

Honoring Innovations Report

“A Newsletter for System of Care Communities in Indian Country” Issue #11, July 2013

A newsletter published by the National Indian Child Welfare Association (NICWA) describing best practices in American Indian/Alaska Native systems of care for current and graduated system of care communities

A “best practice” in the field of American Indian/Alaska Native children’s mental health is a process, method, training, or event that is believed to have a direct link to providing the desired outcome.

NICWA believes that such a practice requires that seven specific criteria are met. The program must: demonstrate potential for longevity; be replicable; exist harmoniously with Indigenous values and teachings, be sustainable, secure community acceptance, include the input of stakeholders across generations, and demonstrate culturally competent staffing.

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Funding Culturally Appropriate Tribal Children’s Mental Health Services with Medicaid

Sustainability remains a dominant issue intrinsic to all conversations about systems of care (SOC). Many tribal communities have encountered great challenges to sustaining SOC initiatives beyond the lifecycle of a SOC grant. It is one thing to reform a system; it is another to secure funding for its longevity. More and more, tribal communities recognize Medicaid as an untapped source of revenue with great potential to significantly augment the long-term sustainability of SOC initiatives.

Medicaid Overview

Medicaid is a dependable revenue stream that can support the delivery of culturally appropriate services. With adequate investment in building the infrastructure for Medicaid billing into SOC initiatives, tribal communities greatly expand health care funding for children’s mental health services, including those that incorporate cultural and traditional practices.

Such use of Medicaid funding complements the SOC core values of being community-based and culturally competent. Also, growing tribal capacity to create billable, culturally relevant mental health services is particularly timely, given the pending expansion of Medicaid—and the increased numbers of American Indians/Alaska Natives (AI/ANs) who will become eligible for it—that will take place in 2014 as part of the Affordable Care Act.

Medicaid is the largest payer of behavioral health services in the United States and is underused by AI/ANs. A federal entitlement health insurance program, Medicaid was established in 1965. It supports health and long-term care services, including children’s mental health services, for low-income Americans who meet financial criteria and belong to one of the categorically eligible groups.

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Additional Resources

Federal resource site on the Affordable Care Act

<http://www.healthcare.gov/>

Centers for Medicare and Medicaid Services information for AI/ANs

<http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/index.html>

Reference glossary of Medicaid-related and other terms

<http://www.cms.gov/apps/glossary/>

NICWA’s Medicaid fact sheet

http://www.nicwa.org/mental_health/SystemsOfCare/documents/MedicaidFactSheet_FINAL.pdf

(continued from page 1)

Medicaid is administered through the states, and each administers programs differently. The state Medicaid plans are unique and serve as contracts between the state and the federal government. It is important to emphasize that the criteria for eligibility, covered services, limitations, and payment methodologies of each service vary greatly from state to state.

Tribes as Medicaid Services Providers

Tribes do not have the regulatory authority to directly administer Medicaid, but there are a number of ways in which tribes can provide Medicaid-funded services. To become a provider eligible for Medicaid reimbursement, tribes must enroll with Medicaid through the state they are located in and obtain a Medicaid billing number. They can choose to enroll with Medicaid under any "provider type" for which they qualify. The term "provider type" is descriptive of the services the program or organization renders and is also specific to the encounter rate that Medicaid uses to reimburse the provider.

Many tribal programs may provide a broad array of services and typically have multiple Medicaid enrollment numbers specific to each category of service. Tribes may enroll as one or more of the three main types: an Indian Health Services (IHS) facility, a Federally Qualified Health Center (FQHC), and a community mental health center.

- **IHS Facility Provider Status.**

To gain this status, a tribal facility must be on the IHS facility list and be either an IHS or a tribal organization operating under a Public Law 93-638 (638) contract or Public Law 106-260 compact (a type of self-governance agreement). The IHS facility list is comprised

Culture itself is not a billable activity, but culturally adapted and appropriate therapeutic services may be.

of those facilities owned or leased and operated by the IHS or a 638 tribe or tribal organization. Services are reimbursed at the IHS encounter rate, which is adjusted annually, typically higher than the state Medicaid rates, and reimbursed by 100% federal funds.

- **Federally Qualified Health Center.**

Non-tribal providers are usually required to have a community health center grant from the Health Resources and Services Administration (HRSA) to qualify as an FQHC. However, tribal facilities and urban Indian programs are deemed to be FQHCs under federal rules and qualify to enroll as such without an HRSA grant. To be enrolled as an FQHC, certain services must be provided by a program or organization, and the center must employ staff with certain qualifications (e.g., physician, physician assistant, nurse practitioner, psychologist, and licensed clinical social worker). Services are reimbursed as cost-based encounter rates and typically involve a combination of state and federal funds.

