



March 2019

VA AND INDIAN HEALTH SERVICE

Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans

Accessible Version

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Why GAO Did This Study

A 2010 MOU set mutual goals for VA and IHS collaboration and coordination related to serving AI/AN veterans. Under this MOU, VA has established reimbursement agreements with IHS and tribal health programs to pay for care provided to AI/AN veterans. In 2013 and 2014, GAO issued two reports on VA and IHS implementation and oversight of the MOU.

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.

To conduct this work, GAO reviewed VA and IHS documents, reports, and reimbursement data from 2014 through 2018. GAO interviewed VA and IHS officials at the headquarters level, and officials at 15 VA, IHS, and tribal facilities in four states—Alaska, New Mexico, North Carolina, and Oklahoma—selected based on factors including the number of reported AI/AN veterans served, and geographic diversity. GAO also interviewed organizations representing tribes and tribal health programs.

What GAO Recommends

GAO is making three recommendations—one each to VA and IHS to establish measurable targets for performance measures and one to VA to establish written guidance for referring AI/AN veterans to VA facilities for specialty care. VA and HHS concurred with these recommendations.

View [GAO-19-291](#). For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

What GAO Found

The Department of Veterans Affairs (VA) and the Department of Health and Human Services' (HHS) Indian Health Service (IHS) established a memorandum of understanding (MOU) to improve the health status of American Indian and Alaska Native (AI/AN) veterans through coordination and resource sharing among VA, IHS, and tribes. Since GAO's last report on the topic in 2014, VA and IHS have continued to jointly oversee the implementation of their MOU—for example, through joint workgroups and quarterly meetings and reports—but they lack sufficient measures for assessing progress towards MOU goals. Specifically, while the agencies established 15 performance measures, they did not establish targets against which performance could be measured. For example, while the number of shared VA-IHS trainings and webinars is a performance measure, there is no target for the number of shared trainings VA and IHS plan to complete each year. GAO's work on best practices for measuring program performance has found that measures should have quantifiable targets to help assess whether goals and objectives were achieved by comparing projected performance and actual results. VA and IHS officials said they are currently in the process of revising the MOU and updating the performance measures used. However, officials have not indicated that any revised measures will include targets.

Total reimbursements by VA for care provided to AI/AN veterans increased by about 75 percent from fiscal year 2014 to fiscal year 2018. This increase mainly reflects the growth in reimbursement from VA to tribal health program facilities—facilities that receive funding from IHS, but are operated by tribes or tribal organizations. Similarly, the number of VA's reimbursement agreements with tribal health programs and the number of AI/AN veterans served under the reimbursement agreements also increased during this period.

Amount of VA Reimbursed Claims, Fiscal Years 2014 through 2018

Category	2014	2015	2016	2017	2018 ^a
Indian Health Service facilities (in millions)	\$7.2	\$7.8	\$7.2	\$6.2	\$8.0
Tribal Health Program facilities (in millions)	\$4.3	\$8.3	\$10.4	\$10.8	\$12.1

Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-19-291

^aFacilities have 12 months from the date of service to file claims for VA reimbursement. Therefore, fiscal year 2018 totals could increase. The fiscal year 2018 data were current as of Sept. 30, 2018.

The VA, IHS, and tribal facility officials GAO spoke with described several key challenges related to coordinating care for AI/AN veterans. For example, facilities reported conflicting information about the process for referring AI/AN veterans from IHS or tribal facilities to VA, 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 a written policy or guidance about how referrals from IHS and tribal facilities to VA facilities should be managed, the agencies cannot ensure that VA, IHS, and tribal facilities have a consistent understanding of the options available for referrals of AI/AN veterans to VA specialty care. This could result in an AI/AN veteran receiving, and the federal government paying for, duplicative tests if the veteran is reassessed by VA primary care before being referred to specialty care.

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Abbreviations

AI/AN	American Indian/Alaska Native
IHS	Indian Health Service
MOU	memorandum of understanding
PPACA	Patient Protection and Affordable Care Act
PRC	Purchased/Referred Care
THP	Tribal Health Program
VA	Department of Veterans Affairs

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March 21, 2019

The Honorable David P. Roe, M.D.
Ranking Member
Committee on Veterans' Affairs
House of Representatives

Dear Dr. Roe:

American Indians and Alaska Natives (AI/AN) have served in the military at a higher rate than members of other racial groups at various points in history, yet AI/AN veterans are more likely than other veterans to lack health insurance or have a service-connected disability.¹ Once separated from the military, some AI/AN veterans are eligible to receive health care services from both the Department of Veterans Affairs (VA) and the Indian Health Service (IHS), an agency within the Department of Health and Human Services. VA and IHS each operate their own health care facilities. AI/AN veterans also may receive care from facilities that are

¹See Department of Veterans Affairs, *American Indian and Alaska Native Veterans: 2015 American Community Survey* (August 2017). Based on U.S. Census Bureau's 2015 American Community Survey Public Use Microdata Sample, VA reported that AI/AN veterans reported serving in the pre-9/11 period of service (August 1990 through August 2001) at a higher rate than veterans of other racial groups (19.9 percent compared to 13.3 percent respectively), and AI/AN veterans were more likely to lack health insurance (5.4 percent vs. 2.3 percent, respectively) or to have a service-connected disability (29.8 percent vs. 20.6 percent, respectively) than other veterans.

operated by tribes or tribal organizations, known as tribal health programs (THPs), which received about 54 percent of IHS's budget in 2017.²

In 2010, VA and IHS expanded upon a 2003 memorandum of understanding (MOU) to improve the health status of AI/AN veterans through coordination and resource sharing among VA, IHS, and tribes. This 2010 MOU outlined mutual goals for VA and IHS collaboration and coordination of resources and health care services provided to AI/AN veterans. For example, it included provisions for joint contracts and purchasing agreements, sharing staff, ensuring providers in VA and IHS could access the electronic health records of shared patients, and the development of reimbursement policies and mechanisms to support care delivered to AI/AN veterans eligible for care in both systems. In December 2012, VA and IHS signed a reimbursement agreement that facilitates reimbursement from VA to IHS facilities for the direct care services they provide to eligible AI/AN veterans. VA has established similar reimbursement agreements with THPs.

In 2013 and 2014, we reported on the agencies' collaboration on efforts related to the MOU, including progress on meeting MOU goals.³ Our 2013 report found that while VA and IHS had developed mechanisms to implement and monitor MOU-related activities, there were inadequacies with the performance measures used to measure MOU progress, and ineffective consultation with tribes regarding the MOU. Our 2014 report found that while VA and IHS had taken a variety of actions under the

²Tribes and tribal organizations can choose to receive health care administered and operated by IHS, or assume responsibility for providing all or some health care services formerly administered and operated by IHS. Under the Indian Self-Determination and Education Assistance Act, as amended, federally recognized Indian tribes can enter into self-determination contracts or self-governance compacts with the Secretary of Health and Human Services to take over administration of IHS programs for Indians previously administered by IHS on their behalf. Specifically, through self-determination contracts, Indian tribes can assume responsibility for administration of programs—for the benefit of Indians because of their status as Indians—that would otherwise be managed by IHS. Through self-governance compacts, Indian tribes can assume responsibility for administration of IHS programs that are otherwise available for tribes and Indians and also consolidate those programs. Pub. L. No. 93-638, 88 Stat. 2203 (1975) (codified, as amended, at 25 U.S.C. §§ 5301-5423). The provisions governing self-determination contracts are found in title I (25 U.S.C. §§ 5321-5332). The provisions governing self-governance compacts with IHS are in title V (25 U.S.C. §§ 5381-5399).

³See GAO, *VA and IHS: Further Action Needed to Collaborate on Providing Health Care to Native American Veterans*, [GAO-13-354](#) (Washington, D.C.: Apr. 26, 2013) and GAO, *Health Care Access: Improved Oversight, Accountability, and Prioritization Can Improve Access for Native American Veterans*, [GAO-14-489](#) (Washington, D.C.: June 10, 2014).

MOU to improve access to care for AI/AN veterans, MOU oversight was inconsistent, written guidance and policies were lacking, and leadership had not prioritized MOU implementation. We made several recommendations to VA and IHS aimed at improving MOU implementation and oversight, which the agencies agreed with and subsequently implemented.

You asked us to provide updated information related to the agencies' efforts to implement the MOU, including the use of reimbursement agreements, since the issuance of our June 2014 report, and to examine issues related to care coordination among VA, IHS, and THP facilities. This report examines

1. the extent to which VA and IHS have continued to oversee implementation of their MOU since 2014;
2. the use of reimbursement agreements for VA to pay for AI/AN veterans' care at IHS and THP facilities since 2014; and
3. key issues related to coordinating care for AI/AN veterans, as identified by selected VA, IHS, and THP facilities.

To address these three objectives, we interviewed federal and tribal officials at the national and local levels. We interviewed VA and IHS headquarters officials, including officials from VA's Office of Rural Health and Office of Tribal Government Relations, and IHS's Office of the Director. We also interviewed representatives from national and regional organizations representing AI/AN tribal organizations and health programs.⁴ Additionally, to obtain the perspective of selected VA, IHS, and THP facilities, we interviewed officials from 15 facilities (4 VA facilities, 3 IHS facilities, and 8 THP facilities) in four states—Alaska, New Mexico, North Carolina, and Oklahoma.⁵ We selected a mix of both IHS and THP facilities, and ensured they reflected geographic diversity as well

⁴Specifically, we spoke with representatives from the National Congress of American Indians, the National Indian Health Board, the National Council of Urban Indian Health, and the Northwest Portland Area Indian Health Board. Officials representing a number of tribes and THPs also participated in our interview with the Northwest Portland Area Indian Health Board.

⁵For the purposes of this report, we are using the term "facilities" to refer to all of the local-level VA, IHS, and THP units selected for interviews. However, in some cases the officials that we spoke with were responsible for the operation and oversight of multiple health care facilities. For example, in Alaska, officials from the VA and one THP that we spoke with were responsible for the operation of multiple facilities in that state. Similarly, the three THPs that we spoke with in Oklahoma operated multiple health care facilities.

as variation in the number of AI/AN veterans they served (according to VA reimbursement data through September 2017).⁶ We selected the 4 VA facilities because they were the facilities with which our selected IHS and THP facilities had signed reimbursement agreements.⁷ We also interviewed officials in the five IHS areas in which the IHS and THP facilities were located.⁸ VA regional officials participated in two of the VA facility interviews. Our findings from these interviews are not generalizable to all VA, IHS, or THP facilities.

