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# Tribal Consultation Listening Session Summary Report:

Draft Revised Veterans Health Administration-  
Indian Health Service Memorandum of Understanding







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# Introduction

Connecting American Indian and Alaska Native (AI/AN) Veterans to the benefits they have earned through their service is a top priority for the U.S. Department of Veterans Affairs (VA). To improve access to health care services for Indian Country's Veterans, the VA Veterans Health Administration (VHA) and the Indian Health Service (IHS) work together under a memorandum of understanding (MOU) to leverage resources and share knowledge toward the common goal of enhancing care for AI/AN Veterans.

Beginning in 2019, VHA and IHS launched a joint effort to engage with tribes about how to best modernize the VHA-IHS MOU, strengthen its implementation, and advance its mutual goals. The process began with an initial meeting with tribes and urban Indian organizations (UIOs) in May 2019.

In line with the agencies' tribal consultation policies and in recognition of the government-to-government relationship between the federal government and tribal nations, VHA and IHS engaged in tribal consultation and UIO confer on this topic. To initiate tribal consultation and UIO confer, IHS distributed a letter to tribal and UIO leaders<sup>1</sup> on September 4, 2019, announcing an upcoming tribal consultation and a comment period for tribal and UIO partners to provide written remarks. The agencies held the initial tribal consultation session on September 16, 2019.

Based on input gathered through tribal consultation, UIO confer, and written feedback, VHA and IHS developed a draft revised MOU. On December 2, 2020, IHS and VHA jointly issued a subsequent Dear Tribal Leader Letter<sup>2</sup> to share the draft revised MOU and encourage further engagement from tribes around it.

To present the draft revisions to tribes and UIOs and gather their feedback directly, VHA and IHS then hosted a series of three listening sessions and two informational sessions on the following dates.

- Listening session: December 9, 2020
- Listening session: January 8, 2021
- Informational session: January 27, 2021
- Listening session: February 17, 2021
- Informational session with UIOs: February 18, 2021

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1 RADM Michael D. Weahkee, IHS. (September 4, 2019). Dear Tribal Leader and UIO Leader Letter. [https://www.ihs.gov/sites/newsroom/themes/responsive2017/display\\_objects/documents/2019\\_Letters/DTLL\\_DUIOLL\\_VA\\_IHS\\_MOU\\_09042019.pdf](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2019_Letters/DTLL_DUIOLL_VA_IHS_MOU_09042019.pdf)

2 RADM Michael D. Weahkee, IHS; Richard A. Stone, VHA. (December 2, 2020). Dear Tribal Leader Letter. [https://www.ihs.gov/sites/newsroom/themes/responsive2017/display\\_objects/documents/2020\\_Letters/DTLL\\_12022020.pdf](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/DTLL_12022020.pdf)

The listening sessions and the call for written comments were designed as the primary avenues for interaction and collection of tribal and UIO feedback on the draft revised MOU. Additionally, the informational sessions provided opportunity for questions and comments from participants.

The agencies continued to solicit written input concurrently with these sessions, extending the comment period to March 2, 2021, per requests from tribes and UIOs. This extension was announced in a letter sent to tribal leadership<sup>3</sup> on February 5, 2021. In total, VHA and IHS received 22 written responses from tribes, UIOs, and tribal and intertribal organizations regarding the draft revised MOU.

The goal of the tribal consultation period was to present the draft revisions to tribal and UIO partners and develop a revised MOU document that aligns with tribal needs, voices, and priorities. The outcomes of the listening sessions will help further refine and shape the draft updated MOU into a tool for strengthening oversight and furthering the MOU goals toward its ultimate purpose, which is to improve the health status of AI/AN Veterans.

This report summarizes tribal input received through the listening sessions, informational sessions, and written submissions. To clearly align tribal feedback with the corresponding portions of the draft MOU, the sections of this report are organized by MOU components in the order in which those components appear in the MOU. Components that drew similar or overlapping feedback are combined, creating the following sections:

- MOU purpose and authority
- Mutual goals and objectives
- Operational planning

Each section begins with a brief synopsis of the MOU component(s), as presented by VHA and IHS during the listening and informational sessions. Following these descriptions are summaries of related tribal input. In addition to categorizing feedback by MOU component, this report also captures overarching themes that emerged during the discussions, which include tribal and UIO involvement in MOU oversight; tribal and UIO inclusion in the development of performance measures for the MOU; and several policy recommendations that apply broadly to the agencies, rather than specifically to the MOU.

The report begins with background information about the MOU and the reasons for revising it, followed by sections that correspond to the MOU components, and concluding with a discussion of the overarching themes that emerged. Notably, this report serves as a record of what was discussed and recommended during the listening sessions and does not speculate on the feasibility of incorporating each suggestion. As such, neither VA nor IHS endorses or takes a particular position with respect to the comments.

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3 Elizabeth Fowler, IHS. (February 5, 2021). Dear Tribal Leader Letter. [https://www.ihs.gov/sites/newsroom/themes/responsive2017/display\\_objects/documents/2021\\_Letters/DTLL\\_02052021.pdf](https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2021_Letters/DTLL_02052021.pdf)

## MOU Background

VA and IHS have a long-standing collaboration to provide access to services for AI/AN Veterans. First signed in 2003, the VHA-IHS MOU is at the core of this collaboration.

The initial 2003 MOU to improve access and health outcomes for AI/AN Veterans was updated on October 1, 2010, in alignment with the most current legislation on health care for AI/AN people: the Indian Health Care Improvement Act, 25 U.S.C. § 1647(a)(2). Built upon a decade of successful collaboration, the 2010 version of the MOU further established the mutual goals of advancing collaboration, coordination, and resource-sharing between the two agencies “to improve the health status of American Indian and Alaska Native Veterans.”

In 2019, the two agencies began a collaborative effort to consult with tribes and seek input from UIOs on revising the MOU to further strengthen services for AI/AN Veterans.

### What exactly does the MOU do?

The VHA-IHS MOU is an agreement between VHA and IHS that serves as a policy document detailing how to best serve AI/AN Veterans. It created a forum for collaboration between the two agencies to expand and enhance services for this population. Notably, the MOU is not a transactional document that involves the exchange of goods and services.

