA and has become partially dependent on the VHA health

IT system, known as the Veterans Information Systems and Technology Architecture (VistA). The RPMS is an early adoption of VistA for outpatient use, and the legacy system was designed with the decision to keep the same underlying code infrastructure as VistA. IHS began developing different clinical applications for their outpatient services, and the VHA adopted code from RPMS to provide this functionality for VistA.

RPMS eventually began to use additional VistA code as the need for inpatient functionality increased. This type of enhancement and support for both the IHS and VHA was made possible because VistA's software components were designed as an Open Source solution. The RPMS suite is able to run on mid-range personal computer hardware platforms, while applications can operate individually or as an integrated suite with some availability to interface with commercial-off-the-shelf (COTS) software products.

Currently, the RPMS manages clinical, financial, and administrative information throughout the I/T/U, although, it is deployed at various levels across the service delivery types. However, in recent years, many Tribes and even several Urban Indian Health Programs (UIHPs) have elected to purchase their own COTS systems that provide a wider suite of services than RPMS, have stronger interoperability capabilities, and are significantly more navigable and modern systems to use. As a result, there exists a growing patchwork of EHR platforms across the Indian health system.

When the VA announced its decision to replace VistA with a COTS system in 2017 (Cerner), concentrated efforts to re-evaluate the Indian Health IT system accelerated, and arose significant concerns as to how VHA and I/T/U EHR interoperability would continue. In 2018, IHS launched a Health IT Modernization Project to evaluate the current I/T/U health IT framework, and to, through Tribal consultation, key informant interviews, and national surveys, develop a series of next steps and recommendations towards modernizing health IT in Indian Country.

Difficulties in achieving IT interoperability among VA, IHS, and THP facilities pose significant problems for Native Veterans' care coordination. Unfortunately, the VHA and IHS have yet to identify a systemic solution towards increasing EHR interoperability between I/T/U and VHA hospitals, clinics, and health stations. A resulting scenario includes situations where a THP provider—having treated a Veteran and referred them to the VHA for specialty care—would not receive the Veteran's follow-up records as quickly as if they had streamlined access to each other's systems.

Now that the VHA is transitioning to the Cerner system, it has worsened concerns around care coordination and sharing of EHRs between I/T/U and VHA systems. The fact is, Native Veterans are suffering today from the lack of health IT interoperability. It is shameful that Native Veterans are put in a position where they have to find their own solutions to streamline EHR sharing, most shockingly exemplified by anecdotes of AI/AN Veterans hand carrying their health records between their IHS and VHA provider.

Congress must ensure that the Indian health system is fully integrated across the development and implementation of the VHA's transition to Cerner; however, thus far it has failed to do so. By the most current estimates, the transition to Cerner will take up to 10 years to fully implement, with a current price tag of roughly $16 billion. None of the existing estimates include calculations of how much it will cost to include IHS in this transition; however, through its Health IT Modernization Project, IHS is attempting to arrive at an estimated dollar figure for this cost.

Tribes and NIHB were pleased to see that the FY 2020 President's Budget included a request for a new $20 million line item in the IHS budget to assist with health IT modernization; however, we were disappointed that the FY 2020 Senate Interior Appropriations package included only $3 million of this request. In comparison, the FY 2020 Senate Military Construction funding bill budgeted $1.1 billion to assist VHA in its transition. Ensuring EHR interoperability between I/T/U and VHA health systems will be impossible if Congress fails to establish parity in appropriations for VHA and IHS health IT modernization.

Conclusion

The Federal Government has a dual responsibility to Native Veterans that continues to be ignored. As the only national Tribal organization dedicated exclusively to advocating for the fulfillment of the federal trust responsibility for health, NIHB is committed to ensuring the highest health status and outcomes for Native Veterans. We applaud the Senate Committee on Indian Affairs 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 health outcomes.

PREPARED STATEMENT OF THE UNITED SOUTH AND EASTERN TRIBES SOVEREIGNTY PROTECTION FUND (USET SPF)

On behalf of the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF), we are pleased to provide the Senate Committee on Indian Affairs with testimony for the record for the oversigh hearing on "Recognizing the Sacrifice: Honoring A Nation's Promise to Native Veterans" and legislative hearing to receive testimony on S.1001 & S.2365. USET SPF is appreciative of the Committee's tcommitment to help address some of the unique barriers that American Indian and Alaska Native (AI/AN) veterans face when returning from service, particularly when seeking healthcare. Whether delivered through the Indian Health Service (IHS) or the Department of Veterans' Affairs (VA), AI/AN veterans have pre-paid for their healthcare, both through the cession of Tribal homelands and the defense of our nation. As part of the federal trust obligation, it is incumbent upon the Committee to improve access to quality and culturally competent healthcare for AI/AN veterans.

USET SPF is a non-profit, inter-tribal organization representing 30 federally recognized Tribal Nations from the Canadian Border to the Everglades and across the Gulf of Mexico.[1] Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service, which contains 36 IHS and Tribal health care facilities. Our patients receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93–638.

As the Committee is aware, AI/AN people serve in the military at higher rates per capita than any other group in the nation. In addition, the VA has found that AI/AN veterans are more likely to have a serviceconnected disability than non-Indian veterans yet face significant disparities in care when compared to other veterans. In the USET SPF region, AI/AN veterans are often faced with access to only either the limited services provided by chronically underfunded IHS and Tribally-operated facilities or no services at all. As the Committee considers measures that would expand and improve access to quality healthcare for AI/AN veterans, USET SPF requests the exercise of this body's oversight functions ensure that the actions of all agencies of the federal government, including the VA, reflect and uphold the trust obligations unique to our population. Below, we provide comments to the Committee regarding how the Federal Government must address these barriers, as well as recommendations on S. 1001 and S. 2365.

IHS–VA MOU

USET SPF requests the Committee exercise its oversight function to facilitate a strengthening of the 2010 memorandum of understanding (MOU) between the VA and IHS. As the Committee is likely aware, in 2010, IHS and the VA entered into an expanded MOU with the goal of improving coordination between both agencies for AI/AN veterans. The intention of the MOU was to better facilitate patient care for AI/AN veterans across country within both agencies. However, a report by the Government Accountability Office (GAO) in 2019, "Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans," found that more action is needed to strengthen oversight and coordination between IHS and the VA regarding implementation of the MOU.

Reimbursement Agreements for PRC in IHS–VA MOU

Since 2010, USET SPF, as well as Tribal Nations and Tribal organizations across the country, has strongly advocated for the VA to reimburse for all services provided by or through Tribal health programs. IHS and Tribal health programs are not always able to directly provide AI/AN veterans with all necessary health care services. Like other AI/ANs, many of these veterans receive essential health services through

[1] USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chickahominy Indian Tribe (VA), Chickahominy Indian Tribe-Eastern Division (VA), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Rappahannock Tribe (VA), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

the Purchased/Referred Care (PRC) program, which authorizes the purchase of services from a network of private providers when care is not available at IHS or Tribal facilities. PRC is an integral part of IHS and Tribal health care systems, as it facilitates access to care that the federal government has failed in providing the funding to deliver directly.

