

The governmental public health system in the United States is comprised of federal agencies, state health agencies, tribal and territorial health departments, and more than 2,500 local health departments. Coordination across these different levels of government is essential to ensuring the public's health. In 1988, the Institute of Medicine defined "public health" as "fulfilling society's interest in assuring conditions in which people can be healthy." Different organizations and agencies achieve this goal in different ways, depending on their mandates or missions.

State and territorial public health agencies (S/THAs) are a vital part of U.S. public health efforts. The structure of these agencies varies, but most S/THAs have offices that support health equity initiatives (84%) and rural health (73%) and provide financial support to primary care providers (75%).<sup>1</sup>

### **State and Local Health Department Governance Classification System**

State and local health departments vary in their governance structure and classification. The relationship between state and tribal health agencies may differ depending on the governance structure in the state. Fourteen out of 53 state and territorial health agencies (27%) ensure access to tribal health services—most of these states and territories are "decentralized," meaning that local jurisdictions have more responsibility for the public's health.<sup>2</sup>

- **Centralized/Largely Centralized.** 75% or more of the state's population is served by local health units that are led by employees of the state and the state retains authority over many decisions relating to the budget, public health orders, and the selection of local health officials. (Fourteen states meet these criteria.)
- **Decentralized/Largely Decentralized.** 75% or more of the state's population is served by local health units that are led by employees of local governments and the local governments retain authority over many decisions relating to the budget, public health orders, and the selection of local health officials. (Twenty-seven states meet these criteria.)
- **Shared/Largely Shared.** 75% or more of the state's population is served by local health units that meet one of these criteria: where local health units are led by state employees, local government has authority over many decisions relating to the budget, public health orders, and the selection of local health officials; OR where local health units are led by local employees, the state has many of those authorities. (Four states meet these criteria.)
- **Mixed.** Within the state there is a combination of centralized, shared, and/or decentralized arrangements. No one arrangement predominates in the state. (Five states meet these criteria.)<sup>3</sup>

All S/THAs are entrusted with 10 essential public health services:

1. Monitoring health status to identify and solve community health problems.
2. Diagnosing and investigating health problems and health hazards in the community.
3. Informing, educating, and empowering people about health issues.
4. Mobilizing community partnerships and action to identify and solve health problems.
5. Developing policies and plans that support individual and community health efforts.
6. Enforcing laws and regulations that protect health and ensure safety.

7. Linking people to necessary personal health services and ensuring the provision of healthcare when otherwise unavailable.
8. Ensuring a competent public and personal healthcare workforce.
9. Evaluating the effectiveness, accessibility, and quality of personal and population-based health services.
10. Researching for new insights and innovative solutions to health problems.<sup>4</sup>

The state or territorial health official (S/THOs) is the head of the S/THA. More than half of the country's S/THOs are executive cabinet-level officials directly appointed by the governor. States with larger populations are more likely to have S/THOs who are directly appointed in this way; in states with smaller populations, the S/THO is more likely to report to a cabinet-level official. In a few southern states, S/THOs report to boards or commissions.<sup>5</sup>

On average, S/THOs have 15 years of experience in the health field before taking office and almost two-thirds are physicians with a doctor of medicine (MD) degree. In more than half of the states, the MD degree is required by statute. S/THOs oversee approximately 120,000 state public health workers, including epidemiologists, public health clinicians (i.e. dentists, physicians, and nurses), maternal and child health directors, information specialists, health educators, primary care office directors, and others.<sup>6</sup>

Funding for state health agency programs comes from federal agencies, state general funds, fees and fines, Medicaid/Medicare, and other sources.<sup>7</sup> State health departments use these funds to work with programs that assess state and local health issues and improve the health of their populations, no matter their geographical location. The state health department acts as an advocate and partner for rural and urban populations. This is especially important as AI/AN populations move to and from rural reservations to urban areas in pursuit of economic and educational opportunities. In collaboration with other non-health state government agencies, federal and local government agencies, and public and private partners, the state public health infrastructure is an essential part of improved health for all populations, including those in tribal jurisdictions.

### Important Statutory Considerations for State and Territorial Public Health

Many laws involving the public health and healthcare system have been signed and implemented into practice. An important point to emphasize is that AI/AN populations are not excluded from participation in any federal program, despite their relationship to Indian Health Services. A few critical examples are listed below:

- **Social Security Act of 1935<sup>8</sup>**  
The Social Security Act of 1935 (SSA) entitled federal, state, and local public-health services to provide for the welfare of the American public, establish old-age benefits to workers, and prevent disease. Originally, SSA primarily addressed maternal and child health, but it has since been amended to include Medicare, Medicaid, and State Children's Health Insurance Plan. The unique government-to-government relationship between the 566 federally recognized Indian tribes and the federal government has led Indian Health Services (IHS) and Centers for Medicare and Medicaid Services (CMS) to join forces to implement outreach and education activities to improve tribal access to these entitlements.