To examine the extent to which VA and IHS have continued to oversee implementation of their MOU since 2014, we reviewed the MOU and a broad range of documents related to MOU activities, such as monthly and annual reports and quarterly meeting minutes. These describe MOU-related activities and progress by VA and IHS on MOU goals and performance measures. We compared this evidence to relevant criteria from our past work on leading practices for interagency collaboration, and assessed the MOU performance measures against our work on the key attributes of successful performance measures.⁹ We also reviewed the actions taken by VA and IHS in response to our 2013 recommendation about improving MOU performance measures.¹⁰

⁶The three IHS facilities we selected were the Gallup Indian Medical Center, the Albuquerque Indian Health Center, and the Claremore Indian Hospital, and the eight THPs selected were the Alaska Native Tribal Health Consortium, the Cherokee Indian Hospital Authority, the Cherokee Nation, the Chickasaw Nation Department of Health, the Choctaw Nation, the Kenaitze Indian Tribe, the Pueblo of Jemez, and the Southcentral Foundation.

⁷We spoke with VA officials from the following four facilities: the Alaska VA, the Raymond G. Murphy VA Medical Center (New Mexico), the Charles George VA Medical Center (North Carolina), and the Jack C. Montgomery VA Medical Center (Oklahoma).

⁸IHS oversees its health care facilities through a decentralized system of 12 area offices, which are led by area directors. IHS's headquarters office is responsible for setting health care policy, helping to ensure the delivery of quality comprehensive health services, and advocating for the health needs and concerns of AI/AN people. The IHS area offices are responsible for distributing funds to the facilities in their areas, monitoring their operation, and providing guidance and technical assistance.

⁹GAO, *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms*, [GAO-12-1022](#) (Washington, D.C.: Sept. 27, 2012); *Tax Administration: IRS Needs to Further Regulate Its Tax Filing Season Performance Measures*, [GAO-03-143](#) (Washington, D.C.: Nov. 22, 2002); and *International Space Station: Measurable Performance Targets and Documentation Needed to Better Assess Management of National Laboratory*, [GAO-15-397](#) (Washington, D.C.: Apr. 27, 2015).

¹⁰See [GAO-13-354](#).

To examine the use of reimbursement agreements for VA to pay for AI/AN veterans' care at IHS and THP facilities since 2014, we reviewed and summarized reimbursement agreements data from VA reports, including data on veterans served at IHS and THP facilities, amounts reimbursed by VA to IHS and THP facilities, and number of prescriptions filled by VA for patients at IHS and THP facilities in fiscal years 2014 through 2018. We assessed the reliability of the VA reimbursement data by interviewing knowledgeable VA officials, reviewing supporting documentation, and reviewing the data for obvious errors or outliers. We determined these data were sufficiently reliable for our purposes. We also reviewed and analyzed information from VA to determine the length of time it took the department to enter reimbursement agreements with THPs. Additionally, we reviewed other documents, such as the reimbursement agreement between VA and IHS, and the reimbursement agreements between VA and our selected THPs.

To examine the key issues related to coordinating care for AI/AN veterans, as identified by selected VA, IHS, and THP facilities, we utilized our interviews with officials at the 15 selected facilities. As applicable, we also reviewed available VA and IHS data related to some of the coordination issues raised in these interviews. We examined the available data on coordination issues and assessed its reliability by interviewing knowledgeable officials, reviewing supporting documentation, and reviewing the data for obvious errors. We determined that the data we report were sufficiently reliable for our audit objectives. As applicable, we assessed the key issues described against relevant criteria in the MOU itself, or our past work on leading practices for interagency collaboration.¹¹

We conducted this performance audit from October 2017 through March 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions on our audit objectives.

¹¹See [GAO-12-1022](#).

Background

AI/AN Veterans

The number of AI/AN veterans eligible for both VA and IHS services is unknown. The U.S. Census Bureau estimates that in 2017 approximately 141,000 AI/AN individuals identified themselves as veterans. This estimate includes only individuals who identified as AI/AN alone and not in combination with another racial group. IHS and VA do not have an administrative mechanism for determining the number of AI/AN veterans who are users of both systems. Instead, each agency separately relies on individuals to identify either as veterans, or as AI/AN, resulting in different counts. Specifically, according to IHS, in fiscal year 2017, 48,169 active IHS users self-identified as veterans.¹² According to VA, in fiscal year 2017, 80,507 VA-enrolled veterans self-identified as AI/AN.¹³

VA and IHS Structure and Benefits

VA is charged with providing health care services to the nation's eligible veterans, and served 6.8 million veterans in fiscal year 2017 with a total health care budget of about \$69 billion. VA's health care system includes 18 regional networks—Veterans Integrated Service Networks—to which each of VA's facilities is assigned.¹⁴ VA has 170 medical centers, which offer a variety of inpatient and outpatient services, ranging from routine examinations to complex surgical procedures. VA's health care system also includes community-based outpatient clinics and other facilities that generally limit services to primary care and some specialty care. When needed services are not available at VA facilities or within required driving

¹²These data reflect the number of self-identified AI/AN veterans known to IHS based on data from IHS facilities, and those THPs that choose to submit data to IHS's National Data Warehouse. Therefore, they likely undercount the total number of AI/AN veterans that are active IHS users because (1) not all THPs choose to submit data to IHS's National Data Warehouse, and (2) not all AI/AN veterans seen in IHS or THP facilities may choose to self-identify as veterans. However, all self-identified AI/AN veterans may not be eligible for VA health care services.

¹³VA reports that approximately 30 percent of their enrollees are missing either ethnicity or race information in its enrollment system. Therefore, these data likely undercount the total number of VA-enrolled AI/AN veterans.

¹⁴The VA regional network offices provide management and oversight to the medical centers and clinics within their assigned geographic areas.

distances or time frames, VA may purchase care from non-VA providers through its community care programs, such as the Veterans Choice Program.¹⁵ Eligibility for VA health care is based on several factors, including the veteran's period of active service, discharge status, the presence of service connected disabilities or exposures, income, and other factors. VA uses factors such as these to categorize eligible veterans into eight enrollment priority groups—established to manage the provision of care.¹⁶ Some veterans qualify for free health care services based on service connected disabilities, income, or other special eligibilities, while others may be responsible for co-payments.

IHS was established to provide health services to members of AI/AN tribes, and its facilities are primarily in rural areas on or near reservations. IHS's fiscal year 2017 budget was approximately \$5 billion, and the agency served about 1.6 million individuals. The agency is organized into 12 federally designated geographic areas.¹⁷ IHS provides services directly through a federally operated network of 25 hospitals, 53 health centers, and 30 health stations in 37 U.S. states. In addition, about 54 percent of IHS's funds are provided to THPs to operate about 580 of their own facilities such as hospitals, health centers, clinics and health stations. IHS also provides funding to 41 nonprofit organizations through the Urban Indian Health program to provide health care services to AI/AN individuals living in urban areas.

IHS and THP facilities are often limited to providing primary and emergency care services. When needed health care services are not

¹⁵Established under the Veterans Access, Choice, and Accountability Act of 2014, the Veterans Choice Program authorizes care for eligible veterans through eligible non-VA providers under certain circumstances. Pub. L. No. 113-146, § 101, 128 Stat. 1754, 1755-65 (2014). The VA MISSION Act of 2018 requires VA to consolidate the Choice Program and its other VA community care programs into one community care program—the Veterans Community Care Program. The new program is expected to begin serving veterans in fiscal year 2019. The Choice Program is expected to continue until that time and will statutorily sunset after June 6, 2019. Pub. L. No. 115-182, §§ 101, 143, 132 Stat. 1393 (2018).

¹⁶See 38 U.S.C. § 1705; 38 C.F.R. § 17.36(b). To manage its provision of health care services for eligible veterans, VA operates a system of annual patient enrollment in accordance with eight priorities listed in statute. VA may change which categories and subcategories of veterans are eligible for enrollment by amending the applicable regulation. See 38 C.F.R. § 17.36(c).

¹⁷The 12 IHS area offices are Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

available at IHS or THP facilities, in certain circumstances the facilities may pay external providers to provide these services through IHS's Purchased/Referred Care (PRC) program.¹⁸ Before the PRC program can provide payment, patients must exhaust all health care resources available to them from private insurance, state health programs, and other federal programs, including VA.¹⁹ Furthermore, eligibility for PRC payment is not automatic, and IHS has reported that PRC funds are not sufficient to pay for all necessary care and, therefore, generally pay for only the highest priority costs, such as emergency care and transportation to that care.²⁰

To be eligible for IHS health care services, an individual must generally be a member or descendant of one of the current 573 federally recognized Indian tribes, as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors.²¹ In instances where an AI/AN veteran is eligible for a particular health care service from both VA and IHS, VA is the primary payer.

¹⁸According to IHS, the general purpose of PRC is for IHS and THPs to purchase services from private health care providers in situations where: 1) no IHS or tribal direct care facility exists; 2) the existing IHS or tribal direct care facility is incapable of providing required emergency and/or specialty care; 3) utilization in the direct care element exceeds existing staffing; and 4) supplementation of alternate resources (e.g., Medicare, Medicaid, or private insurance) is required to provide comprehensive health care to an eligible AI/AN veteran. See Indian Health Service, *Purchased/Referred Care Fact Sheet*, June 2016, accessed December 14, 2018, <https://www.ihs.gov/newsroom/factsheets/purchasedreferredcare/>.

¹⁹IHS also has indicated that any alternate health care resources, including VA, must be "reasonably accessible and available." Therefore, a patient that qualifies for VA services could still have their care paid for through the PRC program if the IHS-funded facility determines that the resource is, for example, too far for the patient to travel.

²⁰Additional PRC program requirements include that to be eligible for PRC payment at a particular facility, an individual must live within a certain reservation or PRC delivery area which generally covers a single tribe or a few tribes local to the area. Additionally, prior approval or notification within 72 hours of emergency cases is generally required for PRC payment.

²¹See 42 C.F.R. § 136.12.

