Long-Term Care Meeting

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Update on Indian Health Reform

by

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Good Morning. It's pleasure to be here today to help address the important issue of long-term care in Indian Country. With the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) and the passage of the Affordable Care Act, we are facing historic health care changes, as Americans and as Native people. I am grateful for this opportunity to speak about some of these important changes that will have a positive impact on our ability to provide quality health care to American Indian and Alaska Native (AI/AN) people, including our elders and those in our communities who are living with disabilities.

I will be giving you an update today on Indian Health Service (IHS) Reform, the Affordable Care Act, and the IHCIA, and what it all means to Tribes, AI/AN patients, and the Indian health care system. This includes the major provisions of the IHCIA that deal with long-term care.

This meeting is a first step. It is the beginning of a critical conversation on how we use the authorities of IHCIA to support and enhance the delivery of long-term care services in our communities.

To put the conversation about long-term care into context, I want to take a few minutes to review for you where we are in the IHS, and where we are going. There is a lot happening in the IHS these days, and we need to consider this as we think about how we could begin the work of implementing long-term care services in this context.

The text is the basis of Dr. Roubideaux's oral remarks at the Long-Term Care Meeting on November 1, 2010. It should be used with the understanding that some material may have been added or omitted during presentation.

In terms of how we are changing and improving the IHS, I set four priorities for the IHS to guide our work over the next few years:

- The first priority is to renew and strengthen our partnership with Tribes;
- Our second priority is, in the context of national health insurance reform, to bring internal reform to IHS;
- The third priority is to improve the quality of and access to care for patients who are served by IHS; and
- The fourth priority is to have everything we do be as transparent, accountable, fair, and inclusive as possible.

We are making some progress on these priorities; however, much of this work involves fundamental changes in how we do business in the organization, so the change will take some time. Long-term care would certainly fit into the third priority.

Our first priority is to renew and strengthen our partnership with Tribes. I truly believe that the only way we're going to improve the health of our communities is to work in partnership with them. The IHS cannot do its work in isolation – we have evidence throughout our system that we work better in partnership with our communities.

I am grateful for my public health training because it helped me see that the solutions to our communities' health problems will not be solved with efforts that just focus on our clinics or hospitals. Look at some of the biggest problems we face – suicide, domestic violence, obesity, cancer, mental health issues – all are influenced by factors in our communities such as education, unemployment, law enforcement, housing, etc. IHS cannot solve these problems alone.

Our Tribes, as sovereign nations, are responsible for the health and well-being of their members, and we can accomplish so much more if we work in partnership with them. So I am grateful that with this new administration, tribal consultation is a priority. It is clear that Tribes have been the leaders in long-term care services in Indian Country. I am anxious to hear the lessons learned they have to bring to the conversation today and in the coming months to years.

President Obama signed the Executive Order on Tribal Consultation at the first-ever White House Tribal Nations conference in November 2009, which supports our partnership in health with Tribes. Secretary Sebelius has also demonstrated her commitment to tribal consultation and partnership by meeting with Tribes on several occasions so far, including an historic moment when the Secretary held a private meeting with tribal leaders in her office on March 3, 2010. These are examples of this administration's dedication to tribal consultation.

In the past year, we have consulted with Tribes on improving the tribal consultation process, improving the Contract Health Services (CHS) program, priorities for health reform, implementation of the IHCIA, and the fiscal year (FY) 2012 budget. We are beginning to implement some of the recommendations from these consultations.

For example, we're improving the consultation process by making the information on consultations more widely available, giving more time for response, considering options to ensure consultation with all Tribes, and building a website to document progress on our consultation activities and workgroups.

The CHS consultation, listening sessions, and best practices meetings are generating a lot of great ideas to improve the way we do business in CHS.

I plan to formally consult on other topics this year, including the Indian Healthcare Improvement Fund, health care facilities construction, and my third priority on improving the

quality of and access to care. And we will consult on implementation of long-term care in IHS as we move forward. Today is not a consultation – it is an opportunity to begin to discuss how we could implement. We will formally consult with Tribes as a next step. All of these consultations are opportunities to partner with Tribes.