- **Maternal and Child Health [Title V]<sup>9</sup>**

S/THAs provide for the welfare of mothers and children through Title V of SSA, which makes financial provisions for states to extend and improve programs for maternal and child health, particularly in rural areas suffering from severe economic distress. Title V allocates resources to establish and strengthen services that identify and improve the welfare of children who are homeless, neglected, and have disabilities. This funding can be used for AI/AN children in the states. Title V funding is passed through the states primarily in these two ways:

1. Formula grants to states: This is the number of children in poverty in the state in relation to the total number nationally. These funds are available for 2 years and must be matched (\$3 state funds for every \$4 federal funds). This constitutes 85% of funding.
2. Discretionary grants: Special Project of Regional and National Significance supports specific projects and requires \$1 state match for every \$2 in federal funds. These projects vary and can include MCH training, genetic and diagnostic testing, research, etc. This constitutes 15% of funding.<sup>10</sup>

For Title V money spent within states:

- 30% funds must be used for preventive/primary care services for children
- 30% funds must be used for children with special health care needs
- No more than 10% can be spent on administration
- The rest is determined by states on the actual services provided and expenditures by service and service category and varies by state.
  - Block grant services: Direct health services, enabling services, population-based services, and infrastructure-building services.<sup>11</sup>

- **Medicare [Title XVIII] and Medicaid [Title XIX]<sup>12</sup>**

Medicaid has been working towards access to healthcare services for many years. American Indians and Alaska Natives (AI/ANs) have the same rights as non-AI/ANs to receive medical services under any approved state Medicare or Medicaid plan. Previously, IHS' authority to receive Medicare reimbursements was limited to services provided in an IHS hospital or skilled nursing home, but IHS now has full authority to bill Medicare for all covered services. IHS receives more than \$700 million annually in revenue from CMS for services provided to Medicaid, Medicare, and the State Children's Health Insurance Program eligible patients.<sup>13</sup>

CMS and IHS released a letter in 2012 requiring tribal consultation to approve Medicaid waivers in AI/AN populations. Exceptions to the Medicaid system are critical to the health outcomes of underserved populations. For example, 1115 waivers in Louisiana and Georgia allow new mothers to say eligible for Medicaid payments beyond 90 days to improve intra-conception care and improve outcomes for the 2<sup>nd</sup> child.<sup>14</sup> This emphasis on tribal input for Medicaid waivers that affect their communities will hopefully lead to stronger relationships between tribal and state leadership.

- **State Children's Health Plans [Title XXI]<sup>15</sup>**

Title XXI of SSA funds the creation of state child health plans that enable states to initiate and extend the provision of child health assistance to uninsured, low-income children. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allocated \$100 million between 2009 and 2013 to enroll uninsured AI/AN children who are eligible for health coverage under Medicaid or State Children's Health Insurance Plans.<sup>16</sup> SCHIP is no cost sharing for AI/AN children.

- **The Public Health Service Act of 1970<sup>17</sup>**

Family planning and preventive care fall under the public health scope of responsibility. Title X of the Public Health Service Act of 1970 is the only federal program devoted exclusively to family planning and provides resources for family planning and related preventive health services.<sup>18</sup> Title X grantees offer family planning services to more than 5 million individuals through a network of community-based clinics including state and local health departments, tribal organizations, and hospitals.<sup>19</sup>

- **The Patient Protection and Affordable Care Act of 2010**

The Patient Protection and Affordable Care Act (ACA) extends access to quality and affordable healthcare services to the lowest income Americans, including AI/AN individuals. Through this expansion of care, an estimated 185,000-380,000 uninsured AIs/ANs who report access to Indian health programs providers would become Medicaid eligible.<sup>20</sup> Furthermore, according to section 5006(d) of the Recovery Act, AIs/ANs enrolled in Medicaid managed care plans may select an Indian healthcare provider as their primary care provider.<sup>21</sup> Additionally, ACA includes permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), the legal authority for the provision of healthcare to AI/AN populations. IHCIA reauthorization facilitates continued improvements in quality and quantity of healthcare delivery services to tribes, allowing tribal members to receive the type and quality of healthcare services that eliminate health disparities between AI/AN populations and the general population of the United States.

### **Focus on Tribal Health from ASTHO's Minority Health Survey 2010**

ASTHO conducted a survey of S/THAs in 2010 to assess the ways that state and territorial health agencies address racial and ethnic minority health, health disparities, and health equity. ASTHO received a total of 51 responses to the survey. Questions gathered information on state demographics and S/THA health priorities; organizational and strategic frameworks for addressing MH/HD/HE; financial and human capital investments in minority health, health disparities, and health equity; and partnerships around minority health, health disparities, and health equity.