The VA and IHS MOU and Reimbursement Agreements

The 2010 MOU between VA and IHS set mutual goals and objectives to facilitate coordinating and resource-sharing between the two agencies. Specifically, the five MOU goals are as follows:

1. Increase access to and improve quality of health care and services to the mutual benefit of both agencies. Effectively leverage the strengths of the VA and IHS at the national and local levels to afford the delivery of optimal clinical care.
2. Promote patient-centered collaboration and facilitate communication among VA, IHS, AI/AN veterans, tribal facilities, and Urban Indian clinics.
3. In consultation with tribes at the regional and local levels, establish effective partnerships and sharing agreements among VA headquarters and facilities, IHS headquarters and facilities, tribal facilities, and Urban Indian Health Programs in support of AI/AN veterans.
4. Ensure that appropriate resources are identified and available to support programs for AI/AN veterans.
5. Improve health promotion and disease prevention services to AI/AN veterans to address community-based wellness.

In accordance with these five goals, the MOU contains specific areas in which VA and IHS agreed to collaborate and coordinate, including:

- *Reimbursement*: development of payment and reimbursement policies and mechanisms to support care delivered to dually eligible AI/AN veterans.
- *Sharing staff*: sharing of specialty services, joint credentialing and privileging of health care staff, and arranging for temporary assignment of IHS Public Health Service commissioned officers to VA.
- *Staff training*: providing systematic training for VA, IHS, THP, and Urban Indian Health Program staff on VA and IHS eligibility requirements to assist them with appropriate referrals for services.
- *Information Technology Interoperability*: interoperability of systems to facilitate sharing of information on common patients, and establishment of standard mechanisms for VA, IHS, and THP providers to access records for patients receiving care in multiple systems.

VA and IHS each designated certain staff to oversee and implement the MOU, but VA is generally responsible for administering the MOU. For example, VA's Office of Community Care provides oversight of the reimbursement agreements—which are a key part of the MOU. Within that office, VA established the IHS/THP Reimbursement Agreements Program to carry out portions of the MOU related to the development of payment and reimbursement policies. Under these policies, in instances where an AI/AN veteran is eligible for a particular health care service from a VA facility, that veteran can instead receive the eligible service at an IHS or THP facility without prior VA approval and, under a reimbursement agreement, VA will reimburse the facility for the service. Some key aspects of the reimbursement agreement program are as follows:

- All IHS facilities are covered under one national reimbursement agreement between VA and IHS.
- THPs each negotiate their own separate reimbursement agreements with VA. While VA uses a reimbursement agreement template based on the agreement with IHS, the terms of each THP agreement may deviate from those in IHS's national agreement.
- Urban Indian Health Programs are generally not eligible for reimbursement agreements.²²
- VA provides reimbursement for outpatient and inpatient direct care services provided at IHS and THP facilities.
- VA also reimburses IHS and THP facilities for costs of outpatient prescriptions for AI/AN veterans, as well as filling prescriptions for AI/AN veterans served at IHS and THP facilities through VA's Consolidated Mail Outpatient Pharmacy program.
- VA does not provide reimbursement for those services from external providers paid for by IHS or THP PRC programs.

VA reports that the process of establishing reimbursement agreements with THPs has multiple phases. The process begins with initial communication between the THP and VA, followed by an orientation briefing. The THP then begins to draft the agreement (based on VA's

²²According to VA officials, Urban Indian Health Programs are generally not eligible to have a reimbursement agreement with VA because they are not identified in statute as one of the organizations that VA may reimburse. See 25 U.S.C. §1645(c). However, two Urban Indian Health Programs are covered under the national reimbursement agreement with IHS because officials report that those programs function as a service unit as defined in 25 U.S.C. §1603(20).

template) and prepare required VA paperwork (e.g., an implementation plan and proof of certification or accreditation). Once drafted, the THP submits the draft agreement and paperwork for review by VA's IHS/THP Reimbursement Agreements Program, followed by review by a VA contracting officer and legal team. The agreement is complete once it is signed by VA and the THP.

VA and IHS Continue to Jointly Oversee the MOU, but Gaps Exist in Measuring Performance

A joint leadership team of VA and IHS officials continues to oversee the implementation of the 2010 MOU through meetings, regular reporting, and the establishment of goals and measures to assess performance—but these measures lack targets for assessing progress toward the goals. VA and IHS officials also told us they are drafting a revised MOU to be broader and more flexible than the existing MOU and are updating the performance measures. However, officials have not indicated that any revised measures will include targets.

VA and IHS Have Continued to Carry Out MOU Oversight Activities and Implementation, and Are in the Process of Revising the MOU

Since our last report in 2014, a joint national leadership team comprised of VA and IHS officials has continued to use quarterly meetings, routine reporting, and MOU goals and measures to oversee MOU implementation and help facilitate collaboration. VA and IHS officials told us that the leadership team consists of officials in VA's Office of Rural Health and Office of Tribal Government Relations, and the IHS Deputy Director for Intergovernmental Affairs. Specifically, the leadership team has met to discuss the progress and status of the MOU, develop implementation policy and procedures, create performance measures and timelines, and evaluate progress on those measures. The leadership team also compiles annual reports on progress in MOU implementation that includes information about activities and challenges on meeting MOU goals using established measures, and information on the reimbursement agreements and outpatient pharmacy program. In addition, VA and IHS issue monthly data reports on the reimbursement agreements, including the total amount disbursed, the number of veterans receiving services

reimbursed by VA, and the number of claims processed for IHS and THP facilities.

The leadership team receives input from workgroups tasked with the responsibility for implementing and developing strategies to address the goals of the MOU. The workgroups primarily consist of VA and IHS staff who meet periodically to discuss goals and report quarterly to the leadership team. Tribal officials have participated in some MOU workgroups, though they are not a part of the MOU leadership team.²³ Since our last report in 2014, the number of workgroups decreased from 12 to three groups. (See table 1.) VA and IHS officials said that there were a number of reasons why the number of workgroups had decreased over time, such as consolidation into broader groups because the missions of some groups were similar. VA officials noted that the 12 original workgroups reflected the structure of the MOU, but over time they realized that there was not a need for workgroups in some of these areas.

Table 1: Change in the Number of VA and IHS MOU Workgroups from 2014 to 2018

Workgroups (2014)	Workgroups (2018)
(1) Services and Benefits	(1) Payment, Reimbursement, and Systems
(2) Coordination of Care	(2) Clinical Services (Pharmacy)
(3) Health Information Technology	(3) Training and Recruitment
(4) New Technologies	
(5) System Level	
(6) Payment and Reimbursement	
(7) Sharing of Care Process, Programs, and Services	
(8) Cultural Competency and Awareness	
(9) Training and Recruitment	
(10) Emergency and Disaster Preparedness	
(11) Alaska	
(12) Leadership	

Source: GAO summary of information from the Department of Veterans Affairs (VA) and the Indian Health Service (IHS). | GAO-19-291

With the establishment of the MOU, VA and IHS have been able to share resources and collaborate on activities to improve access of care for AI/AN veterans. VA and IHS reported that the MOU has helped both

²³In the past, tribal officials have served on certain MOU workgroups such as the Payment, Reimbursement, and Systems workgroup and the Care Coordination workgroup.

agencies develop an outpatient pharmacy program for AI/AN veterans, hold joint training and recruitment events, and establish the reimbursement agreement program, among other accomplishments. The VA, IHS, and THP facility officials we spoke with noted activities related to the reimbursement agreements and a few noted improvements in areas such as training and telehealth as a result of the MOU. However, most of the facility officials generally reported they had not observed improvements in national-level VA and IHS collaboration and coordination in other areas identified by the MOU. Additionally, these facility officials told us that their facilities have not implemented any new policies, procedures, or any specific facility performance goals or targets that were linked to the MOU.

VA and IHS headquarters officials acknowledged that all areas of the MOU have not been implemented at all facilities, and noted that while improvements have been made in many areas, organizational challenges remain, such as in the area of information technology. One IHS headquarters official added that even though VA and IHS have not fully implemented all parts of the MOU, they have addressed each area of the MOU in some manner. For example, one of the goals of the MOU is to improve coordination of care by developing and testing innovative approaches and disseminating best practices. IHS headquarters officials indicated that the agency has addressed this goal in part by creating an Improving Patient Care program that was informed by using VA curriculum and utilizing lessons learned from VA's Patient Aligned Care Teams.²⁴

VA and IHS leadership said they are currently in the process of revising the MOU to be broader and more flexible to better meet the care needs of AI/AN veterans. Regularly monitoring and updating written agreements on collaboration, such as the MOU, is consistent with our key collaboration practices.²⁵ IHS officials said that in contrast to the current MOU, in the new MOU, they are not looking to delineate every area of coordination and instead are grouping topics into broader areas of coordination. In the fiscal year 2017 MOU annual report, VA and IHS noted they were removing outdated language from the MOU and planned to create a more

²⁴VA describes its Patient Aligned Care Team initiative as patient-driven, proactive, personalized, team-based care focused on wellness and disease prevention. VA states that this approach results in improvements in veteran satisfaction, healthcare outcomes, and costs.

²⁵See [GAO-12-1022](#).

comprehensive, flexible MOU that would serve both agencies well into the future. VA and IHS officials indicated that these revisions will address some areas in the current MOU that they have not yet been able to implement. In June 2018, VA officials said that the leadership team had decided upon a revised set of MOU goals and associated objectives. In February 2019, VA and IHS reported that the target completion date for the new MOU was spring 2020.

VA and IHS MOU Performance Measures Are Not Sufficient

VA and IHS have improved their efforts to measure progress towards meeting the five MOU goals since 2014. In response to a recommendation made in our April 2013 report, VA and IHS revised their MOU performance measures in 2015—better aligning the measures with the MOU goals.²⁶ In addition, as a result of our work in 2013, the agencies revised an existing data collection reporting template used to gather information for each measure—such as the measurable objective, rationale and intent of the measures, action plan, milestones, and barriers—to help determine whether MOU goals were being met. While we found that the three existing MOU workgroups had since stopped using this template, a VA official confirmed that they believe relevant information is still captured through its monthly and quarterly reports.

