



COMMENTS REGARDING SENATE FINANCE COMMITTEE REQUEST FOR INPUT ON HOW TO IMPROVE THE MENTAL HEALTH SYSTEM

SEPTEMBER 30, 2013

BACKGROUND

We begin by thanking the Committee for soliciting input on this important topic. Our comments will focus specifically on how to improve mental health services to American Indian and Alaska Native (AI/AN) children. Our 25 years of experience in helping tribal, state, and federal government agencies enhance program services for AI/AN children has reinforced for us the importance of extensive collaboration, culturally appropriate approaches, integrated service systems, and community-based services. These concepts are consistent with the literature in children's mental health that discusses how to effectively address mental illness, and with tribal governments' status as sovereign nations that have the authority and responsibility to ensure the provision of effective services for their citizens.

In order to understand the mental health needs of AI/AN children and how they can be effectively addressed it is important to understand the context within which AI/AN children, families, and communities exist. The expression of unresolved trauma, both historical and present day, is at the root of many of the behavioral health needs of AI/AN children. Historical trauma is the grief and loss that all AI/AN communities experience in reaction to federal policies that forcibly removed AI/AN children from their families and communities to military style boarding schools, separated AI/AN children from their families and tribal communities by relocating AI/AN families to urban areas, and facilitated the adoption of numbers of AI/AN children outside of their communities. The effect of these policies was to alienate and isolate AI/AN people from their culture and natural helping systems. Further, over several generations these policies have resulted in exposure to multiple and frequent traumatic events for AI/AN people without the benefit of resources, especially important cultural resources, to ensuring healing.

Today the results of this unresolved trauma are clearly visible in the high rates of social problems that plague many tribal families, such as higher than average rates of exposure to violence, suicide, alcohol and substance abuse, and poverty. AI/AN children are at 2.5 times greater risk of experiencing trauma than mainstream populations (BigFoot, 2007). These social problems are often the manifestations of trauma that have not been adequately addressed due to a lack of access to effective services today. Simple cause and effect explanations of trauma and approaches to address mental health needs have often proven ineffective in AI/AN communities.

What is working now are tribally developed and implemented approaches that utilize culturally-based methods for addressing trauma and the resulting mental health disorders. The system of care principles, utilized by a number of federal agencies, states, and tribes, are one example of how tribal programs have successfully developed programming and provided services to address the mental health needs of their

children. The system of care model strives to design integrated mental health service delivery systems with multiple entry points (e.g. schools, juvenile justice systems, community centers, and mental health facilities) that include effective communication among the different service providers so as to avoid duplication and inefficiencies, and ensure quality care for clients. A strong system of care does more than collect basic information and refer cases between providers. It creates a system where children and families are the center of the services and the efforts from different providers working closely together allow for services to flow in an integrated fashion from the needs of the client children and families. The system of care principles and model is consistent with tribal values. It represents some of the best thinking in service delivery providing a more culturally specific, more effective and more efficient mental health care system for AI/AN children.

At the heart of many of these systems is Indian Health Services (IHS), which has the primary role and responsibility for providing or contracting with tribal governments for healthcare services to AI/AN populations. IHS data collection shows that it operates on approximately half the estimated budget required to meet the needs expressed in the tribal communities it serves. This is problematic considering that more than 55% of AI/ANs rely on IHS for their healthcare needs (BigFoot, 2008). AI/ANs have fewer mental health professionals per capita available to them than other United States populations. According to a report of the U.S. Surgeon General, 101 AI/AN mental health professionals are available per 100,000 AI/ANs, as compared to 173 per 100,000 for Caucasians (Office of the Surgeon General, 2001). This disparity is more inflated when looking at the even more limited number of child-trained mental health professionals in Indian Country that have specific training to work with children and adolescents.

Questions for Comment

- **What administrative and legislative barriers prevent Medicare and Medicaid recipients from receiving the mental or behavioral health care they need?**
- **What are the key policies that have led to improved outcomes for beneficiaries in programs that have tried integrated models?**
- **How can Medicare and Medicaid be cost-effectively reformed to improve access and quality of care for people with mental and behavioral health needs?**

Medicaid is cited as the most important funding source that determines whether AI/AN health facilities offer needed services. In part because of high rates of poverty and unemployment, Native Americans are less likely than other Americans to have employer-sponsored or other types of private health insurance coverage. In addition, Native Americans are less likely to be enrolled in public health insurance programs like Medicare and Medicaid (Kaiser Commission on the Future of Medicaid, 1997). Some individual-level barriers to increased enrollment include lack of understanding of the benefit of utilizing Medicaid, geographic distances to Medicaid service providers, and cultural barriers, such as a non-traditional approach and clinic methodology in assessing and treating behavioral health issues.

1. **Direct Access to Medicaid and other federal behavioral health funding sources for tribal entities** - Unlike states, tribes remain ineligible to directly apply for and administer a number of federal programs that would support mental health prevention and intervention programs and services, such as Medicaid, Medicare and the Community Mental Health Services Block Grant. This leaves them without resources to support comprehensive behavioral health program development and ongoing service delivery. Their reliance upon state services is greater in these circumstances, and state services come with their own set of barriers, such as; geographic locations far from tribal communities; services not tailored to tribal behavioral health needs or proven methods for addressing those needs; lack of understanding by tribal members on how to

qualify and participate in these services; and variances and gaps amongst states in how they work with tribes to meet tribal behavioral health needs.