However, the VA does not currently reimburse IHS or Tribal programs for services provided using PRC funds. Instead, the VA requires that veterans in need of care return to the VA for a referral instead—an inefficient and time consuming process. USET SPF asserts that this policy fails to prioritize the healthcare necessities of AI/AN veterans by creating additional and unnecessary burdens. The continued lack of coordination of care between the VA and the Indian Healthcare System for the full complement of health care services will only continue to create additional barriers in access to care for our veterans.

This limitation is further contrary to the plain language of Section 405(c) of the Indian Health Care Improvement Act, which provides for reimbursement "where services are provided through the [Indian Health] Service, an Indian Tribe, or a Tribal organization. . ." (emphasis added) without limitation to direct services. It is also in conflict with Section 2901(b) of the Affordable Care Act, which specifies that health programs operated by IHS, Tribal Nations, Tribal organizations, and UIOs are payers of last resort. Through these provisions, Congress clearly intended to shield IHS and Tribal PRC dollars from being used to pay for services when other sources of funding are available, including funding from VA. Accordingly, USET SPF strongly recommends the Committee facilitate measures that would require the VA to reimburse for all services provided by or through Tribal health programs.

Preservation of Existing Reimbursement Agreements in IHS–VA MOU

USET SPF underscores to the Committee that the existing reimbursement agreements within MOU have demonstrated success in facilitating patient care for AI/AN veterans, and therefore must continue to be upheld and preserved. Specifically, we underscore the importance of preserving the IHS All-Inclusive rate on reimbursements for outpatient services for AI/AN veterans delivered through IHS. Should IHS and the VA determine any revisions to the MOU, we request the Committee work to ensure the preservation of the All-Inclusive rate within the MOU. This will ensure that critical dollars remain within the Indian Health System to be able to continue support the services provided to AI/AN veterans in fulfillment of the trust obligation.

Improved VA–IHS EHR Interoperability

As discussed during the hearing, there are challenges with regard to information technology interoperability which have made it difficult for IHS and VA healthcare providers to have access important patient information within one another's EHR systems. Since 2018, the VA has been working to replace the agency's current electronic health record (EHR) system, VistA, to an off-the-shelf EHR known as Cerner Millennium. Since then, IHS has been considering either maintaining its current system, the Resource and Patient Management System, or implementing a new EHR system altogether—previously, IHS and the VA participated in cost sharing for necessary periodic updates.

While the VA and IHS committed to facilitate the interoperability of health information data systems between both agencies to share information on common patients, challenges continue as a result of the differences in EHR systems. USET SPF underscores that interoperability between EHR systems must be prioritized as healthcare providers for AI/AN veterans must have access to real-time, life-saving data, and we strongly recommend the Committee consider the necessary resources to facilitate this interoperability.

S. 1001, Tribal Veterans Health Care Enhancement Act

The VA is a vital access point for AI/AN veterans when seeking healthcare. AI/AN veterans, who may suffer from chronic conditions or injuries sustained as a result of their service, often require specialized care than what the Indian Healthcare System may be able to provide and are referred to a VA facilities. However, AI/AN veterans are currently subject to standard copays for services received within the VA. When healthcare is received through IHS or Tribally-operated facilities, AI/AN veterans are not subject to any cost-sharing. However, AI/AN veterans are subject to certain copayments, such as for urgent care services, when they are receiving care from VA facilities. Subjecting AI/AN veterans to any copayments as a condition of healthcare access is a violation of the federal trust responsibility, which all federal agencies share in equally. Further, AI/AN veterans may be discouraged from seeking critical and life-saving healthcare if they are subject to copays for certain VA services.

USET SPF recognizes that S. 1001 seeks to address the harmful financial impacts of unpaid VA balances accrued by AI/AN Veterans who have been referred to the Department of Veterans Affairs (VA) health system by Indian health clinics. The intent of the bill is to ensure AI/AN veterans receive the care to which they are entitled without incurring copay costs. While USET SPF supports the intent of S.1001, we cannot support this legislation, as it would shift the cost of care for AI/AN veterans from the VA to the severely underfunded IHS and Tribally-operated health clinics, as well as violate current law naming IHS as the payer of last resort. USET SPF contends that the Indian Health System and AI/AN veterans are best served through a waiver of cost-sharing entirely.

Congress has previously recognized the inconsistencies between the federal trust responsibility to provide health care to AI/AN and the assessment of premiums and cost-sharing via federal health programs. In 2009, Congress passed the American Recovery and Reinvestment Act, which eliminated premiums and cost-sharing for AI/AN patients when accessing services via Medicaid and the Children's Health Insurance Program. This provision avoids the assessment of payments to individual AI/AN without impacting already insufficient IHS funds. And it upholds the federal trust obligation by ensuring that care provided to AI/AN continues to be delivered at no cost. With this in mind, we call for this policy to be extended to all federal health care programs and facilities, including the VA.

S. 2365, Health Care Access for Urban Native Veterans Act

Currently, approximately 78 percent of AI/ANs do not live on Tribal reservations. However, Urban Indian Organizations (UIOs) are not currently considered eligible to for inclusion in the VA reimbursement agreements, even though UIOs provide critical healthcare services to AI/AN veterans residing in urban areas. Instead, the VA made a discretionary decision to deem UIOs ineligible for inclusion in reimbursement agreements within the IHS–VA MOU.

S. 2365, the *Health Care Access for Urban Native Veterans Act*, introduced by Senator Tom Udall (D–NM), would rightly include UIOs in existing statute that requires the VA to reimburse IHS and Tribal health facilities for services they provide to AI/AN veterans. USET SPF supports S.2365, which would address the oversight in legislation that made UIOs the only part of the IHS/Tribal/Urban (I/T/U) system to not receive reimbursement under the VA–IHS MOU reimbursement agreement.

USET SPF reminds the Committee that the federal trust responsibility to provide healthcare to AI/ANs in perpetuity is not limited to where an AI/AN veteran resides. We further remind the Committee that Congress created the UIO system to honor a federal trust obligation and assert that UIOs are wellpositioned to play a vital role in closing the gap in service to AI/AN veterans. The passage of S.2365 would increase access to care and provide parity to UIOs by ensuring that all three branches of the I/T/U system receive reimbursement for health care services delivered to AI/AN veterans. We request support from the Committee and Congress on this crucial legislation.

Conclusion

It is shameful that AI/AN veterans continue to face ongoing challenges when it comes to accessing the quality healthcare to which they are entitled. The federal trust obligation to provide comprehensive healthcare to Tribal Nations and AI/AN veterans exists in perpetuity and is shared by all federal entities including IHS, the VA, as well as Congress. It is incumbent upon the whole of the federal government to remove barriers in accessing healthcare for AI/AN veterans, and we encourage the Committee to work to address these problems, in consultation with Tribal Nations, as well as strengthen existing partnerships between the VA and the Indian Healthcare System.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO TO HON. ROBERT L. WILKIE

Question 1. As you know, navigating the VA claims process can be challenging, and I'm thankful we have dedicated Veteran Service Officers (VSOs) across the country ready to help Veterans understand their benefits. However, often due to the financial burdens and bureaucratic red tape associated with the VA requirements for Tribes to create specific organizations for Veterans, Tribes are often unable to receive formal VA recognition necessary to become accredited VSOs. How can the VA reduce this burden?