Nonetheless, while VA and IHS improved their performance measurement efforts since our 2013 report, we found that the revised MOU performance measures still do not have quantitative and measurable targets to assess agency progress toward the goals. We have previously reported that performance measures should have numerical targets or other measurable values, which help assess whether overall goals and objectives were achieved by easily comparing projected performance and actual results.²⁷ Besides having measureable targets,

²⁶See [GAO-13-354](#). We recommended in part that as the agencies move forward with revising the MOU's performance metrics and measures, ensure that the revised metrics and measures allow decision makers to gauge whether achievement of the metric and measure supports attainment of MOU goals.

²⁷These characteristics are based on GAO's body of work on effectively managing performance under the Government Performance and Results Act of 1993 (GPRA), as modified by GPRA Modernization Act of 2010. We have previously reported that successful performance measures as a whole should have four general characteristics: demonstrate results, be limited to a vital few, cover multiple priorities, and provide useful information for decision making. See [GAO-03-143](#) and [GAO-15-397](#).

other key attributes of successful performance measures include linkage to an agency’s goals and mission, clarity, objectivity, and balance.²⁸ None of the 15 revised measures have targets against which performance can be measured to assess progress and evaluate effectiveness. (The results of our assessment are shown in table 2.) For example, while the number of shared VA-IHS trainings and webinars is a performance measure, there is no target for the number of shared trainings VA and IHS hope to complete each year.

Table 2: Assessment of Fiscal Year 2017 Performance Measures Linked to the VA-IHS MOU

Memorandum of Understanding (MOU) Performance Measures	Absence of measurable targets	Task; not a performance measure	Not currently in use	Lacks clear definitions
1. Goal 1: Increase access to care for American Indian and Alaska Native (AI/AN) veterans: Number of VA enrolled veterans served by IHS and tribal health programs (THP) through the VA-IHS and VA-THP reimbursement agreements	yes			
2. Goal 1: Increase access to care for American Indian and Alaska Native (AI/AN) veterans: Total disbursed dollar amount through the VA-IHS and VA-THP reimbursement agreements	yes			
3. Goal 1: Increase access to care for American Indian and Alaska Native (AI/AN) veterans: Total prescriptions filled through VA’s Consolidated Mail Outpatient Pharmacy program for direct AI/AN veteran care	yes			
4. Goal 1: Increase access to care for American Indian and Alaska Native (AI/AN) veterans: Completion of annual metric review	yes	yes		
5. Goal 2: Improve quality and coordination of care for AI/AN veterans: Total number of instances where VA and IHS or THPs share space, equipment, services and/or personnel to provide health care for AI/AN veterans	yes			
6. Goal 2: Improve quality and coordination of care for AI/AN veterans: Quality measures tracked specifically for enrolled veterans served by IHS through the VA-IHS reimbursement agreement	yes		yes	yes

²⁸Our previous work notes that linkage is when a measure is aligned with goals and mission and clearly communicated throughout the organization. Clarity is when a measure is clearly stated and the name and definition are consistent with the methodology used to calculate it. Objectivity in a measure is when it is reasonably free from significant bias or manipulation. Finally, a measure is considered balanced when it ensures that an organization’s various priorities are covered. See [GAO-15-397](#).

Memorandum of Understanding (MOU) Performance Measures	Absence of measurable targets	Task; not a performance measure	Not currently in use	Lacks clear definitions
7. Goal 2: Improve quality and coordination of care for AI/AN veterans: Completion of annual metric review	yes	yes		
8. Goal 3: Encourage patient-centered collaboration and communication between VA and IHS: Number of shared VA-IHS training and webinars	yes			
9. Goal 3: Encourage patient-centered collaboration and communication between VA and IHS: Number of training attendees	yes		yes	
10. Goal 3: Encourage patient-centered collaboration and communication between VA and IHS: Number of meetings between VA Office of Rural Health and IHS leaders to coordinate MOU implementation activities	yes			
11. Goal 3: Encourage patient-centered collaboration and communication between VA and IHS: Completion of annual metric review	yes	yes		
12. Goal 4: Ensure health-promotion and disease-prevention services are appropriately funded and available: Total reimbursement for suicide prevention, tobacco cessation and diabetes management services	yes			
13. Goal 4: Ensure health-promotion and disease-prevention services are appropriately funded and available: Completion of annual metric review	yes	yes		
14. Goal 5: Consult with tribes at the regional and local levels: Number of official communications, consultations, and trainings with tribal communities pertaining to Native veterans issues	yes			
15. Goal 5: Consult with tribes at the regional and local levels: Completion of annual metric review	yes	yes		

Source: GAO analysis of MOU information from the Department of Veterans Affairs (VA) and the Indian Health Service (IHS). | GAO-19-291

VA officials we spoke with stated VA has not considered adding targets to these measures, noting that the nature of the measures and MOU work against establishing targets. For example, officials said that the measures related to the reimbursement agreements are dictated by the needs of the population seeking health care and the providers at the IHS and THP facilities. VA officials we spoke with said instead of targets, they assess success or failure by whether they see incremental growth in the measures. Officials added that they examine these measures quarterly to determine if they have increased, decreased, or remained stable. If the measures are stable or decrease, officials said they consider if these trends can be reversed.

However, the absence of targets limits the ability of VA and IHS to use these measures to assess performance. Without defined measurable targets or goals, VA and IHS lack a clear basis for objectively and strategically evaluating how and where improvements should be made. For example, while it is helpful to count the number of tribal outreach activities conducted, setting an annual target for such activities would allow the agencies to better assess whether they are meeting their goals in this area.

In addition, some of these measures also lacked other attributes important for assessing performance. Specifically, five of the measures listed the completion of an annual metric review, which is a task to execute rather than a desired performance outcome to be measured. VA and IHS also are not using two measures. Specifically, they have not collected any data to track results on the number of VA and IHS employees who attend training and on the quality of health care provided. Relatedly, for the measure on health care quality, VA and IHS have not developed a clear definition against which to measure performance, as specific quality measures have not been determined and data are not being collected.

VA and IHS have documented challenges related to confusion and difficulty in tracking some measures; for example, at a meeting in March 2017, the MOU leadership team discussed that measures were not well tailored to the workgroup structure at that time. IHS officials also acknowledged that the measures currently in place are counting activities, but not necessarily always measuring performance—such as whether trainings held were effective. VA officials said that revising the MOU will give them an opportunity to revisit the performance measures used, and that they are looking to apply lessons learned to do a better job in the future at defining the measures. Similarly, IHS officials noted that the agencies are engaged in conversation about the performance measures to make them more useful. However, as previously noted, VA officials said that they have not considered establishing targets for the measures.

Use of Reimbursement Agreements Has Increased Since 2014 and IHS and THP Facilities Viewed the Agreements as Beneficial

THP facilities' use of reimbursement agreements with VA increased from 2014 through 2018. The selected IHS and THP facilities we spoke with

viewed the reimbursement agreements as beneficial, but also identified some concerns.

The Number of Reimbursement Agreements Entered, and the Amount of Claims Reimbursed and Veterans Served through Them, Have Increased Since 2014

The use of VA's reimbursement agreements with THPs increased from 2014 through 2018, as measured by the number of agreements, claims reimbursed, and veterans served. In addition, there was also an increase in payments made for prescriptions filled through the VA's Consolidated Mail Outpatient Pharmacy program for AI/AN veterans receiving services at IHS and THP facilities. As all IHS facilities are covered under a single national agreement that was instituted prior to 2014, there was less change in the use of reimbursement agreements by these facilities.

Reimbursement agreements entered. The number of reimbursement agreements with THPs more than doubled from 2014 to 2018, increasing about 113 percent. We previously reported, as of May 16, 2014, that VA had 53 reimbursement agreements with THPs. VA data showed that as of December 2018 it had 113 reimbursement agreements with THPs, representing about 34 percent of the 337 total IHS-funded THPs. (See fig. 1.) VA also reported that there were 42 additional pending reimbursement agreements with THPs that were in varying phases of submission, processing, and review. In addition, as in 2014, IHS facilities are covered under a single national agreement, and the number of IHS facilities covered by it has remained similar.²⁹

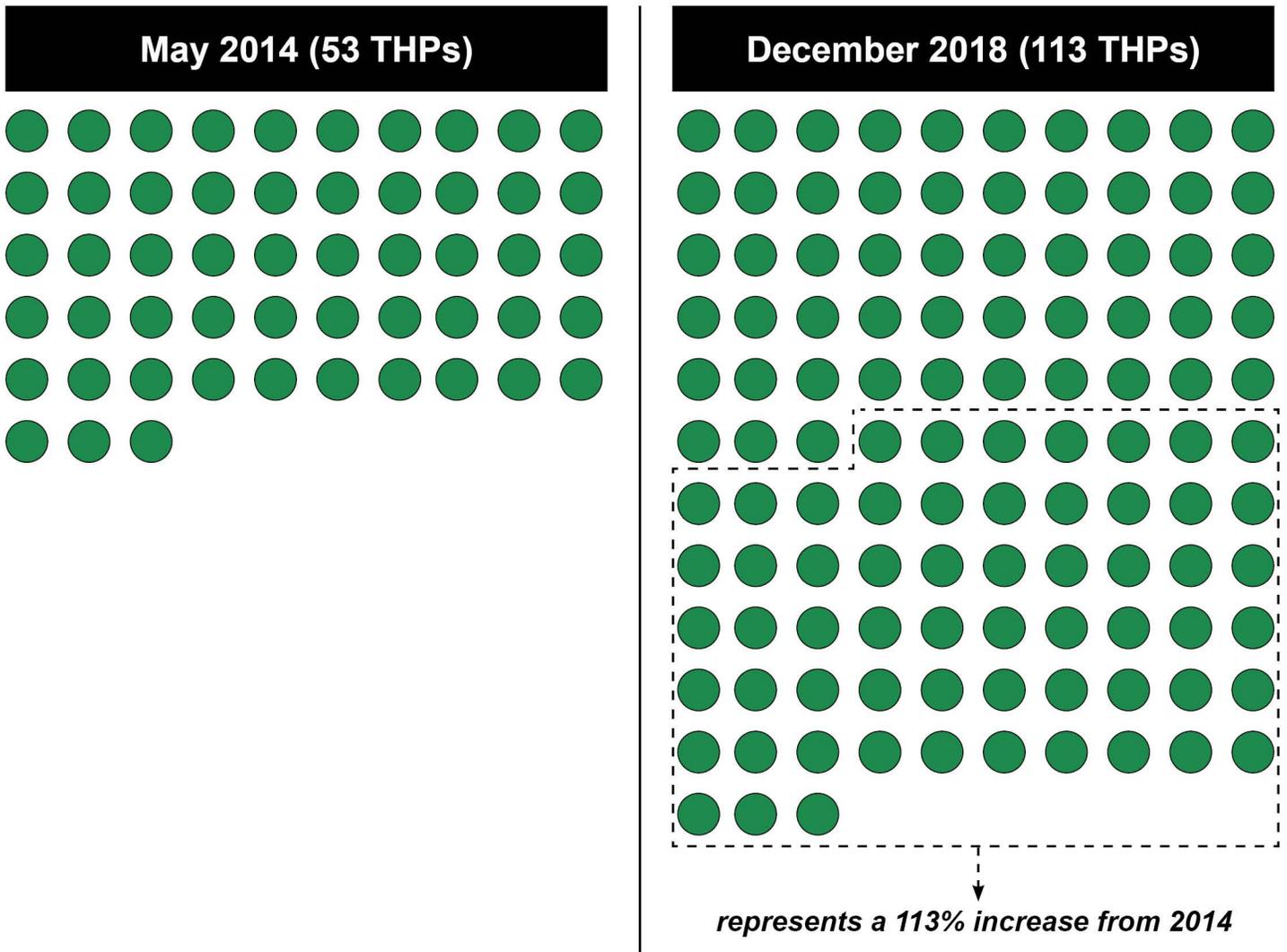
In 2014, we reported that VA officials had conducted outreach through tribal letters and events to educate THPs about the option of establishing reimbursement agreements, and officials told us this outreach has continued.³⁰ As we reported previously, there are several reasons a THP might decide not to have an agreement with VA, such as deciding it was not worth the time and resources needed to establish an agreement.