Since it is not a mandatory requirement some states, even with incentives, are not actively helping tribes develop Medicaid provider status under their state plans. Direct access allows tribal governments to design and implement eligible services in a manner that is most reflective of need in their communities, and provide culturally specific approaches to addressing these needs. It can also help drive further program integration, especially with children in foster care who are eligible for Title IV-E Foster Care and Adoption Assistance. Title IV-E only pays for the services that directly support a child's out-of-home placement. However, most of the children in foster care have multiple needs—counseling and medical—that are critical to their well-being, and further their families also could benefit from supportive services, which could assist the child in their rehabilitation. Having direct access and control over these two programs would give tribes the opportunity to create a robust system of care that covers the full range of needs that children and families have, and uses federal reimbursement to decrease entry into foster care by providing additional family supports, mental health services and medical outreach early on to avoid more intrusive and costly interventions later.

Another opportunity for tribes in a direct access scenario is the ability to work with managed care companies that specialize in managing Medicaid billing and other administrative functions (utilization reviews, eligibility determinations, etc.). Many states use these companies to help manage their Medicaid services and in places like New Mexico that have a large tribal population the state's managed care company has been able to produce significant savings that in a tribal setting could be used to support cultural services shown to produce significant gains in client health and well-being. Managed care companies with tribal assistance and guidance could help drive additional efficiencies in service provision that can help tribes reinvest in the full array of services that are needed to improve overall health and well-being, and reduce costs overall.

Direct access for tribes as a federal precedent is common with other federal programs that serve children and families such as Title IV-E Foster Care and Adoption Assistance, Child Support Enforcement, and Temporary Assistance to Needy Families Block Grant—success has been seen in all of these programs.

2. Encouraging additional state collaboration with tribal governments on Medicaid access—

AI/AN people can be served by a variety of AI/AN health providers, all of which depend upon access to Medicaid in order to offer needed services. These health providers include, Urban Indian Health Centers, IHS operated service units, and tribally contracted health providers (contracted from IHS). While these providers share access to discretionary funds under IHS these funds are not sufficient to develop the comprehensive behavioral health services that are needed to address the level of trauma present in most tribal communities. Medicaid becomes a key resource in this effort, but access is uneven for tribes between states, and several tribes have land and tribal members located in more than one state.

Some system-level barriers stem from challenges that tribes and tribal organizations face in negotiating with state Medicaid offices to become qualified Medicaid providers. Some states may not be aware of the benefits to or cost savings of working with a tribe or tribal organization to become a qualified Medicaid provider, and the higher Federal Medical Assistance Participation (FMAP) rate available when serving AI/AN people. In addition, tribal agencies that serve children in child welfare or mental health may not understand the process or have the tools to help them

become a Medicaid provider, such as onsite technical assistance. Consequently, such negotiations can prove very difficult.

The state of Montana has successfully addressed some of the barriers thereby increasing tribal utilization of Medicaid by recognizing the language stated in Federal Public Law 96-638 (federal tribal contracting law) which addresses Medicaid in Urban Indian Health Centers, Tribal Entities, and Indian Health Services (referred to as U,T and I). The Montana State Medicaid Plan states that, “ Indian Tribes are sovereign nations and a unique government-to-government relationship exists between the Indian Tribes and the State of Montana. The best interests of both is served by engaging in government-to-government relationships and respectfully recognizing the rights, duties and privileges of both Tribal and State citizenship. The State of Montana and Tribes within its borders have worked together in government-to-government relationships and engaged in agreements that benefit Indian and non-Indian residents and promote effective Tribal-State relations.” Montana Medicaid identifies “provider type 57” as the provider designation for all U,T,I services and billing. U,T,I pharmacies bill through the Point of Sale (POS) system to Medicaid. This language in the Montana Medicaid plan makes it clear that tribal entities, as well as urban and IHS, will be eligible to become Medicaid providers, provide eligible services, and bill as appropriate under the Montana State Medicaid plan.

Federal clarification to encourage and mandate states to work with tribal entities on obtaining Medicaid provider status would be helpful in bringing more consistency and equity to tribal access to Medicaid supported services. In addition, providing resources for technical assistance services for tribes and states in this area could be very beneficial, to ensure both entities have the necessary capacity and understanding of the requirements.

- 3. Allowing tribal Medicaid providers under a state plan to utilize federal Medicaid formularies**—Currently states identify what Medicaid billable services can be delivered (a service formulary along with a pharmacy formulary) which can often limit the services that a tribal Medicaid provider under a state plan can provide. Medicaid offers several choices regarding optional services and allows for variance in implementation even among mandatory services. However, what is best suited for a state general population may not work well for a tribal population. Allowing tribal Medicaid providers to select from the eligible federal Medicaid formulary, as opposed to only what the state provides their general population, can greatly improve responses and efficacy for tribal populations. In addition, because the Federal Medical Assistance Percentage (FMAP) for services to tribal citizens served through a state Medicaid plan provides full federal participation, state general funds would not be affected by tribal Medicaid selections.

Conclusion

Medicaid reaches only a small percentage of the eligible AI/AN people, but is one of the most critical funding sources supporting treatment for the mental and behavioral health needs of this population. Whether it is related to inability to directly administer the program, or not having opportunities to become a Medicaid provider under a state plan, access continues to be one of the most significant barriers to increasing participation in this federal program. A lack of access has stifled the development of more effective responses to the mental and behavioral health needs of AI/AN individuals. By providing direct access for tribes, incentivizing state collaboration with tribes to improve their capacity to become a Medicaid provider, and allowing tribal Medicaid providers to utilize federal Medicaid formularies under

their state plan would allow for mental and behavioral outcomes for tribal populations to improve and further cost savings to accrue.

For further information, please contact David Simmons, Government Affairs and Advocacy Director for the National Indian Child Welfare Association at desimmons@nicwa.org or call 503-222-4044, ext. 119.

Selected Sources

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