The MOU also provided a framework for VA and IHS to coordinate to the fullest extent permitted by law. A significant result of this strong interagency collaboration is the VA-IHS National Reimbursement Agreement, under which VA reimburses IHS for direct care services provided to eligible, VHA-enrolled AI/AN Veterans.

Modeled after this successful interagency reimbursement agreement, the VHA THP Reimbursement Agreement Program enables VHA to enter into reimbursement agreements with individual tribal health programs (THPs). These agreements and processes vary based on each tribe’s goals, such as attaining certain reimbursement rates or negotiating a telehealth partnership with VA. Due to variance in what services different IHS and tribal health care systems can provide to patients, VA and IHS aim to partner in a way that ensures that all components of the system have the flexibility for local coordination.

### Why is the MOU being updated?

In 2019, the U.S. Government Accountability Office (GAO) published a report<sup>4</sup> that contained a recommendation for IHS and VHA to revise the MOU and related performance measures so that they reflect best practices for successful performance measures, including the identification of measurable targets. This recommendation served as the impetus for IHS’ and VHA’s initiation of tribal consultation and UIO confer regarding updates to the MOU.

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4 GAO. (2019). 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). <https://www.gao.gov/assets/gao-19-291.pdf>

Additionally, tribal and UIO input, as well as federal legislation and guidance, contributed to the decision to update the MOU by highlighting an opportunity for VHA and IHS to further clarify and fortify this important document. Updating the MOU will more effectively promote its mutual goals, resulting in greater alignment with the current environment and modern considerations, such as telehealth services. Ultimately, these revisions will create enhanced supports for AI/AN Veterans.

## Snapshot of MOU Accomplishments

VA has established reimbursement agreements with 116 THPs and a single IHS site covering 74 tribes to reimburse for direct care services to eligible AI/AN Veterans. Since the program's inception in 2012, VHA has provided IHS and THPs more than \$142 million in reimbursements (as of June 2021).

Additionally, VA's Video Connect program has expanded access to mental health care services for rural AI/AN Veterans who receive care from IHS and THP facilities. To further support mental health for these Veterans, VHA is advancing suicide prevention efforts through the Tribal-VHA Suicide Prevention program and is enhancing the section on AI/AN Veterans in the VA Community Provider Toolkit.

Other successes include the VA Mail Order Pharmacy, which fills prescriptions for more than 330,000 Veterans each day. This option provides a lower processing cost, compared with filling prescriptions onsite at a VA facility, and delivers the prescription directly to the Veteran's mailing address.

## Timeline of the MOU and the Growing Need for Revisions

**February 2003:** VHA and IHS entered into the MOU to collaborate toward improving access to care for AI/AN Veterans.

**October 2010:** The agencies updated the initial MOU. In line with the Indian Health Care Improvement Act<sup>5</sup>, this iteration leveraged the long-standing VHA-IHS collaboration to clearly define the mutual goal of furthering their interagency coordination and resource-sharing.

**June 2014:** GAO issued a report<sup>6</sup> in which it recommended that VA and IHS develop a policy or guidance document to delineate specific roles and responsibilities in implementing the MOU. The report noted that this clarification would help strengthen the MOU's effectiveness and create accountability. Together, VA and IHS worked to resolve the issues raised in this GAO recommendation, leading to GAO's closure of the report.

5 Indian Health Care Improvement Act, 25 U.S.C. § 1647(a)(2). (2003). <https://www.ihs.gov/ihcia/>

6 GAO. (2014). Health Care Access: Improved Oversight, Accountability, and Prioritization Can Improve Access for Native American Veterans (GAO-14-489). <https://www.gao.gov/products/gao-14-489>



**August 2014:** As a legislative response to the GAO report's recommendation, the *Veterans' Access, Choice, and Accountability Act of 2014*<sup>7</sup> mandated that VA and IHS (1) engage in outreach to tribal leaders regarding the opportunity to enter into THP reimbursement agreements, (2) develop performance metrics for evaluating the MOU's effectiveness, and (3) assess the feasibility of providing services to non- AI/AN Veterans at IHS or THP facilities.

**March 2019—Critical event that triggered tribal consultation:** GAO issued a report, *VA and Indian Health Service: Actions Needed to Strengthen Oversight and Coordination of Health Care for American Indian and Alaska Native Veterans*, which called for the leadership of VA and IHS to ensure that performance measures for the MOU are measurable and modeled after metrics that are proven to be effective. Because it required a decision or action that would affect Indian Country, this recommendation was the impetus for initiating tribal consultation and UIO confer.

**May 2019:** In response to these directives and recommendations, VHA and IHS initiated a meeting to gather tribal and UIO input on how to best measure the MOU's performance. Through this discussion, the recommendation emerged to revise the MOU.

**September 2019:** VHA and IHS distributed a Dear Tribal Leader Letter to initiate tribal consultation on the MOU and held a subsequent tribal consultation on September 16 to gather tribal and UIO feedback. The information gathered through this session helped inform the development of the draft revisions.

## What work has been done so far on revising the MOU?

By applying the findings and suggestions that emerged from the tribal consultation and UIO confer process, VHA and IHS created a draft revised MOU that aims to reflect the evolving health care environment and tribal and Veteran needs. The agencies presented this draft revision for discussion at the listening and informational sessions in 2020 and 2021. The written comments and listening session input summarized in this report will further inform and shape the draft MOU that was created based on tribal consultation.

See the appendix for the full text of the draft revised MOU.

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7 *Veterans' Access, Choice, and Accountability Act of 2014*, Public Law 113-146. § 102. (2014). <https://www.govinfo.gov/content/pkg/PLAW-113publ146/pdf/>



# MOU Components

The primary components of the MOU are as follows:

- Purpose
- Authority
- Background
- Mutual goals
- Mutual objectives
- Operational planning

During the listening sessions, VHA and IHS staff delivered brief presentations on each section of the MOU and elicited tribal feedback after each presentation. In this report, the MOU background appears above for context. Consecutive MOU components that drew similar or overlapping input are combined, resulting in three report sections:

- Purpose and authority
- Mutual goals and objectives
- Operational planning

Each of the following sections begins with a brief overview of the MOU component followed by a summary of related tribal input.