²⁹In 2014, we reported that 81 IHS facilities were covered by the national agreement. As of October 2018, 78 IHS facilities were covered under the national agreement. IHS officials attributed the slight variation in the number of IHS facilities covered by the national reimbursement agreement to facilities converting from IHS operation to THP operation.

³⁰[GAO-14-489](#).

Officials from a national tribal organization we spoke with said that smaller tribes without many veterans or resources may not be interested. IHS officials also noted that if a THP's veteran population has alternate payment resources (e.g., Medicaid or private insurance), it may not be worth the steps to implement a reimbursement agreement if the THP will not be billing VA for veterans' services.

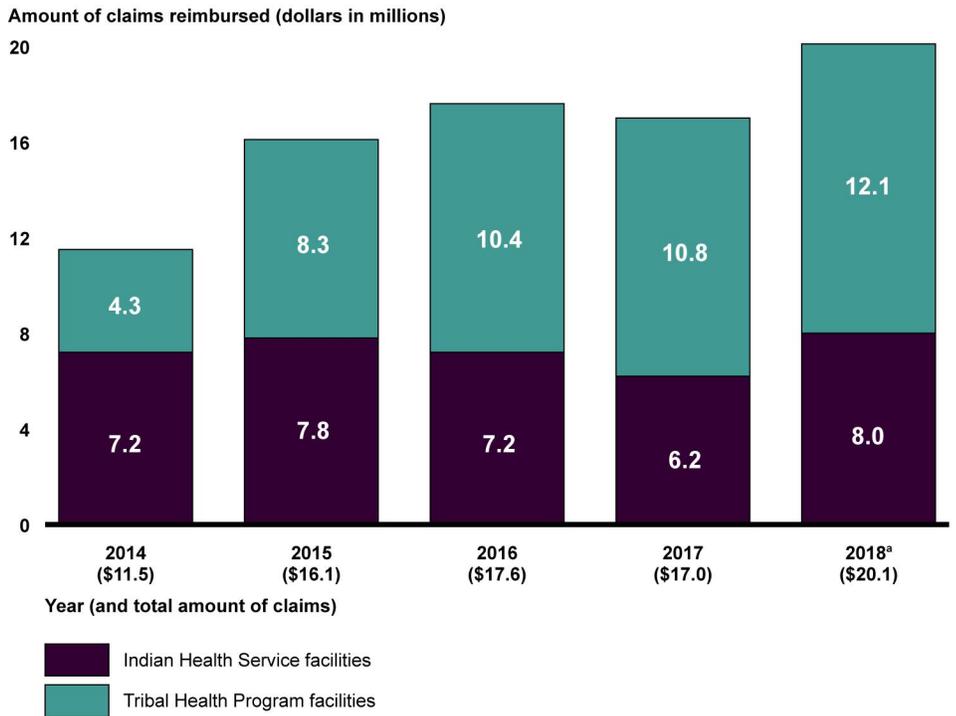
Figure 1: Change in the Number of Tribal Health Program (THP) Reimbursement Agreements from May 2014 through December 2018



Source: GAO analysis of Department of Veterans Affairs data. | GAO-19-291

Amount of claims reimbursed. In fiscal year 2014, VA paid IHS and THP facilities \$11.5 million for services provided to AI/AN veterans, which grew to \$20.1 million in fiscal year 2018. This increase mainly represents the growth in reimbursement to THP facilities—which grew 181 percent, from \$4.3 million in fiscal year 2014 to \$12.1 in fiscal year 2018. During this same time period, reimbursements to IHS facilities remained relatively stable, reflecting the stable number of IHS facilities receiving reimbursements. (See fig. 2.)

Figure 2: Amount of Claims Reimbursed by VA, Fiscal Years 2014 to 2018



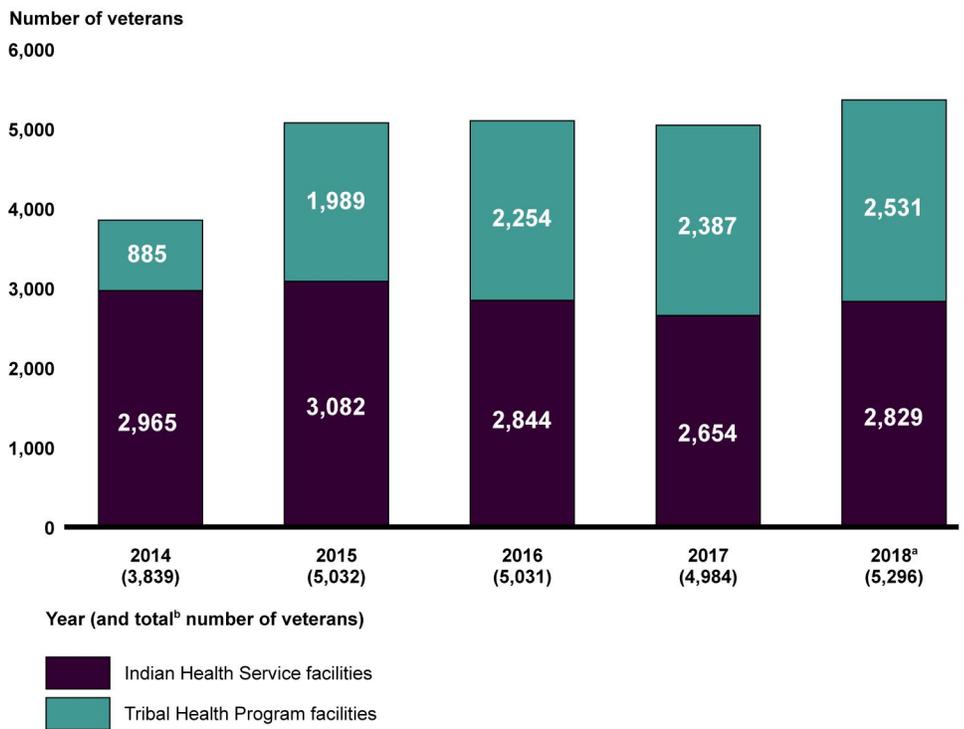
Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-19-291

^aIndian Health Service and Tribal Health Program facilities may file claims for VA reimbursement up to 12 months from the date of service. Therefore, the reported numbers for claims reimbursed could increase. The fiscal year 2018 data we have reported were current as of September 30, 2018.

Veterans served. Between fiscal year 2014 and fiscal year 2018, according to VA data, the number of unique AI/AN veterans receiving services reimbursed by VA each year has increased from about 3,800 in 2014 to a high of nearly 5,300. (See fig. 3.) While IHS facilities accounted for a larger percentage of veterans with reimbursed services compared to THPs, the number of veterans receiving services reimbursed by VA at THPs increased significantly. For fiscal year 2014, 2,965 AI/AN veterans

received services reimbursed by VA at IHS facilities, which decreased slightly to 2,829 in fiscal year 2018. In comparison, 885 veterans received services reimbursed by VA at THP facilities in fiscal year 2014, which nearly tripled to 2,531 veterans in fiscal year 2018.

Figure 3: Number of Unique American Indian and Alaska Native Veterans Receiving Services Reimbursed by VA, Fiscal Years 2014 to 2018



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-19-291

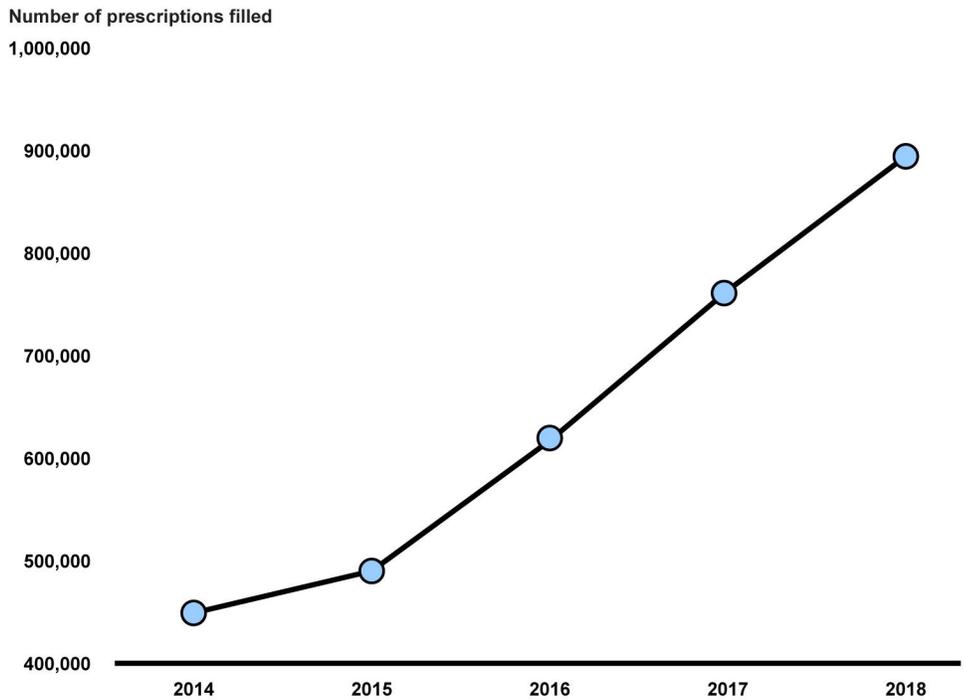
^aTribal Health Program and Indian Health Services facilities may file claims for VA reimbursement up to 12 months from the date of service. Therefore, the reported numbers for veterans receiving services reimbursed by VA could increase.

