Report to the Legislature

Tribal Centric Behavioral Health

2SSB 5732, Section 7 Chapter 388 Laws of 2013

November 30, 2013

Health Care Authority
and
Department of Social and Health Services
Behavioral Health and Service Integration Administration
PO Box 45050
Olympia, WA 98504-5050
360-725-2261

Tribes of Washington State
Recognized American Indian Organizations
Health Care Authority
Washington State Department of Social & Health Services

TABLE OF CONTENTS

Executive Summary

Context

In September 2009, during the Washington State Tribal Mental Health Conference, the vision of a Tribal Centric Mental Health System began. During this meeting Assistant Secretary Doug Porter acknowledged what the Tribes of Washington had known and experienced since the inception of the Regional Support Networks—a Managed Care system without a requirement to acknowledge and constructively work with Tribal Governments cannot adequately respond to, and appropriately serve, American Indians and/or Alaskan Natives (AI/AN). Since that meeting, through the formation of a Tribal Centric Workgroup, the Tribes and the Department of Social and Health Services (DSHS) have strived to address these matters. Over the years the work has grown to move from solely a mental health focus to an integrated behavioral health model which encompasses both mental health and chemical dependency treatment. The membership of the Tribal Centric Workgroup includes DSHS staff, Health Care Authority (HCA) staff, and Tribal representatives appointed through the American Indian Health Commission (AIHC) and the DSHS Indian Policy Advisory Committee (IPAC).

Recent data analysis indicates that while 19 percent of American Indian/Alaskan Native Medicaid eligibles live on Tribal land, 81percent reside outside of a reservation, with a majority of that population living either along the I-5 corridor or in the greater Spokane area. Accordingly, with this geographic distribution across the state, the RSNs are the primary source of outpatient mental health services for AI/AN Medicaid enrollees.

Based on SFY 2011 data, an estimated 15,331 (19.8 percent) of the 77,140 AI/AN Medicaid enrollees received mental health services through the RSNs. Tribal mental health programs provided services to 3,458 (23 percent) of all Medicaid AI/AN who received mental health services during the same period. Of this number, 831 (5 percent) individuals received services from both Tribal and RSN provider programs. Of those who received mental health services, 11,042 (72 percent) AI/AN received mental health services only through the RSN system.[1]

Tribal Centric Workgroup Recommendations

Over the last eighteen months of bi-monthly meetings the Tribal Centric Behavioral Health Workgroup has identified issues, reviewed problems and explored multiple solutions to problems. The Workgroup addressed not only those issues surfaced at the 2009 meeting, but also emerging concerns regarding the provision of mental health services and the interface

[1] Please note that these figures only reflect Medicaid encounters. The Department does not track Veterans Administration services, Medicare only services, private insurance services, IHS services, or services funded directly by Tribes.

between tribal providers, Tribes, individual American Indians and Alaskan Natives, and the RSN system.

The Workgroup identified the defining characteristics that should exemplify a Tribal Centric Behavioral Health System. Those characteristics should demonstrate:

- The value and importance of individual choice.
- The value and importance of AI/AN individuals having access to Tribal and urban Indian programs providing behavioral health services.
- Mandatory changes to RSNs and how they relate with the Tribes and AI/AN individuals.
- Required cultural competency training for RSN and state hospital staff working with the AI/AN population.
- Coordinated and centralized communications between DSHS and HCA in policy development and designing, and modifying billing and reporting procedures.
- Conducting a feasibility study for structuring one or more residential programs. The study should determine what type of facility would best serve AI/AN population (freestanding evaluation and treatment (E&T), crisis triage, dual diagnosis beds, or a combination of all three).

The Workgroup membership strongly voiced that individual choice should be a guiding value of any future system. Workgroup members also emphasized that the future system should also allow AI/AN individuals to continue to have direct access to Tribal and urban Indian behavioral health programs. Those AI/AN individuals who have chosen to receive services through the existing RSN system, or its successor, should be able to continue to receive those services if they so choose. They should be able to do this without disruption and without having to be subjected to an opt-in or opt-out process so that they can continue receiving care.