Answer. The purpose of VA's Accreditation and Discipline Program is to ensure that claimants for Department of Veterans Affairs (VA) benefits have responsible, qualified representation in the preparation, presentation, and prosecution of the

claims for Veterans' benefits. 38 Code of Federal Regulations (CFR) § 14.626. VA accredits three categories of claims practitioners: (1) representatives of recognized Veterans Service Organizations (VSO); (2) attorneys; and (3) claims agents. See 38 United States Code (U.S.C.) § § 5902, 5904; 38 CFR § 14.629. The mechanisms for ensuring the competence, qualifications, and character of the representatives varies for each category. For attorneys, VA generally relies upon the state bar licensure process to ensure the attorney's qualifications. 38 CFR § 14.629(b)(1)(ii). For claims agents, VA conducts a character and fitness investigation and administers a written examination. 38 CFR § 14.629(b)(1)(i). For VSO representatives, VA generally relies upon the recognized VSO to verify the representative's qualifications and to provide training and oversight. 38 CFR § 14.629(a).

For an organization to be recognized as a VSO, it must meet requirements set forth in 38 CFR § 14.628(d), which include a showing that the organization's primary purpose is to serve Veterans, that the organization demonstrates a "substantial service commitment to Veterans" (i.e., has a sizeable organizational membership or provides services to a sizeable number of Veterans), that it commits a significant portion of its assets to Veterans programs, that it maintain a policy and capability of providing complete claims service to Veterans, and that it take affirmative action, including training and monitoring of representatives, to ensure proper handling of claims. VA views these longstanding requirements as essential to ensure that VSOs provide competent and qualified service through their representatives.

Prior to 2017, VA regulations provided for recognition of "national" VSOs, "state" VSOs, and "regional or local" VSOs. In 2017, VA revised its regulations to clarify that tribal organizations may be recognized as VSOs in a manner similar to state organizations. 82 Fed. Reg. 6265 (Jan. 19, 2017). That rulemaking did not change the longstanding requirements for recognition as a VSO, as described above.

In the course of that rulemaking, we received comments indicating that some tribal organizations may have difficulty satisfying the requirements for recognition as a VSO, including the requirements relating to primary purpose, size, funding, and training. In response, VA explained that its goal is to ensure that VA-accredited organizations provide long-term, competent representation to Veterans, and that the requirements in section 14.628(d), which apply equally to all organizations seeking VA recognition, are protective of that mission. 82 Fed. Reg. at 6270. We noted also that the rule provided for recognition of tribal organizations sponsored by "one or more tribal governments," offering a potential means for tribal governments to collaborate to meet the requirements for recognition as a VSO. We further explained that, in providing for recognition of tribal organizations as VSOs, we did not intend to limit other existing mechanisms for obtaining VA accreditation. We noted that "there are several ways that individuals, including tribal members, tribal government employees, and others who work within and serve tribal or Native American communities, may be accredited by VA to represent claimants." 82 Fed. Reg. at 6271. We explained that an individual may apply for accreditation as a representative through an existing VA-accredited organization or may apply for accreditation in an individual capacity as an attorney or claims agent. The 2017 rule also included provisions clarifying that a Tribal Veterans Service Officer could be, but is not required to be, accredited through a recognized state VSO in the same manner as county VSOs may be accredited through state organizations. 38 CFR § 14.629(a)(2).

As VA hopes the foregoing clarifies, the standards VA uniformly applies to organizations seeking accreditation as VSOs serve a critical purpose in ensuring that VSOs provide long-term, competent, and accountable representation to Veterans. At the same time, VA provides several methods by which an individual may become accredited to represent Veterans, either through organizations or in an individual capacity. We do not believe our processes impose unnecessary or excessive requirements upon any individuals who wish to become accredited to represent Veterans.

In order to improve VA's communication to tribal governments regarding the requirements for VA recognition and accreditation, VA's Office of Tribal Government Relations (OTGR) has been informing tribal Veterans offices about the change in VA regulations and offering to assist those that are interested in requesting VA recognition with fully developing their request before submitting it to the Office of General Counsel for review.

Question 1a. Is there a way for the VA to provide grants to help Tribes gain access to VSOs, and is this something the VA is exploring?

Answer. At this time VA does not have legislative authority to provide grants to tribal governments to help them finance the establishment or development of their tribal Veterans offices for the purpose of assisting Veterans with their VA benefits claims. If given such authority, VA would need to issue regulations for implementation and publish a Notice of Funding Availability in the Federal Register. As VA

noted in the response above, there are currently several different pathways for individuals, including tribal members, tribal government employees, and other individuals who serve tribal communities to be accredited by VA to represent Veterans on their VA benefits claims.

Question 2. The transition process presents challenges for every Veteran and finding gainful employment after separating is critical for adjusting back to civilian life. Over half of Native Veterans are unemployed or not in the labor force, and I think the VA could do more to help these Veterans join the workforce. How is the VA helping Native Veterans find employment?

Answer. VA's Vocational Rehabilitation and Employment (VR&E) Program assists Servicemembers and Veterans with service-connected disabilities prepare for, obtain, and maintain suitable employment. VR&E participants are provided all services and assistance necessary to achieve an employment outcome including, but not limited to:

- Educational, vocational, employment, and personal and work adjustment counseling;
- Vocational and other training services and assistance;
- Payment of tuition, fees, books, and supplies, if training is needed;
- Subsistence allowance, if training is needed;
- Job placement and post-placement services;
- Assistance with starting a business;
- Special services to address necessary accommodations to ensure successful training and job placement;
- Coordination of health care services within Veterans Health Administration (VHA); and
- Other incidental goods necessary to achieve employment.
- VA case managers work with local resources and the appropriate VA employment programs to assist Native Veterans to access employment when appropriate for the Veteran.