## MOU Purpose and Authority

The primary purpose of the MOU is to create a collaboration framework through which VHA and IHS can build mutual goals and leverage shared resources to promulgate those goals. Both agencies are wholly committed to engaging with tribes and UIOs to ensure the MOU and any related agreements and actions honor tribal sovereignty, address tribal concerns, and fit the needs of individual Veterans and their families. Based on the MOU framework, VHA entered into a national reimbursement agreement with IHS and numerous local agreements with individual THPs to meet the needs of Veterans and their families at the local level.

## Summary of Tribal Input

Tribal and UIO feedback highlighted the importance of acknowledging and affirming tribal sovereignty within the wording of the MOU. Specifically, commentors referenced upholding the federal trust responsibility and honoring tribal data sovereignty. Further, they recommended providing education to VA on tribal issues and ensuring that the MOU aligns with key legislation.

One of the respondents recommended updating the language of the Purpose section to clarify which activities will promote collaboration between agencies.

## Acknowledging Tribal Sovereignty and Contributions

Several tribal and UIO comments urged the specific mention of tribes, UIOs, tribal health organizations, and tribal consortia in the MOU's *Purpose* section to acknowledge their significant role in providing health care to AI/AN Veterans. *Tribal health providers* was proposed as a subsequent term that is inclusive of all these entities after their initial introduction in the document. Further, respondents specifically commented that the federal government's trust responsibility to tribes, which includes providing health care for AI/AN people and honoring tribal sovereignty, must be clearly articulated throughout.

## Upholding Data Sovereignty

Fully honoring tribal sovereignty includes upholding tribal sovereignty over the management and sharing of data. Several respondents recommended updating the language of the MOU to ensure that it references and promotes "tribal data sovereignty."

## Educating Federal Personnel

Listening session participants encouraged VA to educate all levels of employees and policy officials on issues specific to Indian Country, including tribal sovereignty, the government-to-government relationship between the federal government and tribal nations, and the unique features of the Indian health care system. Such education will equip VA staff to provide culturally competent services and policymakers to ensure that policy decisions do not adversely affect tribes.

## Aligning with Recent Legislation

Several recommendations entailed determining how to reflect and uphold recent key legislation within the revised MOU. They cited three laws and one bill for consideration:

- The Native American Veterans PACT Act<sup>8</sup>
- S. 524: Department of Veterans Affairs Tribal Advisory Committee Act of 2019
- The Proper and Reimbursed Care (PRC) for Native Veterans Act (P.L. 116-311)
- Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315)

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8 This bill, which was passed under Section 3002 of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315), prohibits the collection of co-payments by VA from AI/AN Veterans.

# Mutual Goals and Objectives

The draft updated MOU contains four goals, each with corresponding objectives. To create the flexibility for broad federal collaboration, these updated goals were consolidated from the five goals articulated under the current iteration of the MOU. These broad goals pertain to:

- Access
- Patients
- Information Technology
- Resource Sharing

Tribal comments on the mutual goals and objectives are categorized by goal in the following sections.

## Access

**Goal:** Increase access and improve quality of health care and services to the benefit of eligible AI/AN Veterans served by VHA and IHS. Effectively leverage the strengths of VHA and IHS at the national, regional, and local levels to afford the delivery of timely, optimal clinical care.

### Objectives:

- Build on the successes of the 2010 MOU through performance monitoring and regular meetings.
- Develop, coordinate, and expand new ways to connect facilities operated by VHA, IHS, THPs, and UIOs.

## Summary of Tribal Input

To connect AI/AN Veterans to care, tribes and UIOs emphasized the importance of facilitating access to services by acknowledging urban clinics in the MOU, providing transportation solutions to mitigate challenges in geographic distance, and revising the prescription refill process as outlined in the MOU.

*“The federal government has a dual obligation to Native American Veterans who have pre-paid for their healthcare, both through the cession of tribal homelands and resources, as well as the defense of our nation. All barriers in access to critical health care services for Native American Veterans must be viewed as a violation of this obligation.”*

*– Written Feedback*



### *Including Urban Indian Organizations*

Veterans often choose to visit UIOs, either as their primary providers or as parts of their care teams, and these partnerships need to be seamless to promote access to quality care for Veterans based on their needs, rather than expecting the Veterans to conform to a fragmented system. VA has worked to cultivate relationships at the local and national levels between VA offices and UIOs. Through these partnerships, outreach events are held to help Veterans enroll in benefits and file claims. However, as one commentor noted, “UIOs [had] largely been left out of this agreement until recent legislation<sup>9</sup> made it clear that UIOs should be treated as full partners in the MOU.”

Several respondents urged VA to continue to be inclusive of these programs and treat them as full partners within the language of the MOU. They also requested that VA assess the feasibility of entering into reimbursement agreements with UIOs much like it does with tribal facilities. This request is discussed further under the Policy Recommendations section of this report, since its implementation would require policy changes beyond the scope of the MOU.

*“The VA/VHA needs to seriously consider how to be inclusive of UIO leaders to create parity with IHS and THPs.”*

*– Listening Session Participant*

### *Addressing Transportation Challenges*

Several participants noted that many AI/AN Veterans must travel long distances to receive care and urged VA to use the MOU as a basis for addressing transportation concerns for rural AI/AN Veterans. For example, Navajo Nation Veterans often must travel approximately 300 miles to Phoenix, Albuquerque, or Salt Lake City to access VA services. Another participant highlighted the lack of Veterans’ services across a vast area of northern California between Sacramento and the Oregon border. These comments underscored the urgency of VA’s current efforts to obtain Congressional authorization to expand transportation grant programs for tribes. A national cross-agency effort to resolve transportation challenges for rural Veterans is essential to creating equitable access to care.

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<sup>9</sup> Section 1113 of the Consolidated Appropriations Act of 2021 amended Section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645) to include specific mention of UIOs alongside mentions of tribal organizations in subsections (a)(1) and (c).