- **Community Mental Health Center.**

If a tribal program wants to provide Medicaid-eligible services not included in the state plan under the IHS encounter rate or FQHC provider type, it must enroll with the state as an additional provider type. Other provider types for behavioral health have dif-

ferent enrollment requirements. Reimbursement is based on the Medicaid fee schedule and typically involves a combination of state and federal funds.

It is important to remember that state Medicaid programs are required to serve all eligible populations within their service areas, including AI/ANs. Additionally, national policies offer financial incentives to states to work with tribal programs to provide Medicaid services.

The Indian Health Care Improvement Act of 1976 established a 100% federal match rate for all Medicaid-eligible services provided by IHS and 638 IHS contracted tribal facilities (with some exclusion for urban Indian programs). This means that the state is not required to match the federal reimbursement at their Federal Medical Assistance Percentage (FMAP) rate. Those rates vary anywhere from 30% to 80% state match. With the IHS encounter rate, the federal government reimburses the tribe at 100%, thus potentially saving the state a significant amount of funds compared to services that would be provided through the state.

When considering how culturally appropriate children's mental health services may be funded under Medicaid, the first step is to gain familiarity with the requirements of the federal Medicaid program. Then take a close look at your state Medicaid plan. States are afforded flexibility in terms of additional programs and populations covered beyond the federally established minimum criteria. It is also important to be clear on community standards and expectations around the relationship between culture and billable services. Culture itself is not a billable activity, but culturally adapted and appropriate therapeutic services may be.

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How Medicaid Can Serve as a Funding Mechanism for Cultural and Traditional Behavioral Health Services



Some tribes have found success incorporating services within subsistence activities.

“The right person engaged in the right activity”

In order for services to be Medicaid-eligible and therefore billable, they need to be medically necessary, performed by a billable provider, and appropriately documented. Dan Aune, who as president of Aune Associates Consulting has worked with many tribal communities, elaborates, “The key feature is providing services to kids who have some kind of diagnosis. Medicaid wants there to be a medical necessity to the activity, so there has to be a diagnosis and a treatment course for it.”

Additionally, tribal system of care (SOC) communities who have accessed Medicaid for cultural services share one common trait: each carefully built a team approach to service delivery. For many, this team was comprised of a licensed therapist, a cultural expert, and someone familiar with the Medicaid billing process. Aune explains, “Medicaid, as a payer source, requires that you have the right person engaged in the right activity. Having the person who’s licensed doing the therapeutic piece is what makes it a billable event. Knowing this makes it easy to build the right people into a project to be able to bill Medicaid.”

Stacy Rasmus, Ph.D., an assistant research professor at the University of Alaska Fairbanks, did just that when working with an SOC community in Alaska. “We had a team,” she states. “There was an elder counselor, a behavioral health aide, and a family advocate that would collectively do wraparound with each client. The behavioral health aide was doing assessments, treatment planning, and service delivery [the Medicaid-billable components]. The family advocate was doing the case management and social work. The elder counselor was providing the traditional and spiritual healing. We would all work with the client and family to identify the needs of the child.”

“I can conduct psychotherapy sitting in a chair or sitting on the ice”

Tribes have also made innovative use of Medicaid’s flexibility. Rasmus says, “Reading the Medicaid regulations, it’s clear there’s flexibility regarding where healing, therapy, and therapeutic practices can take place.” Rasmus was able to have a clinic fish net set out on the ice. She and the behavioral health aide would conduct assessments on the walks to and from it with youth. “The fact is that I can conduct psychotherapy sitting in a chair or sitting on the ice,” she states. “Therapy is so context-dependent. You could very naturally run a psychotherapy session while going to check fishing nets or picking berries.”

Rasmus points out that conducting therapy outside of an office setting while employing hands-on activities is similar to other therapeutic techniques such as art therapy, which have long been accepted. She states, “Connecting mind-body together through a process of therapy is embedded within Western scientific validated modalities.”

For young Native men who were struggling through a community-wide suicide epidemic, this approach resonated. “Most of the time, they needed to connect more with the land and animals as part of putting together a stronger identity,” Rasmus explains. “In establishing an integrated approach, we were doing subsistent activities, but we also emphasized that it wasn’t just about catching a fish or setting a net or making a spear. We made these connections really explicit: how making a spear and catching a fish directly addresses the issues this young man is dealing with in his own life and heart.”

Aune indicates that these types of events are billable as long as the person who is licensed and the cultural expert work together. In his work with the Blackfeet equine therapy program, equine therapy-trained staffers worked together with a licensed therapist “who would meet with the group of kids at the beginning, middle, and end of a session so that a psychotherapeutic process was going on along with the cultural activities.”