Thirty-six out of 51 states and DC reported that they served AI/AN populations and included them in their S/THAs' priorities. Of these 36 states, 22 have federally recognized tribes. Of the 36 states that prioritized AI/AN populations:

- Thirty-five states had a primary contact person who works on minority health, health disparities, and health equity issues.
- Thirty-two states had an organizational unit that has primary responsibility on minority health, health disparities, and health equity issues.
- Seventeen states had a strategic plan for minority health, health disparities, and health equity

issues that is part of the overall strategic plan for the agency.

- Seven states had a stand-alone strategic plan specifically for minority health, health disparities, and health equity issues.

### **Tribal Relationships with the State Health Agency**

ASTHO analyzed the Minority Health Survey data to identify states with innovative and promising practices for health equity, and conducted case studies on 16 states. Four states (AK, AZ, MN, and MT) highlighted their work with AI/AN populations and collaborations with state and tribal organizations. These four state health agencies partnered with other organizations to improve health outcomes of native and non-native populations in a variety of programs such as:

- H1N1 vaccination with the Inter Tribal Council of Arizona<sup>22</sup>
- Breast cancer screening with the Montana American Indian Women's Health Coalition<sup>23</sup>
- Cardiovascular screening with the Grand Portage Band of Ojibwe from Minnesota<sup>24</sup>
- Primary and other preventive care services with the Alaska Native Tribal Health Consortium<sup>25</sup>
- State health agency's collaboration with nontraditional partners such as the Montana Department of Transportation informed the state's injury prevention program to address the disparities in alcohol-impaired fatality rates in auto accidents<sup>26</sup>

State health officials are working to integrate the input and involvement of tribal workgroups and coalitions into all levels of the state health agencies. These partnerships leverage scarce resources and ensure cultural competency in providers to eliminate the health disparities among native and non-native populations.

### **Working Successfully with State Health Departments**

When a new state health official takes office, tribes and tribal organizations should invite him or her to meet with them and start establishing a relationship. Two recent partnership meetings with CDC, CMS, ASTHO members, and tribal leadership provided opportunities to share best practices for tribal and state leadership communication. Tribes can get involved with various state-level committees and decision-making groups, such as advisory groups and task forces to include their expertise and leadership if they have not done so already. Ways to get involved include participating in relevant advisory boards and committees, building partnerships, and staying engaged to support sustainable and long term relationships.

Other important tips to help tribal leaders and states work together effectively include:

- Be willing to develop and enhance long-term relationships between your tribe and states, using such vehicles as memoranda of understanding, tribal/state consultation agreements, or strategic partnerships.
- Coordinate with state programs and resource and financial investments in AI/AN health in your tribal jurisdiction.
- Provide a means by which states can contact and work with your office regularly. Success requires a day-to-day relationship "on the ground."
- Tribes may initiate consultations with state and federal partners.
- Create consultation accountability by tracking success and challenges and reporting regularly with each other.

- As there is relatively high turnover among both state health and tribal leadership, it is critical to create a transition plan for new state and tribal leaders on health issues.
- Don't be afraid to acknowledge your own knowledge and cultural limitations and ask to learn. Don't be afraid to ask questions, ask for clarification, and create open communication.
- Health insurance exchanges and other ACA provisions will include nongovernmental entities with low experience with and knowledge of tribal issues- involve these nongovernmental entities as your partners at the earliest possible times by participating in relevant advisory boards, committees, and building partnerships.
- Engage in and contribute to cross-cultural training for new state health agency workers.
- Focus efforts on Medicaid education, enrollment, and reimbursement at the community and local level.
- Commit time and your leaders to this relationship. You can ask for help from many partners who are willing to serve you, such as:
  - [Association of State and Territorial Health Officials](#)
  - [National Indian Health Board](#)
  - [Centers for Disease Control and Prevention](#)
    - [CDC's Office of State, Tribal, Local, and Territorial Support](#)
  - [Health Resources and Services Administration](#)
  - [Centers for Medicare and Medicaid Services](#)

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<sup>3</sup> Ibid.

<sup>4</sup> Centers for Disease Control and Prevention. “10 Essential Public Health Services.” Available at <http://www.cdc.gov/nphpsp/essentialservices.html>. Accessed 09/18/12.

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<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

<sup>8</sup> Social Security. “The Social Security Act of 1935.” Available at <http://www.ssa.gov/history/35act.html>. Accessed 1/9/13.

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<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

<sup>22</sup> Association of State and Territorial Health Officials. "Meeting the Health Equity Challenge: State Case Studies. 2010." Available at <http://www.astho.org/WorkArea/DownloadAsset.aspx?id=4201>. Accessed 1/10/13.

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