I have also held extensive listening sessions with Tribes and have conducted more than 270 Tribal Delegation Meetings at IHS headquarters and at national meetings since being sworn in over a year ago. And I am in the process of visiting all 12 IHS Areas to consult with Tribes, which was one of the recommendations from our consultation last year. I have visited 11 of 12 Areas so far. I will meet with the Navajo Area once their elections are completed.

I have found these visits to be very helpful in understanding broad themes as well as specific Area and tribal needs. Because not all Tribes can afford to travel to Washington, D.C., these Area visits are critical to ensuring that all voices are heard.

It's important that we strengthen our partnership and that Tribes help create the vision for IHS reform. For every decision I make, I always consider the input I have received from Tribes.

In addition to meeting with the entire group during the Area listening sessions, I also met individually with tribal leaders to hear about their priority issues and recommendations from a local perspective. I am grateful that these busy tribal leaders are taking the time to meet with me on health issues. It helps us see how we can move forward in partnership. We all want the same thing – better health care for our patients and our communities. It's important that we find more ways to work in partnership together.

And I appreciate your coming to this meeting today to discuss how we can work together to build the system of long-term care we need in our communities. In light of the new authorities of the IHCIA, this is an opportune time to begin this conversation.

My director's workgroup on tribal consultation met last month and developed some additional recommendations. I also met with the tribal leaders diabetes committee just last week. They are working on a strategic plan to further their work to advise and advocate for diabetes treatment and prevention. And I met with the Tribal Self-Governance Advisory Group this summer and in October. We talked about how we can help advance some of their issues in partnership by helping each other.

We are also developing a policy to confer with urban Indian programs – this is a new provision in the IHCIA. The first meeting of the workgroup was held last month.

And I held a CHS listening session and best practices session in September. In addition to the need for more CHS funding, we heard recommendations on how to improve the way we do business in CHS, such as how we refer patients, negotiate rates, and collect third-party reimbursements. I know CHS is a very important topic to Tribes and improving how we do business is a top priority for the IHS.

My second priority is "in the context of national health insurance reform, to bring reform to IHS." This priority has two parts – and as you all know by now, the first part includes passage of the health reform law, the Affordable Care Act, and the IHCIA.

We are grateful for passage of the Affordable Care Act because it will make quality, affordable healthcare accessible to all Americans, including our First Americans. It is designed to increase access to health insurance, help those who have insurance, and reduce healthcare costs. It also contains the permanent reauthorization of the IHCIA, which provides new and expanded authorities for a variety of healthcare services.

Both laws have the potential to benefit all of the Indian health system. We will be holding ongoing consultations with Tribes on the implementation of these new laws, and we will let you

know about these consultation opportunities along the way. The Department of Health and Human Services (HHS) and IHS sent a letter to Tribes in May initiating consultation efforts. I still encourage you to send your input to the email address consultation@ihs.gov.

We are working quickly to implement tribal priorities among the many provisions in these laws. I recently sent out a letter to Tribes with information on some provisions that are self-implementing, or that were in effect with passage of the law and require little or no implementation activities. I will be sending regular updates to Tribes.

We conducted planning consultation activities in October on topics such as the Access to Federal Insurance Provision and the special provisions related to the Insurance Exchanges in the Affordable Care Act. More information will be sent to Tribes shortly. Don't worry, we are consulting with Tribes and will be doing more to make sure you have input before decisions are made.

One of the most common questions we get is, "How will health care reform help American Indians and Alaska Natives?" Health care reform is mostly about increasing access to affordable health insurance. While many AI/ANs are covered by IHS, many do not have access to IHS, especially in urban areas, or some may want to purchase insurance as an alternative to IHS services.

The new law means that individuals and small businesses will have more affordable options for health insurance through the creation of state-based Exchanges by 2014. They will be able to compare health insurance plans in their state and purchase more affordable insurance. This should result in 32 million more Americans being covered.

And it means that AI/AN individuals or small businesses that want to purchase health insurance will have more affordable options than they do now. This is particularly important for those who do not have access to IHS coverage and/or do not have access to insurance with their job.

Also, there will be no cost sharing for insurance purchased through the exchanges – that means no co-pays or deductibles – for Indian patients who incomes are less than 300% of the poverty level. And AI/ANs are exempt from tax assessments for not enrolling in an exchange plan. This was the first provision in the health reform law that the President publicly supported for AI/ANs – they are exempt from the penalty due to health care being "owed to them."