## *Simplifying Prescription Refills*

To remove obstacles in the prescription refill process, participants recommended revisiting the prescription refill process and authorizing IHS and THP facilities to fill VHA prescriptions within the MOU language. Such clarification would help ensure that patients do not have to travel long distances to pick up prescriptions or refills.

## **Patients**

**Goal:** Facilitate enrollment and seamless navigation for eligible AI/AN Veterans in VHA and IHS health care systems.

### **Objectives:**

- Improve care coordination processes between facilities.
- Expand evidence-based training programs for patient navigation specialists.
- Improve and expand utilization of VHA consolidated mail outpatient pharmacy.

## **Summary of Tribal Input**

Creating a seamless care experience encourages Veterans to seek and connect with the services they need. To help Veterans more easily navigate systems of care, tribes and UIOs encouraged VHA and IHS to bolster care coordination across facilities, recognize and respond to diverse Veterans' needs, and include traditional healing services under reimbursable activities.

### *Bolstering Care Coordination*

To ensure that AI/AN Veterans can access services that their IHS or THP facility may not offer, VA maintains a network of purchased referred care (PRC) providers—the Community Care Network (CCN). Strengthening care coordination across THP, UIO, IHS, and VHA facilities and with any PRC providers is a critical aspect of creating a seamless health care experience for AI/AN Veterans.

VHA and IHS received comments emphasizing the importance of integrating THPs into the CCN through existing VHA-THP agreements without altering the existing reimbursement rates and shared resources under such agreements. However, ultimately, Veterans must be able to access care from THPs regardless of whether those facilities are part of a CCN so they can receive uninterrupted and culturally responsive care.

Participants generally expressed support for expanding patient navigation specialists to help coordinate care and present a seamless experience for Veterans. One participant recommended that VA station AI/AN Veterans representatives in IHS clinics and THP

facilities to aid communication and care coordination. Further, a process should be established for identifying Veteran patients of these facilities to ensure they are not charged for co-payments.

### *Recognizing Diverse Veteran Needs*

Veterans from different service periods have different experiences and needs. For example, best practices for Vietnam Veterans may not translate well for Veterans who served more recently in Iraq. To ensure appropriate services for diverse Veterans' needs, commentors recommended that VHA provide training for personnel on best practices for each service period.

One participant highlighted the unique needs of AI/AN Veterans who are homeless and called for the MOU to include a focus on services that aid homeless Veterans. She described an incident in which belongings were stolen from her sister, who has PTSD and is homeless. Unaware of the programs that may provide more culturally competent support, she found herself in a state housing program that did not meet her cultural needs. This story supports the need for VA to engage in outreach about the programs and options that can assist AI/AN Veterans who are homeless.

Additionally, participants highlighted the importance of culturally appropriate services, including traditional healing activities, in providing effective and meaningful care for AI/AN Veterans. This topic is discussed in greater depth under the Resource Sharing goal, below.

## Information Technology

**Goal:** Facilitate the integration of electronic health records (EHRs) and other information technology systems that affect the health care of AI/AN Veterans.

**Objectives:**

- Monitor the development of new Health Information Technology systems.
- Develop robust Health Information Exchange (HIE) systems.
- Advocate for increased use of telehealth systems and broadband access in rural areas.



## Summary of Tribal Input

Technology enables effective communication within and across the various facilities involved in providing care to AI/AN Veterans, and it therefore plays a pivotal role in coordinating care. To leverage technology in a way that improves Veterans' access to care and health outcomes, tribes and UIOs recommended continuing to support tribes in acquiring technological infrastructure, prioritizing data interoperability, and improving HIE systems.

### *Supporting Tribal Technology Infrastructure*

Many tribes face challenges related to technology infrastructure, such as a lack of broadband access. These barriers are particularly common in rural areas. Several commentors recommended that VHA and IHS continue to invest in facilities, equipment, and software to promote the use of necessary health care technologies in Indian Country.

To avoid duplicate objectives, one tribal respondent recommended that VHA and IHS consider deleting Objective D under this goal, which pertains to supporting tribal infrastructure. The objective is essentially a prerequisite for Objective C, which is to support tribal implementation of telehealth systems.

### *Promoting Data Interoperability*

Data interoperability refers to the capability of different systems and applications to seamlessly exchange data. In the context of health care technology, this capability helps promote comprehensive care coordination for patients. Data interoperability helps to ensure that all facilities involved in a Veteran's care can access patient records, enabling them to provide the most appropriate and effective services to the patient. Further, it eliminates the need for Veterans to manually transfer their information across multiple facilities and upholds tribal sovereignty over data management and sharing. In further support of tribal sovereignty, participants requested a data-sharing approach that returns data to the tribes.

*"All IHS and THPs should have access to a VHA-eligible patient's records to provide acute care."*

*– Written Feedback*

Participants referenced the 2019 GAO report finding of inadequate EHR system interoperability between VA and IHS. To improve data interoperability, participants indicated that VHA and IHS must involve tribes in the process of modernizing the agencies' EHR systems. They recommended that VHA and IHS base their approach to interoperability on tribal priorities and specifically requested that the agencies emphasize tribal data sovereignty in determining the appropriate solution. Specifically, one tribe noted that the MOU text should outline a timeframe for when VHA will provide authorized IHS employees with access to VHA's automated patient records, which are maintained on VA computer systems.

Finally, respondents stated the importance of aligning IHS' modernization of its systems (which entails moving from RPMS to a new solution) with tribal EHR systems to streamline the transition for tribal programs. Involving tribes throughout the modernization process will be essential to choosing a solution that dovetails with the various systems that are already in place throughout Indian Country.

### *Enhancing HIE Systems*

Several respondents recommended prioritizing improvement of the HIE systems to streamline the sharing of patient health information across multiple platforms and facilities and to ensure THP facilities can access Veterans' health records in a timely manner.

## Resource Sharing

**Goal:** Improve access for patient populations through resource sharing, including technology, providers, training, human resources, services and facilities, communication, reimbursement, etc.

### **Objectives:**

- Promote collaboration to share services and health care providers between VHA, IHS, THPs, and UIOs.
- Evaluate new options to reimburse all services provided to AI/AN Veterans.
- Expand telehealth programs to facilitate virtual provider sharing.