VR&E accomplishes this mission by meeting the Veteran population where they are located by the placement of more than 1,000 highly trained Vocational Rehabilitation Counselors (VRC) across the nation at more than 350 locations, including VA regional offices and out-based locations such as college campuses, military installations, other VA facilities, and leased office space. In addition, the use of tele-counseling services increases VR&E's ability to reach individuals who may prefer and benefit from virtual participation. Furthermore, VBA hosts Economic Investment Initiatives, in which VA partners with Federal, state, local, and tribal governments, as well as businesses and nonprofit organizations, to support the total economic wellbeing of Veterans in areas designated as Qualified Opportunity Zones

VA's Office of Transition and Economic Development recently partnered with the U.S. Chamber of Commerce and Hiring Our Heroes to incorporate Hiring Fairs and Career Summit into VA's Economic Investment Initiatives. Additionally, VA hosts Economic Investment Initiatives, in which VA partners with Federal, state, local, and Tribal governments, local businesses and nonprofit organizations, to support the total economic well-being of Transitioning Servicemembers, Veterans, family members and caregivers with the following events:

- Hiring Fairs
- Benefits Fairs (i.e. VR&E, Education, Personalized Career Planning and Guidance (PCPG))
- Workshops (Resume Writing, Direct Hiring Authorities)

In addition, VA's PCPG (historically known as Chapter 36, Education & Career Guidance) is a great opportunity for Servicemembers, Veterans and dependents to receive personalized counseling and support to help guide their career paths, which ensures the most effective use of their VA benefits, and achieve their academic and career goals. PCPG is available free of charge if applicants meet one of the following conditions:

- Veteran or dependent, eligible for educational benefits under a program that VA administers;
- Discharged or released from active duty under honorable conditions, not more than one year ago; or
- Active duty Servicemember with six months or less remaining before scheduled release or discharge from service.

Question 2a. How is the VA ensuring that every Native Veteran is aware of the help VA can provide, and is able to access it, even in areas without broadband or a local representative?

Answer. VA accomplishes this through comprehensive engagement, which includes conducting training and holding outreach events in tribal communities. VA also works with the Indian Health Service (IHS) and Tribal Health Programs within tribal communities to enroll eligible Veterans in VHA health care. VBA hosts Economic Investment Initiatives, in which VA partners with Federal, state, local, and tribal governments, as well as businesses and nonprofit organizations, to support the total economic wellbeing of Veterans in areas designated as Qualified Opportunity Zones. While these initiatives are new, VA recently held one in the South Puget Sound Region of Washington State in conjunction with the Washington State Department of Veterans Affairs and representatives from regional tribal governments to ensure that their membership was included in benefits and outreach efforts specific to their needs.

VA continues to conduct outreach events and claims clinics, and Fiscal Year (FY) 2020 will be the third consecutive year in which VA and OTGR partner to conduct more than 30 claims clinics across the Indian Nations. VA facilitates Stakeholder roundtables with local government dignitaries and VSOs to discuss collaboration and partnership to gain access to tribes and remote communities.

Veterans Benefits Administration (VBA) Minority Veteran Program Coordinators at 56 regional offices provide outreach services to the Native American communities. Additionally, VBA provides annual benefits training to Tribal Veterans Representatives (TVR), so they can educate their Veteran communities about the services and benefits VA provides. In FY19, VBA trained 93 TVRs at five training events. VBA participates and organizes events such as observation of Native American Heritage Month, tribal Pow Wows and partners with the Mobile Vets Center to visit tribal communities and provides information on VA benefits.

Also, VA's Loan Guaranty Service, through a network of Regional Loan Centers (RLC), makes annual contact with every tribe or native community named in the Federal Register as a federally acknowledged tribe. Designated staff from each RLC conduct outreach events, often by invitation or in conjunction with other VA business lines or federal agencies, such as the Departments of Housing and Urban Development and Agriculture (Rural Development). VA Loan Guaranty Service central office staff also attend national conferences such as the National American Indian Housing Council (NAIHC) Annual Convention, NAIHC Legal Symposiums, and the annual convention of the Alaska Federation of Natives; while RLC staff attend regional, state, and local Native American affiliated events. VA Loan Guaranty Service central office and RLC staff collaborate with Regional Relationship Specialists from the VA OTGR to participate in outreach efforts such as Pow Wows, Veteran "Stand-downs," and Veterans benefits fairs. During outreach events, Loan Guaranty Service staff distribute Native American Direct Loan (NADL) literature (pamphlets/post cards) to interested parties and points of contact that can be more broadly disseminated to stakeholders.

Question 3. One of the things I hear from Tribes in Nevada is the need for better coordination. Does VA meet with and take in suggestions from the National Congress of American Indian Veterans Committee?

Answer. Yes, VA leadership and representatives meet with the NCAI Veterans Committee and take recommendations and have done so consistently for the past 8 years.

Question 3a. How are the VA and IHS improving consultation with Tribes at the local level, including in Nevada, to enhance communication and establish effective agreements?

Answer. When it comes to VA/IHS local consultation, local leadership, staff and subject matter experts frequently meet with tribal officials and conduct local training and outreach events in order to foster ongoing communication and relationship building. VA Sierra Nevada Healthcare System supports Rural Native Veterans by multiple methods which include: Providing Volunteer Transportation to and from rural areas and our clinical locations. We have Community Based Outpatient Clinics throughout Northern Nevada in Winnemucca, Fallon and Gardnerville. We have Tribal Health Agreements with local tribes and conduct ongoing Tribal Outreach throughout the region. In addition, we offer Telehealth to the home (VA Video Connect) for rural patients when clinically appropriate.

Question 4. Just a few weeks ago, the VA Inspector General found that the Office of Accountability and Whistleblower Protection, an office created to protect whistleblowers in the VA, has in fact done the opposite, creating a culture alienating those it was mean to protect and without providing the safeguards and unbiased inves-

tigations whistleblowers deserve. What specific actions has the VA already taken to address the IG's report, and what further actions are planned?

Answer. The Office of Accountability and Whistleblower Protection (OAWP) is working collaboratively with OIG to implement its recommendations. As the OIG report highlighted, a lack of oversight, communication, and training for staff were the root causes of the deficiencies. These deficiencies contributed to a lack of trust in OAWP. A new OAWP leadership team, under the direction of Assistant Secretary Bonzanto, has instituted operational changes to address these deficiencies. These operational changes include:

- The Assistant Secretary or her designee reviewing all OAWP investigator recommendations;
- Realignment of OAWP staff to prevent duplication of efforts and increase investigatory resources, with the number of investigators increasing from 30 to 40;
- Requiring that investigators communicate with whistleblowers about the status of their matters on a regular basis to the extent permissible by law;
- implementing an information system, with an audit trail, to track investigations and maintain records in compliance with the law;
- Issuance of VA Directive 0500 to govern how OAWP receives whistleblower disclosures; allegations of senior leader misconduct, poor performance, and whistleblower retaliation; and allegations of whistleblower retaliation against supervisors; and
- Issuance of standard operating procedures for OAWP's Intake, Investigations, Quality, and Compliance teams.

The recent hiring of supervisory investigators with substantial experience overseeing administrative and whistleblower retaliation investigations, and the establishment of smaller investigative teams, has improved the oversight of investigations in OAWP. OAWP investigators also received comprehensive customized training designed by OAWP supervisors in January 2020. They will receive ongoing training to further develop investigative skills. Recognizing that quality control of OAWP investigations is essential, OAWP has established an independent quality review team to ensure investigative reports are thorough and accurate.

Question 4a. And what is the timeline for ensuring that whistleblowers in the VA have proper protection and support?