Another provision in the Affordable Care Act will expand Medicaid coverage to individuals with incomes up to 133% of poverty level starting in 2014. This should help many AI/ANs in our communities.

All of these provisions mean that our patients, American Indians and Alaska Natives, will have more choices – to use IHS, and/or to purchase more affordable health insurance. It does not mean that the IHS will go away. That was a myth.

And it means that the entire Indian health system – Tribes and IHS facilities - may benefit from reduced health care costs, more choices, and better coverage. If more AI/ANs are covered by health insurance and they choose to use IHS, it could mean more third-party reimbursements.

The challenge is that as more patients have the choice of where they can receive their health care, IHS must become more competitive. IHS must demonstrate that it delivers quality health care and provides excellent customer service. So the work IHS is doing to change and improve is even more important now.

HHS is taking the lead on implementation of the Affordable Care Act in general, and IHS is working closely with HHS on the provisions that impact American Indians and Alaska Natives. Provisions already implemented in 2010 include:

- Extended insurance coverage for young adults under 26 years – previously they were not covered and usually could not afford insurance;
- Extended reinsurance for early retirees aged 55-64;
- Access to insurance for those who were uninsured due to pre-existing conditions (Pre-existing Condition Insurance Plan);
- Provision of checks to seniors who reached the Medicare Part D "donut hole" – while only a small proportion of AI/ANs purchase this coverage, it does help;
- Establishment of a new "Patient's Bill of Rights" that includes a number of insurance protections, including
  - No discrimination against children with pre-existing conditions, and
  - Elimination of lifetime limits on insurance coverage
- Small business tax credits
- Efforts to crack down on healthcare fraud; and
- Creation of a website at Healthcare.gov with information on insurance plan choices and other information for consumers. It even references IHS as an option for those who are eligible.

The Affordable Care Act also addresses long-term care in some important ways. I think that over the next couple of days you'll hear more about some of these provisions from our colleagues at Centers for Medicare and Medicaid Services and the Administration on Aging.

And the IHCIA was included in the Affordable Care Act – which is great for Indian Country because this law is the main legislation that authorizes Congress to fund health care services for AI/ANs. And it ***permanently*** reauthorizes the IHCIA.

The IHCIA updates and modernizes the IHS. The provisions are numerous but many of them give IHS new authorities. The IHCIA updates and modernizes the IHS. The provisions are numerous but many of them give IHS new authorities. This includes authorities for the provision of long-term care service, which I will say more about in a moment. But there are also other important provisions that I want to highlight for you, including:

- New and expanded authorities for behavioral health prevention and treatment services;
- New and expanded authorities for urban Indian health programs;
- Authorities for various demonstration projects, including innovative health care facility construction and health professional shortages*;*
- The authority for provision of dialysis services;
- Authorities to improve the CHS program;
- And authorities to improve facilitation of care between IHS and the Department of Veterans Affairs (VA).

These are just examples of what is in the new law.

Now I want to take a few minutes and walk with you through the language of the IHCIA provisions that are specific to long-term care. We all need to know the language contained in the Act. I won't be interpreting it for you or telling you "what it means." We'll be sorting this out together through our conversations today, through future tribal consultation, and through implementation efforts.

The law defines the terms that it uses, including Assisted Living Services, Home and Community Based Services, Hospice Services, and long-term care Services, usually in terms of other statutes or laws. This is important because these are technical and legal definitions that we'll need to work with and understand as we implement the law.

Given those definitions, the Act specifies that the Secretary of Health and Human Services, acting through the Indian Health Service, can provide funding for these services. And it identifies those individuals who might be eligible for these services.

This is the "authorities" part of the law – it tells the IHS what we can do, either directly or through Tribes and tribal organizations. It's important to realize that while this gives us authority to provide these services, it does **not** actually give us any funding to do so. IHS did not have these authorities before this law passed. However, many Tribes have implemented these types of services on their own, and I am looking forward to learning from their experience.

There is also language in the Act that addresses the sharing of staff, services, and facilities between IHS, Tribes, and tribal organizations. This is really important because it can allow us to think creatively and do more with the resources we already have.

There is some regulatory language in the Act, mostly referring to existing regulatory language already in law that guides the sharing of services.

And finally, it encourages the creative use of facilities and space that may be underutilized to help provide these long-term care services.