## Summary of Tribal Input

Resource sharing between federal agencies; across facilities; and to tribes, communities, and Veterans supports integrated care based on best practices. Recommendations for resource sharing aimed to improve several areas, including data management, the referral process, workforce development, cultural competence training, mental health services, telehealth services, and reimbursement processes.

### *Sharing Personnel and Training*

To enhance clinical capacity, tribal input included a recommendation to share services and providers across clinics. Such collaboration across facilities is central to coordinated, readily accessible care. Developing and sharing evidence-based training across these facilities would further support mutual understanding and enhance coordinated care.

### *Sharing Resources with Communities and Veterans*

In addition to sharing resources between facilities, participants recommended sharing information with tribal leaders on key Veterans' issues to propagate better understanding throughout tribal communities. Further, training and education designed specifically for individual Veterans was suggested to help them understand the facilities they can visit and the services that are available.

### *Sharing Data*

More clarity is needed around how tribes can obtain VA needs assessment data to help determine the services needed in tribal facilities. A participant recommended creating funded positions for data analysis, data management, and surveillance to help bridge this gap in the data.

### *Enhancing the Referral Process*

To streamline the referral process, respondents recommended allowing all THP facilities to directly refer patients to VHA specialty care. Additionally, permitting IHS and THP facilities to directly refer patients for PRC without requiring the patient to first return to VA and accepting visits to IHS and THP facilities as annual VHA doctor visits would further establish a system of integrated care. In an example provided via written comments, a patient who needed a brain MRI was unable to undergo the necessary procedure until more than 2 months after the tribal clinic made the referral due to delays in the referral process.

### *Developing the Workforce*

Because tribal areas are often remote and underserved, recruiting and retaining staff can be especially difficult, and this challenge requires new, innovative solutions for workforce development. Tribes and UIOs recommended including workforce development considerations in the MOU, especially as it relates to recruiting and retaining health care professionals. They urged VHA and IHS to implement expansions of the Graduate Medical Education program, a pilot program on graduate medical education and residency included under Section 403 of the VA MISSION Act of 2018. Tribes and UIOs recommended prioritizing IHS and THP facilities under this program. The program facilitates collaborations with medical schools to train health professionals for these facilities, which is an increasingly essential partnership as the gap between the supply and



demand for physicians increases, especially for rural areas. Additionally, expansion of the loan repayment program would significantly enhance recruitment for physicians to serve tribal communities.

### *Promoting Culturally Competent Care*

Culture must be positioned as the background for all objectives and goals, but participants primarily framed cultural competence as being driven by the sharing of information and best practices. Locally driven training for providers and VHA staff is one of the most significant needs related to culturally responsive care. Some AI/AN Veterans have reported that they do not seek care from VA due to a lack of cultural competence among VA staff. There is a particular gap in this knowledge when it comes to serving urban AI/AN Veterans. Cultural education for VA staff should cover tribal sovereignty and the government-to-government relationship between the federal government and tribal nations.

*“Mental health rests in culture. The MOU must acknowledge and endorse the need for cultural competence and traditional healing.”*

*– Listening Session Attendee*

### *Supporting Veterans’ Mental Health*

Culturally appropriate care connects to another significant need for information sharing: mental health supports for AI/AN Veterans. Several participants raised suicide prevention as a priority, noting that VA must support data gathering on Veteran suicides that occur on tribal lands to understand the scope of the issue in Indian Country. Data is central to designing effective prevention efforts, yet no current mechanisms are in place for measuring the effectiveness of VA suicide prevention programs. A further complication to understanding the breadth of this issue is that tribes have limited data on which of their constituents are AI/AN Veterans.

VA has interagency agreements with numerous tribes to provide mental health services to local Veterans through telehealth.

## *Strengthening Telehealth Services*

Participants recommended leveraging telehealth to connect Veterans, especially those who live in rural areas, to health care services. Involving tribes in the ongoing design of these systems will help ensure they function well in Indian Country. Training on how to use telehealth systems is also crucial to expanding their use and effectiveness.

*“To improve the use of telehealth services: emphasize IHS- and VHA-provided training opportunities, provide guidance on how to use the VHA’s mobile platforms, and provide assistance to purchase electronic devices to use these services.”*

*– Written Feedback*

Additionally, respondents called for strengthening reimbursement processes for telehealth, among other recommendations for enhancing the reimbursement methodologies and processes.

## *Improving Reimbursement Processes through Greater Collaboration*

Common recommendations pertaining to reimbursements included enabling full reimbursement of PRC services, per PL 116-311, which states that VA will reimburse IHS and THPs for services provided through the PRC program. Tribes and UIOs requested a more efficient process for processing claims and issuing reimbursements. Enhanced communication across all facilities involved in Veterans’ care, including PRC providers, will help streamline the reimbursement process and avoid delayed or duplicated services or erroneous billing.

One tribe provided an example of a patient who received a letter from VHA instructing her to come to the VHA clinic for a mammogram, despite already being scheduled for a mammogram at a tribal health clinic. The patient attended the VHA appointment and received a medical bill from VHA for more than \$1,000. The bill was eventually turned over to a collection agency because the patient could not afford to pay it. In another example, a Veteran spent seven months maneuvering through the VHA system for testing and referrals and discovered that a PRC provider had already been paid to provide these same services. Both examples point to duplicative issues that arise from unclear reimbursement and referral processes.

Participants also recommended that VHA and IHS:

- Regularly include tribes in all negotiations that would affect reimbursement agreements, including any changes to the reimbursement methodology
- Develop new options for reimbursement, including mechanisms for reimbursing care provided to dually eligible AI/AN Veterans
- Ensure all reimbursement agreement terms are available to tribes and that VA regions are educated on them
- Exempt tribes from any value-based reimbursement processes for other VA/IHS providers

## Operational Planning

As outlined in the MOU, VHA and IHS will work together annually to create, review, and revise an operational plan. Each year's plan will cover strategies, objectives, and metrics to advance the MOU's mutual goals and objectives. Operational planning is a new innovation that will define how to implement the MOU and help ensure the project stays on track.