Answer. VA has taken a number of actions to ensure that employees are educated and trained on whistleblower rights and protections. OAWP developed whistleblower rights and protection training required under 38 U.S.C. § 733 with input provided by OIG and the U.S. Office of Special Counsel. This training provides employees with, among other things, an explanation on the ways in which they can make a whistleblower disclosure, the right of employees to petition Congress, and information on who to contact if whistleblower retaliation occurs. The training also includes an additional supervisory employee module that outlines ways to foster an environment where employees feel comfortable disclosing wrongdoing and the consequences of retaliating against whistleblowers. The training is mandated by the Secretary for all VA employees. VA also mandated whistleblower protection as a critical element for VA senior executive performance plans, in accordance with 38 U.S.C. § 732.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO TO DR. KAMERON MATTHEWS

Question 1. In his testimony, Mr. Fox said the impact of travel distances for health care services on Native Veterans "cannot be understated." Nevada's tribal communities are spread out throughout the state, including in rural areas far from Nevada's two VA medical centers in Reno and Las Vegas. Could you describe what efforts VA is undertaking to bring care closer to Native Veterans, especially those in rural areas? And what specifically is the VA doing to mitigate travel distances for Native Veterans in the state of Nevada?

Answer. VA collaborates with the Indian Health Service and Tribal Health Programs (THP) to ensure the health care needs of Native Veterans are met throughout Nevada, and particularly in rural areas where access may be more challenging. For example, in Southern Nevada, VA is actively engaged in coordinating with the Indian Health Service to serve the needs of 71 Native American Veterans who seek out health care within the local area. In 2016, VA hosted a meeting which brought together tribal and health care leadership from the Parker Indian Hospital, Irene Benn Medical Center, Las Vegas Paiute Tribe (Urban), the Moapa Band of Paiutes Tribe (Rural), IHS, and VA to discuss joint opportunities. Since that meeting, we

have continued to engage in and implement efforts to improve health care availability whether through VA, IHS, or a THP. For example, if Veterans require care not available through IHS or a THP, they are advised of services and benefits that may be available through VA.

Additionally, assistance with transportation to health care may be available for eligible Veterans. VA's Beneficiary Travel program provides eligible Veterans and other beneficiaries mileage reimbursement, the actual cost for use of a common carrier (airplane, train, bus, taxi, etc.), or when medically required, "special mode" (ambulance, wheelchair van) transport for travel to and from a VA facility or VA-authorized health care facility for examination, treatment, or care for which the Veteran is eligible (subject to applicable requirements).

Question 2. Mr. Dupree wrote in his testimony that you are not certain the VA Native American Veteran Direct loan program is working as well as it could work, in part due to the lack of VA outreach. How are you helping to spread awareness of the program for our Veterans? How are you making the application process as accessible as possible to allow more Native Veterans to participate?

Answer. Loan Guaranty Service has a NADL Program Manager who manages the program at the national level and works to ensure annual outreach with all tribal/Native American groups. Outside of attending national Native American housing conferences and outreach events, the VA Home Loan Web site offers detailed information regarding the NADL program and provides contact information to speak directly with a VA representative. Each RLC has a NADL coordinator that serves as a subject matter expert for the program as well as the loan originator, processor, and closer for NADL Home Loans. They achieve this by providing service to Native American Veterans in person and virtually. Awareness of the NADL program is also achieved through the distribution of pamphlets and other materials that highlight key information about the program. VA's Loan Guaranty Service welcomes the opportunity to share information about the NADL program. If a tribe is interested in Loan Guaranty Service's participation at an outreach event, they may contact the RLC that serves the jurisdiction for coordination.

In order for a Native American Veteran to obtain a loan through VA's NADL program, the tribal organization having jurisdiction over the Veteran must have entered into a Memorandum of Understanding (MOU) with VA. 38 U.S.C. § 3762. The NADL Program Manager works closely with the tribal organizations to ensure the MOU development process not only meets the needs and goals of the organization, but also meets the statutory requirements of VA's NADL program. These efforts are designed to ensure the highest level of participation in the NADL program by Native American Veterans.

Question 3. One of the things I hear from Tribes in Nevada is the need for better coordination. Does the VA meet with and take in suggestions from the National Congress of American Indians' Veterans Committee?

Answer. Please see the response to Question 3.

Question 3a. How are the VA and IHS improving consultation with Tribes at the local level, including in Nevada, to enhance communication and establish effective agreements?

Answer. Please see the response to Question 3.

Question 4. As you know, navigating the VA claims process can be challenging, and I'm thankful we have dedicated VSOs across the country ready to help Veterans understand their benefits. However, due to bureaucratic red tape and financial restrictions, Tribes are often unable to receive the VA training to become accredited VSOs or find that the requirement to have a separate funded entity to be financially burdensome. How can VA help reduce these burdens so that Tribes gain access to VSOs?

Answer. Please see the response to Question 1.

Question 4a. Is there a way for the VA to provide grants to cover the financial burden, and is this something the VA is exploring?

Answer. Please see the response to Question 1.

Question 5. I appreciate the Administration's willingness to give a deeper breakdown of the data requests made during the hearing, and ask for data to support the following:

What is the delta between eligible service members and those who are actually using their VA coverage? Do you have a state by state or regional (as defined by the Bureau of Indian Affairs) breakdown of those numbers?

Answer. Of the estimated 13.9 million Veterans who are eligible to enroll in VA for health care in FY 2018, 8.8M are enrolled (end-of-year count). The table sets forth the total number of total, eligible, and enrolled Veterans by state.

Fiscal Year 2018 End of Year (EOY) Veterans Summary by State—Source: 2019 VA Enrollee Health Care Projection Model

State	EOY Total Veterans 2018 Estimate	EOY Estimated Eligible Veterans Estimate	EOY Enrolled Veterans 2018 Actual
National	19,602,300	13,894,800	8,810,400
Alabama	365,900	258,200	169,100
Alaska	68,800	48,500	33,800
Arizona	500,100	340,500	231,100
Arkansas	219,300	165,200	109,800
California	1,629,200	1,154,200	734,900
Colorado	398,800	273,200	169,100
Connecticut	177,200	122,700	70,900
Delaware	70,800	48,000	26,600
District of Columbia	27,400	19,400	12,800
Florida	1,491,000	1,065,100	711,800
Georgia	694,200	478,900	312,700
Hawaii	111,500	84,300	46,500
Idaho	120,900	85,900	60,600
Illinois	609,900	421,600	260,900
Indiana	401,100	282,000	178,700
Iowa	201,300	147,600	93,200
Kansas	191,400	138,200	84,000
Kentucky	291,700	212,100	136,800
Louisiana	280,500	203,000	128,700
Maine	111,300	82,600	54,500
Maryland	380,300	248,900	149,500
Massachusetts	310,600	224,400	127,800
Michigan	570,700	386,000	223,100
Minnesota	318,100	239,800	158,200
Mississippi	189,100	142,300	93,700
Missouri	434,400	312,700	192,100
Montana	90,200	67,900	48,200
Nebraska	127,300	95,000	66,300
Nevada	214,600	155,800	110,200
New Hampshire	102,700	71,700	43,500
New Jersey	340,600	235,700	130,800
New Mexico	156,600	109,400	74,800
New York	747,100	559,900	355,100
North Carolina	728,200	518,500	333,700
North Dakota	51,300	39,800	26,300
Ohio	753,800	522,200	329,100
Oklahoma	300,100	216,700	135,900
Oregon	297,000	209,700	139,300
Pennsylvania	793,300	573,400	327,600
Rhode Island	61,100	44,600	26,300
South Carolina	400,700	285,100	188,900
South Dakota	64,700	50,800	38,000
Tennessee	465,700	329,200	212,300
Texas	1,574,000	1,114,100	741,600
Utah	132,600	93,600	58,000
Vermont	42,100	31,000	19,500
Virginia	719,900	465,400	272,800
Washington	552,300	368,100	219,300
West Virginia	140,000	109,200	74,600
Wisconsin	354,300	256,500	163,000
Wyoming	46,900	36,800	25,400
Puerto Rico	76,400	71,100	63,000
Other U.S. Islands	12,200	10,800	7,100
All Other Overseas*	58,600	40,300	0
Philippines	28,300	23,000	6,600
U.S. Virgin Islands	4,300	4,200	2,500