^bThe number of unique veterans served by Indian Health Services and Tribal Health Program facilities for each fiscal year do not sum to the total number of veterans because American Indian and Alaska Native veterans may have been seen at both types of facilities.

Prescriptions filled. Similar to increases in the numbers of AI/AN veterans served under the reimbursement agreements, AI/AN veterans' utilization of VA's Consolidated Mail Outpatient Pharmacy program has also increased. Prescriptions filled through this program more than doubled—from more than 440,000 prescriptions in fiscal year 2014 to nearly 886,000 prescriptions in fiscal year 2018. (See fig. 4.) VA and IHS annual reports indicate that the pharmacy program has been one of the

most successful collaborations between VA and IHS for AI/AN veterans, providing more than 2 million prescriptions for VA-IHS patients since the pharmacy program collaboration began in 2010. While this program was originally limited to AI/AN veterans served at IHS facilities, in December 2016, VA and IHS entered into an Interagency Agreement that extended the program to THPs.

Figure 4: Number of Prescriptions Filled for AI/AN Veterans through VA's Consolidated Mail Outpatient Pharmacy Program, Fiscal Years 2014 to 2018



Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-19-291

Note: VA's Consolidated Mail Outpatient Pharmacy program was originally limited to American Indian/Alaska Native (AI/AN) veterans served at Indian Health Service facilities. However, in December 2016, the program was extended to AI/AN veterans served at tribal health programs.

IHS and THP Facilities Viewed the Reimbursement Agreements as Beneficial, but Identified Some Concerns

Officials from the majority of IHS and THP facilities we contacted said they were generally pleased with the reimbursement agreements. Among those, officials from one THP noted that the revenue received from their reimbursement agreement freed up other resources that allowed them to hire an additional part-time worker to conduct VA outreach activities.

Additionally, a representative of a national tribal organization noted that IHS and THP facilities' funding is limited and this revenue helps them extend services to eligible AI/AN veterans.

However, officials from a number of IHS and THP facilities also had concerns about the agreements, including the lack of reimbursement for PRC program services provided by IHS and THP facilities, the length of time it took to enter into the agreements, and the time frames of the agreements:

Lack of reimbursement for PRC program services. Officials at most IHS and THP facilities we contacted said they believed VA should reimburse facilities for services from external providers paid through the PRC program. Officials at some facilities said they have had to deny PRC services due to a lack of program funds. According to some facility and IHS area office officials, this issue is particularly relevant in states where Medicaid was not expanded under the Patient Protection and Affordable Care Act (PPACA).³¹ In states where Medicaid eligibility was expanded, more AI/AN individuals may therefore be eligible for Medicaid—potentially freeing up PRC funds. For example, an IHS official noted that prior to Medicaid expansion in his state they would have to limit PRC funds to be used only in life or death scenarios after May or June of each year, but that currently his facility was not limiting any PRC services. Given the limitations in PRC program funds, officials from a national tribal organization and some THPs noted they have raised the possibility of including the PRC program in the reimbursement agreements with VA, although the program was ultimately not included.

VA officials noted that there is no statutory requirement for them to include the PRC program in the reimbursement agreements and also

³¹Under PPACA, enacted on March 23, 2010, states may opt to expand their Medicaid programs to cover non-elderly, non-pregnant adults who are not eligible for Medicare, and whose income does not exceed 133 percent of the federal poverty level beginning January 1, 2014. Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases income eligibility from 133 percent to 138 percent of the federal poverty level. PPACA also permitted an early expansion option, whereby states could expand eligibility for this population, or a subset of this population, starting on April 1, 2010. As of December 2017, there were 31 “expansion states”—those states and the District of Columbia that chose to expand Medicaid eligibility—and 19 “non-expansion states”—those that had not expanded Medicaid eligibility to this additional adult population.

identified several other reasons for not including it. For example, they said that VA does not want to pay for services externally that it already offers internally and that it would prefer to coordinate the patient's care within VA's existing programs, such as VA's own programs for purchasing care from external providers—like the Veterans Choice Program.

The length of time to enter into an agreement. Officials from a few THP facilities and one national tribal organization we spoke with noted concerns about the amount of time it took to enter into reimbursement agreements. Our analysis of VA reimbursement agreement data shows that the median amount of time that it took to enter an agreement with THPs was over 1 year (about 403 days). We found that the number of days from the first contact by a THP to the actual signing of the agreement ranged from 96 days (over 3 months) to 1,878 days (more than 5 years).

According to VA records and interviews, there were reasons for delays in completing reimbursement agreements, including lengthy negotiations, incomplete submission of information from the THPs, lapses in communication between VA and the THP, and a THP's lack of medical certification or accreditation.³² VA officials explained that the amount of time increases if the THP does not want to use the VA-approved reimbursement agreement template or wants to change the terms of the agreement. For example, an official from one THP facility said that it took 2.5 years to finalize its reimbursement agreement due, in part, to internal challenges with their legal counsel and external challenges with negotiating the terms of the agreement during a time when the VA was developing a national reimbursement agreement template. VA officials also explained that entering the agreement with IHS was simpler than entering agreements with THPs because it was a national agreement between two federal agencies and, for example, did not require having a contracting officer review the agreement—an extra step needed for agreements with non-federal agencies.

The length of time reimbursement agreements are in effect. Officials from a few THP facilities expressed a desire for longer reimbursement agreements that would permit greater planning ability. The agreement between VA and IHS was initially set for 3 years. It was then extended

³²In order to receive reimbursement, VA requires THPs to meet Centers for Medicare & Medicaid Services certification and conditions of participation, or have accreditation through the Joint Commission on Accreditation Association for Ambulatory Health Care.

twice, once for 2 years and once for 1.5 years. The time frames for THP agreements have generally been extended consistent with extensions to the national agreement. Officials from one THP we spoke with said that having short-term reimbursement agreements causes problems with internal organizational planning and it would be beneficial to have a longer term non-expiring agreement that can be cancelled so that THPs do not continue to expend resources to complete new agreements or amendments every 2 years. In June 2018, VA and IHS signed an amendment to extend the terms of the national reimbursement agreement through June 30, 2022. VA officials said they are currently in the process of working with THPs to similarly extend their agreements.

Facilities Cited Varying Levels of Coordination, and Key Challenges Included Making Referrals from IHS and THP Facilities to VA

In speaking to officials at selected VA, IHS, and THP facilities about key issues related to coordinating care for AI/AN veterans, we found that the extent of coordination they reported varied widely. For example, three IHS and THP facilities said they had little to no care coordination with their local VA partners; noting, for example, that they rarely refer veterans to VA since they offer more services than the closest VA facilities. Other facilities described more extensive and formalized care coordination, including shared funding of certain VA and THP employees, or VA employees on site at THP facilities to manage veterans' care and referrals to and from VA. In Alaska, for example, where services offered by VA are very limited, VA instead has formal sharing and reimbursement agreements established with 26 THPs, which provide the majority of services to AI/AN veterans, as well as some non-Native veterans. Two of the THP facilities we spoke with in Alaska have VA employees working on site to help coordinate veterans' care. VA and IHS headquarters officials indicated that the MOU was intended to allow for variation in the level of coordination at the local, facility level not to create demands or obligations on facilities. One VA official noted that as the new MOU is developed, both VA and IHS want to continue to allow VA, IHS, and THP facilities to engage in whatever level of coordination makes sense.

Despite variation in the extent of coordination, officials identified several common challenges regarding coordination between local VA, IHS, and THP facilities:

Referring patients to VA facilities. Officials from 9 of the 15 VA, IHS, and THP facilities we contacted reported conflicting information about the process for referring AI/AN veterans from IHS and THP facilities to VA facilities for specialty care. For example, 4 of the IHS and THP facilities we spoke with said that AI/AN veterans generally could not be referred directly to VA specialty care by IHS or THP providers without first being seen and referred by a provider at VA. These facility officials indicated that this practice was a barrier to care. These officials also noted that this could result in the patient receiving, and the federal government paying for, duplicative tests. However, officials at another IHS facility indicated that IHS and THP facilities should be able to refer patients directly to VA specialty care. Additionally, during an interview at a VA facility, local and regional officials had differing understandings of whether IHS and THP facilities could refer patients directly to VA specialty care.

VA and IHS headquarters officials both reported that in general, IHS or THP facilities cannot refer a patient to VA specialty care without that patient first being seen in VA primary care. However, VA officials reported that there is no national policy or written guidance on how to refer patients from an IHS or THP facility to a VA facility. VA officials said that the coordination process is left to the local VA facility and the respective IHS or THP facilities and the process can vary from one facility to another—explaining why differing information was reported by facility officials. Our past work on interagency collaborative mechanisms identifies that it is a leading collaboration practice to have written guidance and agreements to document how agencies will collaborate.³³ Without a written policy or guidance about how referrals of AI/AN veterans from IHS and THP facilities to VA facilities may be managed, VA and IHS cannot ensure that VA, IHS, and THP facilities have a consistent understanding of the options available for these referrals.