## Summary of Tribal Input

Participants underscored the importance of involving tribes and UIOs in developing each year's operational plan. They recommended that VHA establish policies and guidance regarding operational planning to delineate roles and responsibilities and emphasize the key role of tribal input. Such actions would enhance the implementation and oversight of the MOU. Seeking feedback from tribes and providing them with updates through regular reporting should be continual processes throughout the MOU's implementation.

## Oversight and Guidance

To continue expanding upon the successes of the current MOU, tribes proposed holding quarterly oversight meetings that include tribal representation. Further, respondents recommended reevaluating the topics of the MOU workgroups to ensure there are sufficient workgroups to align with the shifting mutual goals and objectives under the revised MOU.

Several respondents recommended that VA and IHS establish a tribal advisory committee specific to the MOU to guide the agencies as they finalize and implement the MOU and to provide input on training, research and development, and collaboration. The committee should include tribal representation from each IHS area.

Several respondents commented on the reduced number of workgroups outlined in the draft MOU. They urged the reevaluation of this approach, noting the importance of workgroups in promulgating the goals of the MOU. They recommended establishing a workgroup to align with each goal to promote consistent progress and provide regular updates.



## Projects for Facilitating Access to Care

Listening session participants identified several projects for potential inclusion in operational planning to promote increased access to care for AI/AN Veterans. These recommendations included:

- Expanding transportation programs for tribes to address transportation challenges facing AI/AN Veterans
- Authorizing IHS and THP facilities to fill VHA prescriptions to make prescription pickup more readily accessible for Veterans

## Overarching Themes

Often during listening sessions, themes emerge that span several of the topic areas discussed. During the VHA-IHS MOU listening sessions, two cross-cutting themes emerged. They are:

- Ensure tribal representation in drafting revisions of the MOU
- Include tribes in determining the metrics for measuring the MOU's effectiveness

## Tribal Inclusion in Future MOU Drafts

A substantial number of tribal comments underscored the need for tribes to actively contribute to the development of policies that affect them, as well as the goals those policies promulgate. Numerous participants stated that tribes must be actively involved in the drafting of any key documents like the MOU, in acknowledgment of tribal sovereignty and the government-to-government relationship between the federal government and tribes. Tribal participation in this stage is essential for ensuring the document reflects the importance of tribal self-governance and self-determination. Tribes also have vast health care delivery experience to contribute to the drafting process.

To provide tribes an opportunity to participate in drafting the document, several commentors urged VHA and IHS to suspend the finalization of the draft MOU and create a workgroup comprising members from VHA, IHS, and tribes from each IHS area to develop a revised MOU that considers tribal insights from the outset and in every stage of drafting.

A written comment provided the following guidance for how to ensure that tribes interpret the tribal consultation outcomes as meaningful and see their input acknowledged: First, identify recommendations that arose during tribal consultation. Next, respond to tribes about how each recommendation or concern was incorporated into decision making or, alternatively, noting why a suggestion was not feasible or warrants further consultation.

Participants also emphasized the need to elevate the voices of individual AI/AN Veterans in the process of drafting the MOU. While tribal leader input through tribal consultation reflects the concerns and needs of their constituents at a high level, individual AI/AN Veterans also need a forum for influencing this key document.

To promote true partnership, tribes noted they are seeking a platform to discuss the effectiveness of the MOU and reimbursement agreements on a regular basis, regardless of when major updates are warranted. Effective tribal consultation means including tribes in workgroups to execute the MOU, regular maintenance of the MOU, and oversight meetings to ensure accountability in its implementation.

## Tribal Involvement in Developing Metrics

To bolster the MOU's success, respondents highlighted the importance of including tribal input in the development of metrics. They recommended establishing and implementing metrics to measure the MOU's effectiveness through ongoing tribal consultation and collaboration with THPs and UIOs. Two of the participants suggested that VHA and IHS explicitly define metrics for each of the four mutual goals within the text of the MOU. Another tribe recommended that the metrics should incorporate:

- SMART objectives (specific, manageable, attainable, relevant, and time-based) for each of the four goals
- Specific outcome measures for each objective
- Provisions for assessing key performance areas, including referrals and care coordination; timely, patient-centered, and safely rendered care; and telehealth support
- Critical performance measures that were not achieved in the last MOU, which include disease prevention, tribal consultation, and patient-centered collaboration
- Successes and quantifiable targets provided by THPs
- Cultural responsiveness

# Policy Recommendations

In the course of listening session dialogue and within written comments, several recommendations emerged that do not pertain to the MOU specifically, but rather, suggest broad policy directions for VA and IHS. These items are summarized below.

- Explore the feasibility of establishing direct reimbursement agreements with UIOs to enhance care coordination and apply the successes of the VHA-THP agreements to urban clinics. Aside from two UIOs identified by the Indian Health Care Improvement Act as part of the IHS direct federal system, reimbursement authority only extends to the federal system and THPs operating under Title I or Title V of the Indian Self-Determination and Education Assistance Act.
- Expand the VA-IHS collaboration by establishing a VA office within IHS headquarters and at IHS facilities and, similarly, establishing an IHS office within VA. This arrangement would help ensure that programs serving AI/AN Veterans are fully supported and would promote integrated care. Additionally, housing a VA office at IHS would help provide a guaranteed space for specialized clinics for Veterans, rather than forcing these programs to rely on space in facilities that may be subject to closure. Securing buildings and facility space is an important aspect of partnership.
- Use the *Presidential Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships*, issued January 26, 2021, as a guide for strengthening government-to-government relationships.
- Create a VA Tribal Advisory Health Care Committee to guide VA in providing culturally competent services for AI/AN Veterans.
- Articulate traditional healing activities as reimbursable services. As a model for reimbursing these services, one participant referenced a pilot program for fee reimbursement for traditional healing ceremonies, which the Phoenix-based Carl T. Hayden VA Medical Center previously operated.
- Revise the VA-IHS Consolidated Mail Outpatient Pharmacy Interagency Agreement to clarify the non-committal language of “exploring options” to extend access to the CMOP for UIOs.
- VHA and IHS should not enter into the VHA-IHS reimbursement agreement until VA agrees to full reimbursements, to which tribes are entitled, per 25 U.S.C. 1645(c) and the PRC for Native Veterans Act.