*Residence data for enrollees living overseas are not available so there are no enrollment projections for this region.

VA does not have an estimate of users by Bureau of Indian Affairs region. The Enrollment System (ES) does not provide enough data points to accommodate this request.

Additionally, we note that the system does not provide a means to identify the total number of Veterans with Native American heritage. Also, since the race demographic is a "self-report" item on VA's Application for Health Benefits (VA Form 10–10EZ), that data point listed in ES would not be an accurate representation of the total number of Veterans who identify as American Indian or Alaska Native.

Question 5a. What specific actions is the VA taking to close that delta?

Answer. Although the specific data are unavailable, VA routinely engages in enterprise-wide outreach efforts to tribal communities through tribal consultation, Webinars, onsite training sessions, and in-person briefings with individual tribes, tribal Veterans Service Officers, regional inter-tribal organizations, and advocacy organizations. The following are examples of results of the ongoing outreach and relationship building the agency engages in with tribal governments and tribal communities:

- Tribal Consultation: VA has conducted tribal consultation annually since the agency policy was established in 2011. As an example, in 2016, the agency conducted tribal consultation with 567 federally recognized tribes to identify the top 5 Priorities for Veterans living in Indian Country. Tribal leaders, national and regional tribal organizations, Veterans, and other designated representatives offered their input regarding access to medical care; addressing housing and homelessness; treatment for Post-Traumatic Stress Disorder and mental health; understanding benefits, including benefits for families; and transportation. This information is used by the agency to focus and prioritize partnerships and initiatives within tribal communities.
- Urban Indian Health Programs: VA engages with Urban Indian Programs as an outreach requirement to strengthen access to care for American Indian and Alaska Native (AI/AN) Veterans living in urban areas. VA holds quarterly calls with the IHS Office of Urban Indian Health and works to facilitate introductions to and collaborative relationships between IHS-funded Urban Indian Health Program personnel and the closest VA facility leadership and staff.
- VA Claims Clinics: FY 2019, VA collaborated with 25 tribal governments to facilitate 30 claims clinic events in 13 states. An estimated 965 Veterans were served and submitted a total of 472 claims for VA benefits.
- VA Leadership and Tribal Engagement: VA works to ensure senior VA leadership, including the Secretary and leaders from all three administrations, have frequent contact and communication with AI/AN Veterans.

Question 5b. Of those Veterans who have some other form of coverage outside of the VA, what type of coverage do they have, and what portion of tribal Veterans have each type?

Answer. The following table below is from the 2018 VA Survey of Enrollees. The survey data represent estimates and estimates of insurance coverage tend not to vary from year to year.

In 2018, 51.3 percent of Veterans had Medicare (51 percent in 2017, 52 percent in 2016). Six percent of Veterans reported having Medicaid in 2018 (6.6 percent in 2017 and 6.4 percent in 2016). In addition, 21.2 percent of Veterans reported having Tricare in 2018 (19.8 percent in 2017, 19.5 percent in 2016) and 27.6 percent (28 percent in 2017 and 28.3 percent in 2016) respondents reported having private insurance (outside of VA). The survey does not allow respondents to select which other private insurance that they may have (Blue Cross Blue Shield, Cigna, Kaiser, etc.). In 2018, 19.2 percent (20.2 percent in 2017 and 20.1 percent in 2016) self-identified as having no insurance.

The estimated number of enrollees who self-identified as American Indian/Native Alaskan in the same survey was 217,580. (We note that respondents could select multiple racial and ethnic categories.) Twenty-seven percent of these enrollees are estimated to have no health care coverage outside VA. Estimated percentages of this population with other types of coverage break out as follows:

- Medicare 42 percent
- Medicaid 11 percent
- Tricare 24 percent
- Private Insurance 25 percent

For Veterans who selected private insurance, options were not selected for what specific type of insurance, so we are unable provide this information.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO DR. KAMERON MATTHEWS

Question 1. The VA provides many diverse services to our Nation's Veterans—from health care to education and training to home financing assistance. Depending on a Veteran's age, service needs often differ. For example, younger, post 9/11 Veterans many need more assistance with childcare and job training. How is the VA making sure it is working with Tribes to serve the diverse needs of Native American Veterans—whether they just completed their military service or whether they've been retired for decades?

Answer. Through the Transition Assistance Program, the Department of Veterans Affairs (VA) connects and educates all transitioning Servicemembers on resources, benefits, and training available to them, and how to utilize those benefits before they separate. VA also sponsors Economic Investment Initiatives (EII), which bring together partners and stakeholders to address concerns of Veteran populations located in Qualified Opportunity Zones around the country as well as providing education, training, and direct services to Veterans, Servicemembers, and their families. On February 13, 2020, VA sponsored a follow-up Stakeholder Roundtable event to specifically address challenges faced by Native American Veterans.

VA's Vocational Rehabilitation and Employment Service also meets claimants' diverse needs by developing individualized rehabilitation plans designed to address each claimant's abilities, aptitudes, and interests, to include honoring and incorporating cultural perspectives, to ensure that each claimant reaches his or her rehabilitation goals.

Question 2. A 2015 report by VA's Office of Rural Health recommended that the VA find ways to partner with Tribal Colleges and Universities (TCUs) to better serve Native Veterans—especially those young Native Veterans returning from recent conflicts. However, the same 2015 report also indicated that information on the VA's collaboration with TCUs is extremely limited. Since publishing that report, how has the VA worked to partner with TCUs?

Answer. VA's Office of Rural Health (ORH) created a project in 2015 to work with Tribal Colleges and Universities to reach transitioning Native American Veterans. The project ran from 2015 through 2017, however, due to the multiple barriers, including administrative changes at the local Tribal College level, we were not able to progress beyond that.