(continued from page 3)

At Pascua Yaqui, incorporating cultural elements into behavioral health services extends beyond its equine therapy program. Dennis Noonan, project director of the Sewa Uusim program, elaborates, "Whenever possible, we do it in the mental health counseling, group counseling, and family therapy available through the clinical direct services."

"We don't know enough about it, and so we can't"

Using a team-based approach that taps the cultural expertise of a Native community and embeds traditional healing and subsistence and other cultural activities into children's mental health treatment plans aligns well with SOC values and a philosophy that encourages developing community-based, culturally appropriate wraparound systems. At the same time, one of the more pressing challenges in accessing Medicaid as a funding source for such activities is finding someone for the team who is well-versed in Medicaid billing and can ensure a program meets eligibility requirements and complies with other regulations.

Navigating Medicaid's billing system is complex due in very large part to the fact that each state operates Medicaid differently. According to Aune, creating Medicaid-billable cultural services entails "...programs building operational capacity so that someone who understands billing can oversee those activities." At Pascua Yaqui, Noonan says, "We work with the state system. We put staff in place here that understands the state Medicaid system."

Building capacity also extends to developing more members of a tribal workforce who are licensed and trained in Medicaid systems over time. In the short term, Noonan suggests, "If you don't have it within your tribal community, you have to get creative. Sometimes there are retired people who can help give you some ideas and expertise on how to move through the system."

Indeed, the complexity of Medicaid's billing system is not for the faint of heart. Often confusion regarding what is required to bill for traditional and cultural practices results in inaction.

"It takes a really special knowledge of both worlds, and that is hard to find," Rasmus explains. "You have hesitancy of tribal leadership, even those who are really knowledgeable of their own tribal-based healing approaches. Because they are less knowledgeable in state Medicaid regulations, they think they can't bill for tribal healing services. Then on the other side, you have behavioral health directors, who are often not Native. They are very competent and knowledgeable of the Medicaid billing system but come with a more limited knowledge about tribal healing modalities. They have no idea how to integrate the two. I think sometimes it comes down to fear on both sides. People think, 'We don't know enough about it, and so we can't.'"

"It's a huge win"

And yet, those who have embraced Medicaid as a payer source for cultural and traditional services overwhelmingly tout its potential to serve as a significant revenue stream for children's behavioral health programming. According to Aune, "Medicaid is a completely untapped source of funding. This is part of my excitement for working with tribes to get them to develop their own systems. They're going to get paid much better than at any state rate."

In Noonan's equine therapy program, "You do a lot of group work that can be structured to be group therapy. By billing Medicaid for group therapy, you can help offset some of the costs of individual therapy, which is also part of the program. Between this and leveraging tribal support, if we structure our program creatively, we can sustain our entire equine therapy program through billing. This is saying a lot. Equine therapy is much more expensive than other types of therapy."

Furthermore, with increased numbers of AI/ANs becoming Medicaid-eligible in 2014 [See "Will the Patient Protection and Affordable Care Act Improve the Health of Natives?"], Aune sees great potential to increase behavioral health revenue and services in tribal communities. He explains, "A lot of tribal communities depend on IHS services where there is one pot of money for behavioral health care in any given year. They almost always run out. If more eligible people get enrolled in Medicaid, IHS doesn't have to use that pot of money because Medicaid is the 'first payer,' and the IHS dollars are



Equine therapy programs have successfully billed Medicaid for their therapeutic services.

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Peers Become New Payer Source for Behavioral Health Services

Tribal system of care communities may be able to tap the expertise of peers to provide billable services in their behavioral health programs. Some tribal programs already rely on peers to provide the cultural and traditional activities and healing practices within behavioral health programs. For them, determining if these peer support specialists are eligible under state Medicaid requirements to become billable providers could result in increased revenue for their services.

With the caveat that every state has different regulations governing the eligibility of peer-to-peer services, more and more states are clarifying exactly who may be considered peer support specialists.

Dan Aune elaborates, "It is a payer source. The good thing about peer support is that there's a peer in every community. The identifying feature is that they have a 'lived experience.'" In many wraparound projects, peer support comes from parents whose children have been in foster care or involved with the juvenile justice or mental health systems. Parents with those experiences can serve as a peer to a parent who is currently going through similar experiences. Yet, the definition of peer may be widening, adding a great incentive for tribes to contact their state Medicaid offices to learn more.

Aune adds, "That whole movement is huge. Research shows that there are good outcomes when peers are involved."

(continued from page 4)

the 'second payer.'