So this is basically what the law says. That's where we start – with the authority to provide these services to our patients. But there is much to do – we must see what has been done so far, consult with Tribes on how they want us to implement this provision, and then we have to mobilize the right people and resources to make this happen. This meeting is a good first step.

Another common question about the IHCIA, beyond what is in the new law, is about what IHS plans to do to implement the provisions in it.

IHS is taking the lead on implementation of the IHCIA. It is clear that IHS cannot implement the entire law all at once and that this will need to occur over time. IHS is working very hard on reviewing provisions and developing next steps and timelines. Some provisions are immediate, and some require funding or additional work.

IHS and HHS also must take time to consult with Tribes on this important new law. We must consult in a meaningful but efficient way so implementation can move forward. We are working very quickly, but also very carefully – we want to do this right the first time.

HHS and IHS initiated consultation with Tribes on the Affordable Care Act and the reauthorization of the IHCIA in May with a letter to Tribes requesting input on the process for consultation and priorities for implementation. The input received to date makes it clear that Tribes want to be consulted before policy decisions are made. HHS and IHS will announce plans for regular consultation with Tribes. We will also plan to consult with Tribes on the long-term care provisions – we heard they were a top tribal priority.

We recognize that education and communication are priorities at this time. So we are taking steps to keep everyone informed:

- You can find updates on our implementation process on my Director's Blog at ihs.gov;
- As I mentioned a minute ago, HHS just unveiled a new website – healthcare.gov – that helps the public understand how health reform benefits them.

- We are using *Dear Tribal Leader* Letters to keep you updated. HHS and IHS sent a letter to tribal leaders in May requesting consultation on health reform and the Indian Healthcare Improvement Act. The letter included a fact sheet and tables that summarize the provisions relevant to Indian country.
- In July, IHS sent a letter to Tribes that summarized some provisions that are already in effect or were self-implementing.
- We will be announcing soon more self-implementing provisions and initiating some consultation activities on some topics of great interest, including the Federal Employees Health Benefit program provision and the Special Provisions for Indians related to the State Exchanges.

I encourage you to learn everything you can about this important new law and its impact on Indian health care.

The letter IHS sent to tribal leaders in July explains some provisions in the Indian HealthCare Improvement Act that are self-implementing or require little to no implementation. This is the first in a series of letters to Tribes with this type of information.

An example of a self-implementing provision includes Section 113 – exemption from payment of certain fees. This requires federal agencies to exempt Tribes from paying licensing, registration, or other fees imposed by federal agencies. Because of this new law, the Drug Enforcement Administration (DEA) will no longer charge tribal providers a fee to prescribe controlled substances. The DEA has already notified its field offices of the new law. So there is nothing else to do to implement this provision; it is self-implementing.

There are numerous other sections that are mentioned. I encourage you to review the letter if you have not already done so.

Section 157, Access to Federal Insurance, was indentified by Tribes as a top priority for implementation. This provision allows Tribes, tribal organizations, or urban Indian organizations to purchase coverage for their employees from the Federal Employees Health Benefits Program. While the authority was present on the day the law was passed, a mechanism needs to be developed to administer this option. IHS is assisting the Office of Personnel Management with implementation of this provision, and Tribes were sent a letter requesting consultation and input this month.

The second part of this priority is about bringing internal reform to the IHS. In order to get the support we dearly need, the IHS must demonstrate a willingness to change and improve. It is clear that Tribes, staff, and our patients want change.

By internal IHS reform, I mean we need to look at what we do well, and be honest about where we need to improve.

I want to thank those of you who provided input last year on your priorities for how to change and improve the IHS. There is so much to do – it really helped me to hear from you about your priorities on where you think we should begin this important work.

Tribal priorities for internal reform included:

- More funding for IHS, including a review of how we allocate funding;
- Improvements in the CHS program; and
- Improvements in the tribal consultation process.

We're working on these priorities, as I have already described. We're also making progress on the top staff priorities for internal IHS reform. Overall, staff emphasized improving the way we do business and how we lead and manage our staff. I can understand this – as a clinician, I just wanted to see and help patients, but the way we were doing business was getting in the way. I imagine many of you have felt this same sort of frustration at one time or another.