However, under the VA-Indian Health Services (IHS) Memorandum of Understanding, signed in 2010, ORH continues to work to increase outreach to Native Veterans. Capitalizing on past experience, ORH is partnering with IHS to create a Rural Native Veteran Health Care Navigator Program to assist Native American Veterans with issues in transitioning to Veterans Health Administration (VHA) health care. This project is in its initial stages with a plan to roll out a small-scale pilot towards the end of Fiscal Year (FY) 2020 and expansion to more sites in 2021. If the pilots are successful, ORH will create an enterprise wide initiative to disseminate the program across the country.

Question 3. The VA's Homeless Programs Office testified last Congress about the successes of the Tribal HUD–VASH demonstration program. Please share an update about how the program is doing.

Answer. Tribal Department of Housing and Urban Development (HUD)-VA Supportive Housing (HUD–VASH) is a partnership between VHA, HUD's Office of Native American Programs (ONAP), and tribes, which provides permanent supportive housing in Indian areas to homeless and at risk of homelessness Native Veterans. The program currently serves 26 tribes with expansion expected in the next 6 months. VA provides case management and supportive services to promote tenancy in housing supported by HUD grant funding for rental assistance. VA case managers work with local resources and the appropriate VA employment programs to assist Native Veterans to access employment when appropriate for the Veteran.

Program Highlights Through November 18, 2019:

- There were 350 Veterans housed in Tribal HUD–VASH. Estimates of 500 units of rental assistance were provided by HUD's ONAP.
- 20 of the 350 are graduates, meaning they no longer require case management but continue to utilize the rental assistance provided by Tribal HUD–VASH.
- 26 more Veterans were approved by the Tribally Designated Housing Entity (TDHE) waiting for or looking for housing.
- 6 additional Veterans were referred to TDHEs for the TDHE to determine if the Veteran met their eligibility requirements.

- 1 further Veteran was admitted into Tribal HUD–VASH and was in the initial case management to prepare for the TDHE referral.
- 363 Veterans were enrolled in case management in Tribal HUD–VASH.

Staffing:

- 26 total case managers are funded for Tribal HUD–VASH.
- 25 are full-time-equivalent employee; 1 is through a contract with the tribe's housing authority.
- 22 case managers are on board.
- 4 case managers are in the process of being hired with all 4 in the On-Boarding/Credentialing stage.
- All tribes where there are vacancies in the permanent staff have temporary/interim case management.

Question 4. Many Tribes participating in the HUD–VASH program are interested in building Veterans-specific housing. To support this goal, the National American Indian Housing Council (NCUIH) suggested the VA, HUD, and USDA could assist Tribal HUD–VASH grantees to take on these building projects by offering additional supports—e.g. leveraging the VA's direct loan and loan guarantee authorities. Has the VA met with HUD or USDA to discuss ways to support Tribal development of Veteran specific housing on reservations?

Answer. VA works closely with HUD in the implementation and expansion of the Tribal HUD–VASH program. However, VA does not provide any funds or development loans or grants for the HUD–VASH program. Tribal HUD–VASH grantees are encouraged to consider project-basing their awards to renovate or construct housing opportunities to meet the needs of Tribal HUD–VASH. The HUD–VASH National Program Office is available to assist any HUD–VASH program with the process of project-basing, which has to be done in partnership with the Public Housing Agency or in the case of Tribal HUD–VASH, TDHE, or Tribe. VA's Loan Guaranty Service has met with HUD and USDA on outreach efforts and to discuss best practices related to tribal Veteran homeownership. VA actively participates in tribal consultations to solicit feedback from Native American leaders on how to improve delivery of the Native American Direct Loan (NADL) benefit. In order to leverage VA's authority to develop Veteran specific housing on trust lands, tribal affiliates would need to work within the legislative confines of the NADL program. By statute, the VA NADL program was created to allow Native American Veteran borrowers to utilize their home loan benefit on Federal Trust land. See 38 United States Code (U.S.C.) §§3761–3765. The program is designed to allow Native American Veterans the same opportunity that a Veteran who is purchasing on non-tribal lands would possess. Banks and mortgage companies often do not lend on Federal Trust land due to the inability to foreclose and sell the property in the case of default. Consequently, the NADL program was created to make loans to individual Native American Veterans who chose to purchase or build on tribal lands.

Question 4a. Can Tribes use any of VA's direct loan or loan guarantee programs? Or, are these programs limited to use by individual Veterans only?

Answer. Individual Veterans who are recognized by tribes may use either program dependent upon where they wish to live. A VA-guaranteed loan is made by lenders in the private market. The NADL program provides individual Native Americans Veterans direct loans to purchase or build a home on Federal Trust land. A Native American Veteran who desires to purchase a home on non-Federal Trust land may obtain a VA-guaranteed loan. VA is not prohibited from guaranteeing loans for individual Native American Veterans who live on Federal Trust land. Most private lenders do not lend on Federal Trust land due to the complicated nature of foreclosing on properties if the loan goes into default. Investors have been historically hesitant to acquire these loans due to issues in obtaining clear title to the property. As a result, VA is unable to guaranty loans that lenders do not originate.

Question 5. RADM Chris Buchanan testimony stated: "When seeking treatment at a VA medical center, tribal Veterans currently are charged a copayment that the individual pays. Current law (25 USC 1621u) does not permit a provider, including VA, to impose financial liability on a patient pursuant to an authorized IHS PRC referral." Is the VA in compliance with the 25 USC 1621u when it assesses copayments on IHS patients referred to VA through IHS's PRC system? And, if not, under what statute does VA use to authorize its assessment of copayments on IHS patients referred to the VA through IHS's PRC system?

Answer. If IHS refers an eligible Veteran to VA for hospital care or medical services, the care VA provides to the Veteran is authorized by title 38, U.S.C., and for some eligible Veterans, a copayment may apply. VA is required by law to charge

copayments to certain Veterans who receive VA health care. See 38 U.S.C. §§1710, 1710B, and 1722A. VA cannot exempt categories of Veterans from copayment requirements without authorizing legislation. Note that VA's regulations set forth the health care services that are not subject to copayment requirements and the categories of Veterans exempt from VA copayment requirements, to include Veterans with a service-connected disability rated 50 percent or more and Veterans whose annual income is below the applicable threshold. See 38 C.F.R. §§17.108(d)-(f), 17.110(c), 17.111(f). VA and IHS are committed to working with the Office of Management and Budget to reconcile any conflict between the Indian Health Care Improvement Act and VA's Title 38 authority regarding the application of VA copayments.

Question 6. GAO report 18–137 details how issues with VA's human resource data system contribute to an alarming lack of accountability for VA management. GAO is working on a similar review—at the request of this Committee—to look at the Indian Health Service's (IHS) management practices and procedures for addressing employee misconduct. Does the VA have a standard system for documenting and tracking reports of misconduct like patient endangerment or abuse?

Answer. In October 2019, VA began using a new employee relations platform to track and manage all employee misconduct cases. This system will be mandated for use across the VA. The new system is a Commercial-off-the-Shelf cloud-based solution that will allow the VA to track, manage, and report on employee relations cases that may lead to disciplinary action including removal of a VA employee. Some incidents involving alleged patient endangerment or abuse could fall in the category of employee misconduct and will be tracked by the new system.