Information technology interoperability and access. Officials at 10 of the 15 VA, IHS, and THP facilities we contacted cited challenges related to accessing each other's health information technology systems. Most stated that a lack of interoperability of their electronic health records caused challenges, while a few IHS and THP facilities also mentioned that the lack of access to VA systems makes it difficult to verify a veteran's eligibility or determine the services for which VA will reimburse. For example, one THP noted that if an AI/AN veteran was sent to VA for a

³³See [GAO-12-1022](#).

service, the THP provider would not receive the veteran's follow-up records as quickly as if they had access to each other's systems. Improving systems' interoperability was a focus area identified in the MOU, and an IHS official indicated that while the agencies had some initial work on the topic, no systematic solutions were identified. We have previously identified VA's lack of systems interoperability—particularly with the Department of Defense—as a contributor to the agency's challenges related to health care.³⁴

VA and IHS officials identified some potential workarounds to this lack of interoperability, although they noted that some of the described workarounds could be time consuming and may not be feasible for all facilities:

- An IHS headquarters official said that IHS and VA each have the ability to request the sharing of information from an individual electronic health record held by the other agency through secure emails—although the official noted that this is not as fast or efficient as being able to log in to each other's systems.
- VA officials also reported that VA belongs to the eHealth Exchange—a national health information exchange—and said that IHS or THPs could join that, through which they would be able to access information about common veteran patients.³⁵ However, IHS reported that although the agency explored connecting to the eHealth Exchange several years ago, testing and onboarding costs to participate were prohibitive. IHS noted that several individual facilities across the IHS system have elected to invest in connections with regional health information exchanges. Similarly, two THPs we spoke

³⁴For example, in 2015, we designated VA health care as a high-risk area for the federal government. In part, we identified limitations in the capacity of VA's existing information technology systems, including the outdated, inefficient nature of certain systems and a lack of system interoperability as contributors to the department's challenges related to health care. VA's issues were highlighted in our 2015 high-risk report, *GAO, High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015) and 2017 update, *GAO, High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, [GAO-17-317](#) (Washington, D.C.: Feb. 15, 2017).

³⁵Health information exchanges can enable the electronic sharing of health-related information among providers and other entities, such as public health departments, regardless of where the care is delivered. The eHealth Exchange is a national-level exchange that includes four federal agencies (VA, the Department of Defense, the Centers for Medicare & Medicaid Services, and the Social Security Administration), and non-federal organizations, such as hospitals, medical groups, pharmacies, and regional and state health information exchanges.

with reported being a part of other, more locally-based health information exchanges, but noted that VA was not part of these exchanges.

- A VA official noted that there is an enrollment guide that details how enrollment and eligibility verification will be managed between IHS, THP, and VA facilities. This guide describes how IHS or THP facilities can request veterans' enrollment and eligibility information from the VA Health Eligibility Center using a templated spreadsheet that sends requests via email through a secure data transfer service. VA's Health Eligibility Center verifies the list and returns the completed enrollment/eligibility excel spreadsheet to the IHS or THP facility securely. IHS and THP facilities can also contact the VA Health Eligibility Center directly by telephone for fewer than five veterans per call, or their local VA medical center by telephone to verify one AI/AN veteran's enrollment and eligibility per call.
- IHS or THP facilities could also enter an arrangement with a local VA facility to have VA employees or co-funded employees on site at IHS or THP facilities, or to have VA-credentialed employees that can access VA systems to share information. However, these options may not be systemic solutions that work at all facilities. An IHS headquarters official noted, for example, that not all IHS or THP facilities have the type of relationship with their local VA facility that would lead to the establishment of such arrangements.

In terms of the potential for improving interoperability in the future, VA is in the process of implementing a new electronic health record system, and we have previously reported that VA has identified increased interoperability as a key expected outcome of its decision to switch systems.³⁶ Officials from two VA and THP facilities were hopeful that this new system will help improve interoperability since some THPs use an electronic health record system from the same company that VA has a contract with. Additionally, an IHS headquarters official said that IHS is also reevaluating its information technology platform and one requirement of any new IHS system will be to enhance interoperability with VA, pending the funding to do so. IHS also reported that the agency will consider health information exchange participation as part of the agency's information technology modernization efforts.

³⁶See GAO, *VA IT Modernization: Preparations for Transitioning to a New Electronic Health Record System Are Ongoing*, [GAO-18-636T](#) (Washington, D.C.: Jun. 26, 2018).

Staff turnover. Officials from 9 of 15 facilities identified staff turnover at VA, IHS, and THP facilities as an impediment to having better or consistent coordination. VA, IHS, and THP facility officials described situations in which the coordination between facilities was dependent on specific staff or facility leadership. According to officials, when there was turnover among these staff or positions went unfilled, or were eliminated, the coordination decreased or came to a halt. For example, officials at one VA facility said that they have found that if a sitting tribal government expresses interest in VA collaboration, they have to act quickly and work with the tribe before there is turnover and new tribal leadership comes in with different priorities. Additionally, officials from one IHS facility described a situation in which they had previously coordinated with their local VA facility through that facility's AI/AN liaison. However, the coordination lapsed when the liaison left VA and the position went unfilled. Similarly, a THP official stated that coordination with VA was previously led by a nurse case manager on site who was a joint VA and THP employee. The official said that since that person's retirement, she did not know who to contact at VA to coordinate veterans' care.

Officials at one IHS facility noted that due to turnover and attrition they would like to see more education for front line staff at both IHS and VA, so they can more efficiently obtain care for patients at the VA. VA headquarters officials acknowledged that staff turnover and retraining is a challenge that they will need to continually address as the MOU is carried out. In our prior work related to IHS and VA, we have found that both agencies face challenges related to staff turnover and training.³⁷

VA Co-Payments. Officials at 3 of the 11 IHS and THP facilities we contacted, as well as IHS headquarters officials and representatives of two national tribal organizations said that the copayments that VA charges veterans represented a barrier to AI/AN veterans receiving care.

³⁷For example, in 2017, we reported that IHS had leadership turnover in key positions, and that inconsistent area office and health care facility leadership is detrimental to the oversight of facility operations and the supervision of personnel. See GAO, *Indian Health Service: Actions Needed to Improve Oversight of Quality of Care*, [GAO-17-181](#) (Washington, D.C.: Jan. 9, 2017). And in addition to information technology challenges and other issues, VA's 2015 designation by GAO as a high risk area was also related to inadequate training for VA staff. In our 2017 update, we noted that VA had not met any of our criteria for removing this area of concern from the High-Risk List, and a number of recommendations related to inadequate training remained open. See [GAO-17-317](#). See also GAO, *Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges*, [GAO-17-30](#) (Washington, D.C.: Dec. 23, 2016).

While AI/AN veterans do not have any cost-sharing for care provided at IHS or THP facilities, they are subject to the same copayments as other veterans when they receive care from VA facilities.³⁸ VA data shows, for example, that of the 80,507 VA-enrolled self-identified AI/AN veterans in fiscal year 2017, about 30 percent were charged copayments, averaging about \$281.56 billed per veteran. Officials from one THP noted that this kind of financial liability may discourage AI/AN veterans from getting care at VA, or lead them to return to the THP after they realize they will have to pay for care at VA.

While some of our interviewees suggested that VA should waive copayments for AI/AN veterans, a VA official said they do not have the legal authority to do this. The official said that their statute specifies the categories of veterans for which they must charge copayments and VA is not authorized to waive the copayments for AI/AN veterans on the basis of their AI/AN status without statutory exemptions.³⁹ While certain AI/AN veterans may qualify for waived copayments based on their inclusion in other statutory categories, AI/AN veterans are not specifically listed as a category for which copayments can otherwise be waived.⁴⁰ VA officials also cautioned that because AI/AN veterans may qualify for waived copayments through these other categories, the possibility of copays should not discourage IHS or THP facilities from referring AI/AN veterans to VA.

Conclusions

Since 2014, VA and IHS have continued to work together to oversee and implement their MOU aimed at improving the health care provided to dually eligible AI/AN veterans. While the agencies have made progress in

³⁸While some veterans qualify for free health care services based on a service-connected condition or other special eligibilities, such as former prisoner of war status, most veterans are required to complete a financial assessment or means test at the time of enrollment to determine if they qualify for free health care services. Veterans whose income exceeds VA income limits as well as those who choose not to complete the financial assessment must agree to pay required copayments to become eligible for VA health care services. As of October 2018, the copayment for outpatient primary care services was \$15, while the copayment for outpatient specialty care services was \$50.

³⁹38 U.S.C. § 1710(f) and (g) list the categories of veterans that are subject to copayments.

⁴⁰See 38 U.S.C. § 1710(a)(1) and (a)(2) for categories of veterans not statutorily required to pay copayments and implementing regulations at 38 C.F.R. § 17.108.

certain areas of the MOU, especially those related to reimbursement, other parts have seen less attention. VA and IHS are now updating the MOU, and plan to revisit the related performance measures. This gives the agencies an opportunity to evaluate how well their existing oversight mechanisms have been working, and to improve these mechanisms accordingly in the future. Regardless of these updates, the agencies need to have effective performance measures. While the agencies took steps to improve MOU performance measures in response to one of our prior reports, these steps were not sufficient and the measures they set lack important attributes, including measurable targets. VA and IHS have indicated that they plan to reevaluate performance measures as they update the MOU, but have not indicated that these new measures will identify targets. Absent targets, VA and IHS are limited in their ability to measure progress towards MOU goals and ultimately make strategic decisions about how and where improvements should be made.

At the local level, care for AI/AN veterans relies on coordination among individual VA, IHS, and THP facilities. However, variations in relationships among these many facilities and staff turnover creates challenges, which heightens the importance of clear and consistent guidance from the national level. Yet no written guidance exists related to referring AI/AN veterans to VA facilities for specialty care. Without such guidance, VA and IHS cannot ensure that facilities have a consistent understanding of the available referral options for AI/AN veterans. Enhancing their guidance in this area will help VA and IHS ensure that AI/AN veterans have access to needed care.