To improve the way we do business, we're working with HHS and our Area Directors to improve how we manage and plan our budgets and improve our financial management. We're working to make our business practices more consistent and effective throughout the system.

To improve how we lead and manage staff, we're working on specific activities to improve and streamline the hiring process by making it more efficient and proactive, and less time-consuming. We're also working on improvements in pay systems and strategies to improve recruitment and retention. Many of you know how difficult it is to recruit and retain healthcare providers. We need to make sure the way we do business is not causing us to lose the opportunity to hire and keep good staff.

We are also responding to the concerns raised in the hearing on the Senate Committee on Indian Affairs investigation of the Aberdeen Area. Some of the issues raised are unacceptable, and we are acting to correct them immediately. We are implementing stronger reforms to ensure that we hire the right people, deal with problem employees rather than shuffle them around, increase security in our pharmacies, and make sure that our providers have updated licenses or else they cannot practice.

Many of these improvements are happening behind the scenes, so you may not be seeing specific improvements yet, but they are fundamental improvements that will pay off over time.

At a recent Human Resources Summit that we held with representatives from all IHS Areas and key staff involved in the hiring process, they came up with some very good recommendations for improving and shortening the hiring process.

I have also sent messages to IHS staff on improving our business and management practices – such as the importance of customer service, ethics, performance management, and professionalism. Many of our staff members want improvements in these areas, and our work starts with a strong message from the top that these are important areas for all of us.

We're also improving our performance management process to include the agency priorities and to make sure we do a better job of rewarding employees who perform well and holding those accountable who do not.

Nothing is more frustrating than working with or being taken care of by someone who is unprofessional, or who does not treat patients or staff well. Our patients – and staff – deserve to be treated with respect and kindness at all times.

Overall, we need to improve how we do business as an agency – yes, we are a "service" organization with a great mission, but we also have to function as an efficient and effective business to survive, given the challenges we face. And with the Affordable Care Act making insurance coverage more accessible, we need to be as competitive as possible so that our patients will always consider us their first choice for health care. So changing and improving the IHS is more important than ever.

As we do better as a business, you can be assured that as an American Indian physician who has worked in IHS clinics, I will make sure we don't forget that our ultimate focus is on the patient.

In relation to our third priority, to improve the quality of and access to care, I started by identifying the importance of customer service – how we treat our patients and how we treat each

other. I am now starting to see activities to improve customer service throughout the system and am starting to hear stories about some improvements. However, we still have a lot of work to do to improve our customer service.

We also plan to expand the Improving Patient Care (IPC) initiative to 100 more sites over the next 3 years. This is our "medical home" initiative that puts the focus of our healthcare team on serving the patient. We're now beginning phase 3 of the IPC.

And I began collecting best practices in providing quality care last year – we need to avoid reinventing the wheel by doing a better job of sharing what we're doing well and disseminating that information more effectively. We know our programs and facilities are doing some great things, especially in the provision of culturally competent care.

I would like to hear from you about your best practices and ideas to improve quality – you can send them to quality@ihs.gov.

We recently held a quality of care summit with IHS staff – they generated a larger number of recommendations to improve quality.

Other ways we are working to improve quality care include collaborations with other departments and agencies. Given that we have limited resources in Indian health, we have to leverage all resources to improve care for our patients.

For instance, we have been meeting with the Department of Interior on health issues in our communities – I met with Assistant Secretary of Indian Affairs Larry Echohawk, and he understands how we must work together to address some of the most difficult health problems we are facing in tribal communities.

I also am working with other Operating Division heads in HHS to expand availability of resources and services for American Indians and Alaska Natives. For instance, I have worked with Mary Wakefield, Administrator of the Health Resources and Services Administration, on workforce issues, and Pam Hyde, Administrator of the Substance Abuse and Mental Health Services Administration, on suicide and behavioral health efforts. I am grateful for all the HHS leaders who are working with us – and especially those who are willing to help us begin our discussion of implementing long-term care. Some of those leaders are following me on the agenda today. It's clear that we need everyone to help us with this enormous task of implementing long-term care in IHS.

I also met with Secretary Shinseki from the VA. We are working to collaborate on several activities, including coordination of care for veterans who are eligible for both IHS and the VA. We just signed a VA-IHS Memorandum of Understanding (MOU) – updated from the one we signed in 2003 – to help improve how we coordinate care for our veterans and will be consulting with Tribes on implementation shortly. The VA can also help us with understanding how to implement long-term care services because they already provide these services. This is a topic in the updated MOU.