Communities can think of starting tribally run community mental health centers. You just extended the whole health care system from a clinic- and crisis-based system with IHS, to a community-based, outreach model. And you've added a whole lot more health care dollars into the community with Medicaid. It's a huge win."

"Why aren't more Native tribes and corporations doing this?"

Creating such community-based outreach models is exactly what many SOC communities intend to do. In the Alaska program where Rasmus worked, "We wanted to give tribes the ability to effectively treat their own people. By establishing more culturally based modalities for intervention, we were trying to figure out a way to make [Western and non-Western] worldviews comes together, for care to be truly integrated. It truly is a system of care when services are integrated. I thought this approach was really innovative. You wonder, 'Why aren't more Native tribes and corporations doing this?'"

National Indian Child Welfare Association Training Institute August 20–21, 2013

NICWA's Medicaid Toolkit: A Tool for Building and Expanding upon Tribal Children's Mental Health Delivery Systems

This two-day institute unveils a new tool NICWA developed for tribal programs interested in accessing and increasing the use of Medicaid as a payer source for children's mental health services.

Topics covered by this training include a review of state and federal criteria, identification of viable payer sources, a strategic business planning process, infrastructure and operational billing and collection practices, and the role of culture.

Early-bird registration deadline is July 30, 2013.

For more information, visit www.nicwa.org/training/institutes or contact NICWA Event Manager Lauren Shapiro at (503) 222-4044 ext. 118 or Lauren@nicwa.org.

Will the Affordable Care Act Improve the Health of Natives?

by Dan Aune

President Obama signed the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, and included the Indian Health Care Improvement Reauthorization and Extension Act, that permanently reauthorizes the Indian Health Care Improvement Act. It strengthens and improves health care opportunities for 1.9 million American Indians/Alaska Natives (AI/ANs) across the country. Two elements of the ACA will likely have a substantial effect on access to health care for the AI/AN community:

1. Medicaid expansion will likely increase the number of AI/ANs enrolled in Medicaid, if aggressive outreach and enrollment practices are funded.
2. Health insurance exchanges will vary from state to state, and until federal regulations are issued and states pass enabling legislation, it is not clear the extent of the state health exchange authorities or requirements.

Medicaid expansion allows states to participate in the expansion of Medicaid eligibility rules. This essentially makes Medicaid an insurance product similar to Blue Cross Blue Shield, Aetna, or Kaiser Permanente. On January 1, 2014, any uninsured person of any income level who does not have a viable offer of insurance from their employer will be able to purchase health insurance from health insurance exchanges. If they are below 400% of poverty, they will be eligible for subsidies in the exchange or for Medicaid, Children's Health Insurance Program (CHIP), or a state basic health plan.

Native communities will not only have IHS, but will gain the value of significant numbers of families, children, and individuals becoming eligible for the



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Medicaid, CHIP, and other insurance products. The essential community benefit is that increased health care money will flow into the community and will grow the health care service choices.

Health insurance exchanges bring choice of insurance products to consumers and will act much like an "insurance store." Insurance companies will work directly with Native communities through "Healthcare Navigators" to explain the choices and assist with enrollment. Ideally, insurance companies will be sensitive to hire Native navigators, bringing both employment and cultural sensitivity to the process.

The ACA's simple aim is to "bring access to healthcare to all." Native communities with children's system of care (SOC) projects can benefit in the following ways:

- Be in a position to engage their families, youth, and children in the enrollment process that will provide a financial source to pay for services
- Develop and transition SOC projects into community mental health center provider programs

- Gain access to new healthcare revenue sources
- Collaborate with state Medicaid division staff or state-managed care organizations
- Increase the wellness of the community
- Initiate a broader continuum of mental health, substance abuse, and primary care services
- Develop a healthcare workforce

On a broader scale, the ACA will improve health care for Native Americans in myriad ways. It aims to improve recruitment and retention of health care providers by updating the scholarship program and exempting health care professionals employed by a tribally operated health program from state licensing requirements within the boundaries of the reservation, so long as the professional is licensed within the United States. Funds for use in construction or operation of Indian health facilities may transfer from federal or state agencies. Services such as cancer screening and long-term care will be expanded.

In behavioral health, the ACA will address new mental and behavioral health concerns, such as fetal alcohol spectrum disorders, child sexual abuse, and domestic violence. It also streamlines Substance Abuse and Mental Health Services Administration grants for Indian youth suicide prevention, authorizes tribal use of pre-doctoral psychology and psychiatry interns, and creates health demonstration projects for suicide prevention telemental projects and curricula.

More information can be accessed at www.healthcare.gov.

Dan Aune is president of Aune Associates Consulting (AAs). AAs has provided consultation in over nine tribal nations and 20 states. The AA's website is <http://auneconsulting.net/>.