## Conclusion

VHA and IHS are committed to partnering with tribes and UIOs to increase access to care and improve health outcomes for AI/AN Veterans. This commitment was the impetus for updating the VHA-IHS MOU to further refine and strengthen the document's goals and oversight mechanisms. Through the series of listening sessions and written input from tribes and UIOs, the agencies gathered valuable input on each component of the MOU, including each mutual goal. Across the recommendations gathered, themes that surfaced frequently were:

- Intentional inclusion of UIOs in the MOU text
- Collaboration toward resolving challenges that individual Veterans face related to transportation, mental health, homelessness, and other access and wellbeing concerns
- Education for multiple audiences, including cultural competence training for federal personnel and outreach to communities and individual Veterans to raise awareness of available services
- Integrated systems of care, including enhanced processes for referrals and reimbursements, to deliver a seamless health care experience for Veterans
- Data interoperability between federal agencies and with tribal and UIO programs in a way that supports tribal sovereignty over data management
- Cultural responsiveness and support for traditional healing across the care system
- Tribal and UIO involvement in the oversight of the MOU's implementation
- Inclusion of tribes and UIOs in all aspects of the MOU maintenance and updates, including the drafting process and the development of performance metrics

These insights will inform the development of a strong, modernized MOU that will ultimately streamline and enhance the care that AI/AN Veterans receive.





# Appendix: Draft VHA-IHS MOU

**Memorandum of Understanding  
Between the  
United States Department of Veterans Affairs Veterans Health Administration  
and  
United States Department of Health and Human Services Indian Health Service**

**I. Purpose:** The purpose of this Memorandum of Understanding (MOU) is to establish a framework for coordination and partnering to leverage and share resources and investments in support of each organization's mutual goals. The United States (U.S.) Department of Veterans Affairs (VA) Veterans Health Administration (VHA) and the U.S. Department of Health and Human Services (HHS) Indian Health Service (IHS) recognize the sovereign status of tribal governments and value the important role that both tribal governments and Urban Indian Organization (UIOs) have in the delivery of health care services to American Indian and Alaska Native (AI/AN) Veterans. Accordingly, VHA and the IHS recognize the value of tribal input into the policies, programs, and services that effect AI/AN Veterans. Although this MOU may serve as an agreement between two Federal agencies, both agencies commit to engaging in communication, collaboration, Tribal Consultation and Urban Confer consistent with their respective policies, applicable statutes, regulations, and Executive Order(s).

With full delegated authority of VA and HHS Secretaries to do so, VHA and the IHS enter into this MOU to facilitate a broad range of collaboration between the agencies that will allow for the development of additional agreements around specific activities. This MOU recognizes the importance of coordinated and cohesive effort on a national scope, while acknowledging that implementation of such efforts may require local adaptation through a local MOU<sup>10</sup> to meet the needs of individual Veterans and their families, as well as local VHA, IHS, Tribal Health Programs<sup>11</sup> (THPs), and UIOs<sup>12</sup>.

**II. Authority:** The Indian Health Care Improvement Act, 25 U.S.C. §§ 1645, 1647; 38 U.S.C. §§ 523(a), 6301-6307, 8153.

- 10 The term "local memorandum of understanding" means a MOU between the Secretary of Health and Human Services (or a designee, including the IHS Director or the director of any IHS Area Office) and the Secretary of Veterans Affairs (or a designee) to implement this MOU.
- 11 The term "tribal health program" means an Indian tribe or tribal organization that operates any health program, service, function, activity, or any facility funded, in whole or part, by the IHS through, or provided for in, a contract or compact with the IHS under the Indian Self-Determination and Education Assistance Act (25 U.S.C. § 5301 et seq.). 25 U.S.C. § 1603(25).
- 12 The term "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in 25 U.S.C. § 1653(a). 25 U.S.C. § 1603(29).

### III. Background:

The mission of the IHS is to raise the physical, mental, social, and spiritual health of AI/AN to the highest level. The vision of the IHS is healthy communities and quality health care systems through strong partnership and culturally responsive practices. The IHS will achieve its mission through three strategic goals: To ensure that comprehensive, culturally appropriate personal and public health services are available and accessible to AI/AN people; To promote excellence and quality through innovation of the Indian health system into an optimally performing organization; and, to strengthen IHS program management and operations.

The mission of VA is to “care for him who shall have borne the battle and his widow and orphan.” Those words were spoken by Abraham Lincoln during his second inaugural address and reflect the philosophy and principles that guide VA in everything it does. VA’s priorities in service to all Veterans include:

1. Provide Veterans with greater choice in health care;
2. Focus resources in things that matter to Veterans;
3. Modernize VA;
4. Improve timeliness of services; and
5. Prevent suicide.

VHA and IHS enter into this MOU to further their respective missions and priorities. This MOU builds upon decades of successful collaboration, including the 2003 and the 2010 VHA and IHS MOUs. VA and IHS agreed with the recommendation made in the June 2014 U.S. Government Accountability Office (GAO) report to establish written policy or guidance designating specific roles and responsibilities for agency staff to hold leadership accountable and improve implementation and oversight of the MOU. Health Care Access: Improved Oversight, Accountability, and Prioritization Can Improve Access for Native American Veterans (Publication No. GAO-14-489).

It is the intent of this MOU that, through coordination, and collaboration, both organizations will achieve greater accountability, prioritization, and success in service to AI/AN Veterans, as well as more effectively serve as stewards of public resources.