The signing of the Tribal Law and Order Act is an example of a collaborative effort that will help us improve health in our communities by addressing the serious problem of violence against women. Many federal agencies are collaborating on implementation of this law, and we are involved in those activities. Violence against Indian women is unacceptable, and we all need to work to eliminate it in our communities.

Our fourth priority is to make all our work transparent, accountable, fair, and inclusive. Since I began my tenure as the Director of IHS, I have worked hard to improve our transparency and communication about the work of the agency. This includes working with the media,

sending more email messages and *Dear Tribal Leader* letters, holding regular internal meetings, and giving presentations at meetings like this.

We have also enhanced our website with the IHS Reform page, Director's Corner, and Director's Blog, which contain important updates and information about reform activities.

And we're looking at ways to improve IHS-wide communication among Areas, Service Units, and Headquarters. We need to be functioning as **one unit, as a team**, in order to provide the best services possible to our patients. This includes not just federal sites, but our tribal and urban sites as well. We are all a part of the same team.

We're also emphasizing accountability and fairness in the way we do business – by evaluating our programs and focusing on areas of greatest benefit, and by always considering fairness when dealing with staff and making programmatic decisions.

Inclusiveness is a part of these priorities because as the IHS Director, I have to ensure that all my decisions consider the impact on all our patients, whether they are served in an IHS, tribal, or urban Indian health facility. Balancing the needs of the various parts of our healthcare system is a challenge, but inclusiveness is very important as we work to improve the IHS.

As I just mentioned, we have enhanced our IHS website. One addition is my "Director's Corner," which is linked to the IHS home page. There you can get information on presentations, *Dear Tribal Leader* letters, updates on internal IHS reform, and other messages. You will also see an orange "Director's Blog" button that you can click on that will take you to my blog. I plan to use the Director's Blog to post brief updates on our activities and the latest IHS news at least weekly. This is one of many efforts to be more transparent about what we're doing as an agency.

I have posted pictures of many of my consultation and listening session on my blogs, as well as pictures from Tribal Delegation Meetings. I think it's important for the public to know that meeting with Tribes is important to the agency, and putting updates and pictures on the blog helps. This really is the place where you can get the most up-to-date information. I encourage you to check this site every one to two weeks.

So what are our accomplishments so far? Well, we are making progress on IHS reform, but a lot of the work is internal to the organization right now and much of the work to improve the way we do business is in progress. Certainly the most visible progress to date for this new administration is the increases in funding for the IHS:

- The FY 2010 budget with its 13 percent increase has the largest percent increase in over 20 years for IHS. We're just now feeling the impact of this increase. For example, there was a $100 million increase in CHS funding – this meant an increase in the range of 14-30 percent in each IHS Area, which will result in more referrals being paid.
- And this increase included a substantial increase in our Catastrophic Health Emergency Fund, which pays for high cost cases. This year, we may be able to make it to the end of the year and not run out in June, as has been the past experience.
- The FY 2011 President's budget proposed an almost 9 percent increase, and we're waiting to see if Congress decides to keep that increase in the budget.
- The Recovery Act funding provided $590 million for health facilities construction, sanitation facilities construction, maintenance and improvement, equipment, and health information tedchnology. Some of you may be seeing this funding benefiting your communities now. For instance, hospital

constructions in Eagle Butte, South Dakota, and Nome, Alaska, are making progress.

Overall, we are beginning to make progress on our priorities and are moving forward on the challenging work to change and improve the IHS. The changes we're working on are fundamental improvements in how we do business as an agency, and I believe they will help address many of the priorities for change as expressed by staff and by Tribes**.**

Our staff, our patients, and the tribal communities we serve need to see that we heard their priorities and their input, that we're committed to changing and improving, and that we're now implementing specific activities to change and improve IHS.

This includes the opportunity to begin creating the kinds of long-term care services and support that are vitally needed in our communities. These services must allow our elders and those in our Tribes and communities living with disability to be active participants in our communities.

I am really looking forward to this conversation with you. With your help, I am confident we can make real progress in improving health care for American Indian and Alaska Native people. Thank you.