Recommendations for Executive Action

We are making a total of three recommendations, including two to VA and one to IHS. Specifically:

- As VA and IHS revise the MOU and related performance measures, the Secretary of Veterans Affairs should ensure these measures are consistent with the key attributes of successful performance measures, including having measurable targets. (Recommendation 1)
- The Secretary of Veterans Affairs should, in consultation with IHS and tribes, establish and distribute a written policy or guidance on how referrals from IHS and THP facilities to VA facilities for specialty care can be managed. (Recommendation 2)

- As VA and IHS revise the MOU and related performance measures, the Director of IHS should ensure these measures are consistent with the key attributes of successful performance measures, including having measurable targets. (Recommendation 3)

Agency Comments

We provided a draft of this report to VA and the Department of Health and Human Services for review and comment. We have reprinted the comments from VA in appendix I and the comments from the Department of Health and Human Services in appendix II. Both departments concurred with our recommendations. The Department of Health and Human Services also provided technical comments, which we incorporated as appropriate.

In response to our recommendations to ensure revised performance measures include key attributes of successful performance measures, VA and the Department of Health and Human Services provided information about the process for finalizing the new MOU, including conducting tribal consultation. They noted that VA and IHS will work together to ensure that performance measures under the new MOU include appropriate measurable targets.

Regarding our recommendation to VA about establishing and distributing a written policy or guidance on how referrals from IHS and THP facilities to VA facilities for specialty care can be managed, VA noted the Office of Community Care is working on a process to enhance care coordination among all VA and non-VA providers—including IHS and THP providers. VA noted that for IHS and THPs, this will include establishing forms and procedures to refer patients to VA for specialty care, and that VA will provide training to applicable staff once the process and procedures are finalized. VA also noted that it is in the process of establishing an advisory group that will include tribal, IHS, and VA representation, and will make recommendations related to care coordination guidance and policies. The target completion date for establishing this group is spring 2020.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretaries of VA and the Department of Health and Human Services,

and other interested parties. In addition, the report will be available at no charge on GAO's website at <http://www.gao.gov/>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or farbj@gao.gov. Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix III.

Sincerely yours,

A handwritten signature in black ink that reads "Jessica Farb". The signature is written in a cursive, flowing style.

Jessica Farb
Director, Health Care

Appendix I: Comments from the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

March 5, 2019

Ms. Jessica Farb
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Farb:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***“VA AND INDIAN HEALTH SERVICE: Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans”*** (GAO-19-291).

The enclosure contains the actions to be taken to address the draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in black ink that reads "Robert L. Wilkie".

Robert L. Wilkie

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***VA AND INDIAN HEALTH SERVICE: Actions Needed to
Strengthen Oversight and Coordination of Health Care
for American Indian and Alaska Native Veterans***
(GAO-19-291)

Recommendation 1: As VA and IHS revise the MOU and related performance measures, the Secretary of Veterans Affairs should ensure these measures are consistent with the key attributes of successful performance measures, including having measurable targets.

VA Comment: Concur. The Department of Veterans Affairs (VA)/Indian Health Services (IHS) Memorandum of Understanding (MOU) leadership team has drafted revisions to the MOU to remove outdated language and create a more comprehensive, flexible MOU, pursuant to the Indian Health Care Improvement Act at 25 United States Code § 1647, that will serve both agencies well into the future. In accordance with Executive Order 13175, "Consultation and Coordination with Indian Tribal Governments," and respective agency's policy on Tribal consultation, VA and IHS will conduct Tribal consultation to ensure the MOU reflects input from Tribes, Tribal Organizations, and American Indian and Alaska Native Veterans. Upon completion of Tribal consultation, both agencies will process the new MOU through their approval and clearance chains for signature by the Secretary of Veterans Affairs and Director of IHS. This MOU will replace and supersede the October 1, 2010, MOU. VA and IHS will continue working together to ensure that performance measures include appropriate measurable targets. Target Completion Date: Spring 2020.

Recommendation 2: The Secretary of Veterans Affairs should, in consultation with IHS and tribes, establish and distribute a written policy or guidance on how referrals from IHS and THP facilities to VA facilities for specialty care can be managed.

VA Comment: Concur. Veterans Health Administration (VHA) Office of Community Care is working on a process to enhance care coordination among all VA and non-VA providers including IHS and Tribal Health Program (THP) providers and facilities. For IHS and THP, the process will include establishing standard forms and specific procedures to refer patients to VHA for specialty care. Once the process and procedures are finalized, VHA will provide training to all applicable staff.

VHA is also in the process of establishing an advisory group that will include a Tribal representative from each of the 12 identified IHS areas, a member from IHS, and appropriate members from VHA. This group will focus on care coordination and will analyze the effectiveness of the new care coordination process to ensure that it is working as intended. The advisory group will also make recommendations to VHA to help establish written guidance and policies on care coordination. Target Completion Date: Spring 2020.

Appendix II: Comments from the Department of Health and Human Services

**Appendix II: Comments from the Department
of Health and Human Services**



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

FEB 26 2019

Director, Jessica Farb
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Farb:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*VA and Indian Health Service: Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans*" (GAO-19-291).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Matthew D. Bassett".

Matthew D. Bassett
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - VA AND INDIAN HEALTH SERVICE: ACTIONS NEEDED TO STRENGTHEN OVERSIGHT AND COORDINATION OF HEALTH CARE FOR AMERICAN INDIAN AND ALASKA NATIVE VETERANS (GAO-19-291)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

Recommendation 3

As the Department of Veterans Affairs (VA) and Indian Health Service (IHS) revise the Memorandum of Understanding (MOU) and related performance measures, the Director of IHS should ensure these measures are consistent with the key attributes of successful performance measures, including having measurable targets.

HHS Response

HHS concurs with GAO's recommendation.

The VA and IHS MOU leadership team have drafted revisions to the MOU to remove outdated language and create a more comprehensive, flexible MOU, pursuant to the Indian Health Care Improvement Act at 25 U.S.C. § 1647, in support of our mutual goals. The IHS and VA will continue working together to ensure that performance measures include appropriate measurable targets.

In accordance with Executive Order 13175, "Consultation and Coordination with Indian Tribal Governments," and federal tribal consultation policies, IHS and VA will conduct tribal consultation to ensure the MOU reflects input from Tribes, Tribal organizations, and American Indian and Alaska Native Veterans. Upon completion of tribal consultation, IHS and VA will process the new MOU through their approval and clearance chains for signature by the Secretary of VA and Director of IHS. This MOU will replace and supersede October 1, 2010, MOU. The target completion date for the new MOU is spring 2020.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Jessica Farb, (202) 512-7114, farbj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Kathleen M. King (Director), William Hadley (Assistant Director), Christina Ritchie (Analyst-in-Charge), Jennie Apter, Shaunessye D. Curry, Jacquelyn Hamilton, and Vikki Porter made key contributions to this report.

Appendix IV: Accessible Data

Data Tables

Accessible Data for Figure 1: Change in the Number of Tribal Health Programs (THP) Reimbursement Agreements from May 2014 through December 2018

Date	Number of THPs
May 2014	53
December 2018	113 (represents a 113% increase from 2014)

Accessible Data for Figure 2: Amount of Claims Reimbursed by VA , Fiscal Years 2014 to 2018

Year	Amount of claim for each facility (dollar in millions)		Total amount of claims for year (dollar in millions)
n/a	<i>Indian Health Services</i>	<i>Tribal Health Program</i>	n/a
2014	7.2	4.3	11.5
2015	7.8	8.3	16.1
2016	7.2	10.4	17.6
2017	6.2	10.8	17.0
2018	8.0	12.1	20.1

Accessible Data for Figure 3: Number of Unique American Indian and Alaska Native Veterans Receiving Services Reimbursed by VA, Fiscal Years 2014 to 2018

Year	Number of veterans served by each facility		Total number of veterans for year
n/a	<i>Indian Health Services</i>	<i>Tribal Health Program</i>	n/a
2014	2,965	885	3,839
2015	3,082	1,989	5,032
2016	2,844	2,254	5,031
2017	2,654	2,387	4,984
2018	2,829	2,531	5,296

Accessible Data for Figure 4: Number of Prescriptions Filled for AI/AN Veterans through VA's Consolidated Mail Outpatient Pharmacy Program, Fiscal Years 2014 to 2018

Year	Filled Rxs
2014	440,575
2015	481,472
2016 ^a	608,496
2017	755,000
2018	885,702

Agency Comment Letters

Accessible Text for Appendix I Comments from the Department of Veterans Affairs

Page 1

March 5, 2019

Ms. Jessica Farb Director, Health Care

U.S. Government Accountability Office

441 G Street, NW

Washington, DC 20548

Dear Ms. Farb:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: "VA AND IND/AN HEALTH SERVICE: Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans" (GAO-19-291).

The enclosure contains the actions to be taken to address the draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Robert L. Wilkie

Enclosure

Page 2

Department of Veterans Affairs (VA) Comments to Government
Accountability Office (GAO) Draft Report

VA AND IND/AN HEALTH SERVICE: Actions Needed to Strengthen
Oversight and Coordination of Health Care for American Indian and
Alaska Native Veterans

(GAO-19-291)

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or guidance on how referrals from IHS and THP facilities to VA facilities for specialty care can be managed.

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Accessible Text for Appendix II Comments from the Department of Health and Human Services

Page 1

FEB 26 2019

Director, Jessica Farb

U.S. Government Accountability Office

441 G Street NW

Washington, DC 20548

Dear Ms. Farb:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "VA and Indian Health Service: Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans" (GAO-19-291).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Matthew D. Bassett

Assistant Secretary for Legislation

Attachment

Page 2

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED - VA AND INDIAN HEALTH SERVICE: ACTIONS NEEDED TO STRENGTHEN OVERSIGHT AND COORDINATION OF HEALTH CARE FOR AMERICAN INDIAN AND ALASKA NATIVE VETERANS (GAO-19-291)

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Recommendation 3

As the Department of Veterans Affairs (VA) and Indian Health Service (IHS) revise the Memorandum of Understanding (MOU) and related performance measures, the Director of IHS should ensure these measures are consistent with the key attributes of successful performance measures, including having measurable targets.

HHS Response

HHS concurs with GAO's recommendation.

The VA and IHS MOU leadership team have drafted revisions to the MOU to remove outdated language and create a more comprehensive, flexible MOU, pursuant to the Indian Health Care Improvement Act at 25 U.S.C. § 1647, in support of our mutual goals. The IHS and VA will continue working together to ensure that performance measures include appropriate measurable targets.

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