IV. Mutual Goals: To the maximum extent permitted by law, available resources, and funding, VHA and the IHS will coordinate and partner to leverage and share the resources and investments in support of the following four goals:

1. Access – Increase access and improve quality of health care and services to the benefit of eligible AI/AN Veteran patients served by VHA and IHS. Effectively leverage the strengths of VHA and the IHS at the national, regional and local levels to afford the delivery of timely, optimal clinical care.
2. Patients – Facilitate enrollment and seamless navigation for eligible AI/AN Veterans in VHA and IHS health care systems.
3. Information Technology – Facilitate the integration of electronic health records and other information technology systems that affect the health care of AI/AN Veterans.
4. Resource Sharing – VHA and the IHS will improve access for their patient populations through resource sharing, including technology, providers, training, human resources, services and facilities, communication, reimbursement, etc. This MOU does not authorize the expenditure or reimbursement of any funds. This MOU does not create a binding contractual obligation, obligate either Party to expend appropriations or other monies or enter into any contract or other obligation, or create any rights between the Parties. Should any exchange of funds or resources be necessary, the Parties will first enter into a supplemental binding instrument.

**V. Mutual Objectives:** To achieve the MOU's four goals, VHA and the IHS agree to actively collaborate and coordinate on the mutual goals listed above, and the objectives that come from these goals:

1. Access
  - a. Build on the successes of the 2010 MOU through performance monitoring of the implementation of the MOU through joint VHA and IHS quarterly meetings to discuss and monitor MOU metrics. For example, in the area of reimbursement agreements, monitor the continued administration of the structure of the financial relationship between VHA and the IHS as it relates to reimbursement agreements and health care services in the community for AI/AN Veterans.
  - b. Develop, coordinate, and expand new ways to connect facilities operated by VHA, the IHS, THPs, and UIOs.
2. Patients
  - a. Improve care coordination processes between facilities operated by VHA, IHS, THPs, and UIOs, as authorized by law.

- b. Develop, coordinate, and expand evidence-based training programs for VHA, IHS, THP, and UIO patient navigation specialists to assist AI/AN Veterans in navigating VHA, IHS, THP, and UIO care systems.
  - c. Improve and expand utilization of VHA consolidated mail outpatient pharmacy by IHS and THPs care providers, including exploring options to extend access to UIOs and non-Resource and Patient Management System electronic health record (EHR) sites.
3. Information Technology
- a. Closely monitor the development of new Health Information Technology systems and advocate for full interoperability of VHA, IHS, THP and UIO EHR systems to the fullest extent allowable.
  - b. Develop robust Health Information Exchange (HIE) systems among VHA, IHS, THPs, and UIOs care systems where they currently do not exist.
  - c. Monitor and continue to advocate for increased use of telehealth systems to connect VHA, IHS, THP, and UIO care facilities to provide patient care, including mental and behavioral health care, to AI/AN Veterans closer to home.
  - d. Monitor and continue to advocate for increased access to broadband services in rural and remote locations where AI/AN Veterans reside.
4. Resource Sharing
- a. Promote collaboration to share services and health care providers between VHA, IHS, and THPs care facilities and UIOs to the fullest extent allowable by law.
  - b. Evaluate new options to reimburse all services provided to AI/AN Veterans at IHS and THPs facilities.
  - c. Expand telehealth programs that connect VHA, IHS, THPs, and UIOs Care facilities to facilitate virtual provider sharing.
  - d. Develop and expand collective resources and learning options, including, but not limited to, training, research and development, collaboration, communications, Tribal Consultation, Urban Confer, etc. For example, ex officio participation in HHS and VA advisory committees (e.g., HHS National Advisory Committee on Rural Health and Human Services, VA Veterans' Rural Health Advisory Committee, IHS Direct Service Tribes Advisory Committee, IHS Tribal Self-Governance Advisory Committee, etc.).



**V. Operational Planning:** To facilitate attainment of the mutual goals and objectives in this MOU, VHA and the IHS will work together to create an operational plan each fiscal year. The plan will include the goals and objectives specified above, as well as the tactics used to attain them. The plan will also specify points of contact, workgroups, targets, and metrics created to measure processes and outcomes. VHA and the IHS will jointly review, revise (as appropriate), and renew the Operational Plan each fiscal year.

## **VI. Other Considerations**

1. VHA and the IHS will comply with all applicable federal laws and regulations, including those regarding the confidentiality of health information and the release of information to the public. For example, medical records of VHA and IHS patients are federal records and are subject to some or all of the following laws: the Privacy Act, 5 U.S.C. § 552a; the Freedom of Information Act, 5 U.S.C. § 552; Confidentiality of Records, 42 U.S.C. § 290dd-2; the Health Insurance Portability and Accountability Act of 1996; VA's Confidentiality of Certain Medical Records, 38 U.S.C. § 7332; Confidential Nature of Claims, 38 U.S.C. § 5701; Medical Quality Assurance Records Confidentiality, 38 U.S.C. § 5705, and Federal regulations promulgated to implement those acts.
2. VHA will provide authorized IHS employees with access to VHA automated patient records maintained on VA computer systems to the extent permitted by applicable federal confidentiality and security laws and policies. Additionally, the IHS will likewise provide authorized VHA employees with access to patient records of AI/AN Veterans maintained by the IHS to the same extent permitted by applicable federal confidentiality and security laws and policies.
3. Both parties to this MOU are federal agencies and their employees are covered by the Federal Tort Claims Act, 28 U.S.C §§ 1346(b), 2671-2680, in the event of an allegation of negligence. It is agreed that any and all claims of negligence attributable to actions taken pursuant to this MOU will be submitted to legal counsel for both parties for investigation and resolution.
4. This MOU replaces and supersedes the MOU signed by the VA Under Secretary for Health and IHS Director on October 1, 2010.
5. This MOU does not authorize the expenditure or reimbursement of any funds. This MOU does not create a binding contractual obligation, obligate either Party to expend appropriations or other monies or enter into any contract or other obligation, or create any rights between VA and IHS. Should any exchange of funds or resources be necessary, the Parties will first enter into a supplemental binding instrument.

**VII. Termination:** This MOU can be terminated by either VA or IHS upon issuance of written notice to the other party not less than 30 days before the proposed termination date. The 30-day notice may be waived by mutual written consent of both parties involved in the MOU.

**VIII. Effective Period:** VHA and IHS will review the MOU at least annually to determine whether terms and provisions are appropriate and current.

**IX. Severability:** If any term or condition of this MOU becomes invalid or unenforceable, such term or provision shall in no way affect the validity or enforceability of any other term or provision contained herein.





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