Question 6a. Has the VA's Chief Information Officer of human resources department ever met with their IHS counterparts to discuss the need for human resources IT modernization?

Answer. VA's HR technology leadership has met with several agencies regarding the need for human resources IT modernization, including the Department of Health and Human Services (HHS); however, we have not met with an IHS counterpart. VA has met with the human resources IT leadership from HHS to discuss human resources IT and understand that HHS and IHS use the same human resources shared service provider. VA's communications with HHS, including IHS, are ongoing.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO RADM CHRIS BUCHANAN

Question 1. In your testimony, you stated: "When seeking treatment at a VA medical center, tribal veterans currently are charged a copayment that the individual pays. Current law (25 U.S.C. 1621u) does not permit a provider, including VA, to impose financial liability on a patient pursuant to an authorized IHS PRC referral." Does IHS believe VA has the authority to assess copayments on IHS patients referred to VA through IHS's PRC system?

Answer. The Indian Health Service (IHS) believes that 25 U.S.C. § 1621u prohibits a provider, including the Department of Veterans Affairs (VA), from assessing copayments on IHS patients referred to VA through the IHS Purchased/Referred Care (PRC) program. IHS and VA are committed to working with the Office of Management and Budget to reconcile the conflict between the Indian Health Care Improvement Act and VA's Title 38 authority.

Question 2. The provision of law you cited (i.e., section 222 of the Indian Health Care Improvement Act) states that it is the responsibility of the Secretary of Health and Human Services to inform providers of this prohibition. If IHS believes VA does not have authority to access copayments on IHS patients with PRC referrals, has the Department communicated with the VA about the conflict between their practices and the Indian Health Care Improvement Act?

Answer. Yes, IHS sent a letter dated October 15, 2013, to the VA Under Secretary for Health and have informally met with the VA about this conflict between the VA practices and the Indian Health Care Improvement Act. IHS and VA are committed to working with the Office of Management and Budget to reconcile the conflict between the Indian Health Care Improvement Act and VA's Title 38 authority.

Question 3. GAO report 18–137 details how issues with VA's human resource data system contribute to an alarming lack of accountability for VA management. GAO is working on a similar review—at the request of this Committee—to look at the IHS's procedures for addressing employee misconduct. Does IHS have a standard

system for documenting and tracking reports of misconduct like patient endangerment or abuse?

Answer. In 2019, IHS released new professional standards and stronger requirements for IHS employees to report suspected sexual abuse and exploitation of children by health care providers (Indian Health Manual Part 3, Chapter 20), and as part of that new policy issued mandatory training for all IHS employees, contractors, and volunteers.

IHS is implementing a new credentialing and privileging software (ASM Credentialing System) and new adverse events reporting software (Datix). The ASM Credentialing System and Datix replace existing systems that had limitations in their ability to efficiently operate in the current Indian health system. The IHS Office of Quality is leading the implementation and monitoring of these transitions.

Credentialing and privileging of health care practitioners for medical staff membership is one of the most critical tasks of the Agency and is directly related to the quality of healthcare provided at IHS facilities. A strong credentialing and privileging policy and process decreases the potential for patient harm by verifying the training, competence, character, and ongoing successful clinical performance of its medical staff. The ASM Credentialing System allows us to better credential and privilege providers through use of industry leading software, auto and continuous verification, automated checklists, and digital documentation. The credentialing and privileging software provides information on a provider's malpractice history, prior adverse events, and physical and mental health.

Availability of an adverse events reporting system is consistent with the Joint Commission (TJC), and Centers for Medicare and Medicaid Services (CMS) mandates that facilities have a mechanism to track adverse events. CMS rules require some provider types to assure that any incidents of abuse are reported and analyzed and appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable law. The reporting of all adverse events, including sexual abuse, will be required to be entered into the Datix software.

IHS is developing an employee relations tracking module using the ServiceNow technology that will increase the reporting and case management tracking of misconduct and performance issues across all IHS areas. This information will allow IHS the ability to identify training, resources, and other services that may be necessary to address critical needs. The go-live of this new module is scheduled for late spring/early summer 2020.

Question 3a. Has IHS's Chief Information Officer or human resources department ever met with their VA counterparts to discuss the need for human resources IT modernization?

Answer. The IHS Chief Information Officer (CIO) supports all business owners of software systems by ensuring the appropriate technical and IT security requirements are met to host the selected software on the IHS network. The IHS CIO is currently engaged with the VA with a specific focus on clinical and health IT modernization efforts.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO TO RADM CHRIS BUCHANAN

Question 1. What is the delta between eligible service members and those who are actually using their VA coverage? Do you have a state by state or regional (as defined by the Bureau of Indian Affairs) breakdown of those numbers? What specific actions is the VA taking to close that delta?

Answer. Veterans identified in the IHS health record are self-identified and the reporting is not mandatory and does not imply VA or Tricare eligibility. Some Veterans may not realize that they can self-identify, and some may self-identify who might not qualify for veterans' benefits. While the IHS continues to collaborate with the VA on related issues, this question is more appropriate for VA to respond.

Question 2. Of those veterans who have some other form of coverage outside of the VA, what type of coverage do they have, and what portion of tribal veterans have each type?

Answer. According to IHS data regarding insurance coverage among individuals self-reporting as being veterans in the IHS user population, in 2018, 17.7 percent reported only having health care coverage from the VA, 24.2 percent had Medicaid coverage, 40.2 percent had Medicare Part A coverage, 31.8 percent had Medicare Part B coverage, and 49.8 percent had private insurance coverage. The sum of these percentages is more than 100 percent because a person may have more than one type of coverage. These numbers reflect coverage status for at least part of the year and may not be for the full year. These percentages based on IHS users' self-re-

ported information may be inaccurate because beneficiaries self-identify as veterans, they may not be eligible for health services from VA, and many may not identify as veterans who are eligible for VA services. While the IHS continues to collaborate with the VA on related issues, this question is more appropriate for VA to respond.

RESPONSES TO THE FOLLOWING QUESTIONS FAILED TO BE SUBMITTED AT THE TIME THIS HEARING WENT TO PRINT

WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO HON. JESTIN DUPREE

Addressing Old vs. Young Veteran Needs

Question 1. The VA provides many diverse services to our nation's veterans—from healthcare to education and training to home financing assistance. Depending on a veteran's age, service needs often differ. For example, younger, post-9/11 veterans may need more assistance with child care and job training. Do you believe the VA sufficiently working with Tribes to serve the diverse needs of Native American veterans—whether they just completed their military service or whether they've been retired for decades?

Partnering with Tribal Colleges

Question 2. A 2015 report by VA's Office of Rural Health recommended that the VA find ways to partner with Tribal Colleges and Universities (TCUs) to better serve Native veterans—especially those young Native veterans returning from recent conflicts. However, the same 2015 report also indicated that information on the VA's collaboration with TCUs is extremely limited.

a. Are you aware of any collaboration efforts between the VA and Fort Peck Community College?

b. Do you believe the VA should do more to partner with TCUs?