The Workgroup stipulated that to adequately and appropriately serve the AI/AN population, especially those Tribal members living on reservations, the RSNs must make serious and significant changes in the way they interact with Tribes and Tribal members. The Department should aggressively monitor and verify that RSNs are following the recommended changes to insure that meaningful change actually occurs. The Department should implement corrective actions and penalties for those RSNs who do not insure that AI/AN consumers are afforded the same access, rights and benefits available to all other Medicaid eligibles within the RSN. Additionally, RSNs must comport themselves with Tribes in a manner honoring their government-to-government relationship.

Background

Washington has an estimated 193,000 AI/AN people residing in the State (see Table 1). The AI/AN population is approximately 2.9 percent of the total state population and 3.9percent of the total 4.9 million AI/AN populations in the United States. Washington has the sixth largest AI/AN population in the county, with California (662,000 AI/N population) having the largest population, followed by Oklahoma (482,000) and Arizona (334,000).

Table 1
Washington AI/AN Health Insurance Status

	Total		Uninsured		
	Number	% Total	Number	% Total	% Uninsured
Under 138%	67,836	35.2%	20,743	48.2%	30.6%
138% - 400%	77,350	40.1%	17,379	40.4%	22.5%
Over 400%	47,989	24.6%	4,877	11.4%	10.2%
Total	193,175	100.0%	43,000	100.0%	22.3%

Source: Fox-Boerner 33 State Database for American Indians and Alaska Natives, Alone and in Combination. American Community Survey. 2008-2010 pooled data.

A significant proportion of Washington's AI/AN population resides in urban areas. Forty-one percent (78,600 ACS estimate) of Washington's AI/AN population reside in the Seattle-Tacoma-Bellevue Metropolitan Statistical Area (MSA) and six percent (12,400 ACS estimate) reside in the Spokane MSA.

Recent data indicates that approximately 43,000 (22 percent) of the AI/AN people in Washington were uninsured and 55,500 (29 percent) had Medicaid coverage. Washington's 2010-2011 overall uninsured rate for nonelderly was 16.2 percent.[2] In comparison to 33 other states with reservations, Washington had the eleventh lowest uninsured rate and the twelfth highest Medicaid rate among the 33 States.[3]

The Affordable Care Act's (ACA) Medicaid expansion and Exchange tax credit subsidies can provide health coverage for a significant number of AI/AN people living in Washington. A recent GOA report estimated that over 31,000 AI/AN in Washington will be eligible for the 2014 Medicaid expansion, and over 50,000 will be eligible for tax credit subsidizes available through the Washington Health Benefit Exchange.[4]

---

[2] Source: "The Uninsured A Primer", Kaiser Commission on Medicaid and the Uninsured (October 2012).

[3] Source: American Community Survey. Report prepared by Fox-Boemer and the California Rural Health Board funded by the Centers for Medicare and Medicaid Services. The population estimates are based on 2008-10 pooled data.

[4] Source: GAO Report – 13-553. "Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment", (September 2013).

Washington Tribes

There are 29 federally recognized Tribes in Washington. The Tribal reservations are clustered in the western portion of the State, with three reservations on the eastside (see Exhibit 1). Those eastside reservations are, however, the first, second and fourth geographically largest reservations. These Tribes are also the Tribes with an Indian Health Services presence.

While Tribal membership is not public information, Washington's Tribes reported providing health care to 66,000 AI/AN people in 2012 (see Exhibit 2). The Yakima Indian Nation had the largest user population (12,800) and the Hoh Tribe had the smallest (26). The average user population across the 29 Tribes was 2,280, with four of the Tribes accounted for 50 percent of the total user population.

American Indian/Alaskan Native Service Delivery System

As required under Federal trust responsibilities, treaty rights and federal law, the federal government has a responsibility for providing health care for tribal members and other AI/AN people. The Johnson O'Malley Act of 1934 affirmed the federal government's financial responsibility for Indian health services. It authorized the Secretary of the Department of Interior to contract with state and local governments and private organizations to provide educational, medical, and other assistance to American Indian people who no longer lived on the reservation. The Indian Health Services (IHS) was created in 1955 as an agency in the Department of Health & Human Services (HHS).

The Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638, ISDEAA) changed the Indian health care delivery system forever by allowing Tribes the authority to assume the responsibility for administering their own health programs. In order to do so, Tribes entered into contracts with the federal government to operate health programs that were provided by IHS. The Act also made grant funds available to Tribes for planning, developing, and operating health programs. Subsequent federal legislation further expanded the concepts of P.L. 93-638 by authorizing Tribes to enter into self-governance compacts negotiated with IHS to assume responsibility for service delivery and resource management.

Washington's Tribes are national leaders in self-governance. Twenty-eight of the Tribes have 638 operated programs, two Tribes have both 638 and IHS operated programs and one Tribe is only IHS operated (see Exhibit 3).

Indian Health Services

Indian Health Services is the primary source of funding for tribal and urban Indian

health programs. It provides federal appropriations that are used to provide direct medical and specialty care services to eligible AI/AN people. In addition to ambulatory primary care services, dental care, mental health care, eye care, substance abuse treatment programs and traditional healing practices are financed through direct service funding.

The IHS Contract Health Service (CHS) program provides funding for services that are not directly provided by the Tribal programs. The CHS program provides funds that are used to purchase inpatient and specialty care services from private health care providers where no IHS or Tribal direct care facility exists. CHS is not an entitlement program and an IHS referral does not imply that the cost of care will be paid. If IHS or a Tribe is requested to pay, then a patient must meet residency requirements, notification requirements, medical priority, and use of alternate resources.

Nationally, an estimated 75 percent of Tribal CHS programs are funded at 45 percent of forecasted need.[5] Because of this severe under funding, IHS has special rules dealing with its eligibility and provider payments.[6]

The Pacific Northwest does not have an IHS hospital or specialist services. Tribes must purchase all inpatient care and the vast majority of specialty care from private health care providers using CHS dollars. Many Washington Tribes have operated under Priority 1 for many years, meaning CHS funds are so limited, they can only be used to purchase health care that will save life or limb.

Medicaid

Washington's Medicaid program currently covers 1.2 million people, about 15 percent of all Washington residents and nearly one-half of all children. While there is not a full accounting of AI/AN enrollment in Medicaid due to self-reporting and under-reporting, an estimated 40,000 AI/AN people are enrolled in the program.

Medicaid is the second largest source of coverage for AI/AN people and, excluding IHS funding, it is the largest public health insurance program for Indian people. While published data is not available, a 2005 GAO study and available Tribal participation data reported that Medicaid payments were the largest non-IHS source for Washington's Tribal health

---

[5] Source: Indian Health Services' December 30, 2010, Dear Tribal Letter.

[6] The IHS CHS medical priority of care is determined as levels, I, II, III, IV, and V. The funding and volume of need by the population have required that most Area can only be provided through CHS authorization the highest priority medical services - Level I. These medical services are generally only emergency care service, i.e., those necessary to prevent the immediate threat to life, limb, or senses. The IHS Medical Priorities Levels are: I. Emergent or Acutely Urgent Care Services; II. Preventive Care Services; III. Primary and Secondary Care Services; IV. Chronic Tertiary Care Services; and V. Excluded Services.

programs, and that Medicare was another federal funding source.[7] In their 2005 study, the GAO visited 13 Tribal facilities. While the amount of reimbursements that facilities obtained varied, Medicaid revenue accounted for about one-quarter (range from two percent to 49 percent) of budgeted direct service revenue for health clinics.

Washington's Tribes have aggressively sought third party payment strategies. All but one of the Tribes have contracted with the state Medicaid agency to be providers in order to access Medicaid financing to help provide health services to tribal members (see Exhibit 3). Twenty-six of the Tribes have Medicaid contracted medical program, 27 Tribes have mental health programs and 26 Tribes have chemical dependency programs. Twenty-four Tribes have both medical and mental health programs, and 26 Tribes have both mental health and chemical dependency programs.

In state fiscal year (SFY) 2011, Tribal programs provided care to approximately 30,600 Medicaid enrollees. Of this total, 20,400 (67 percent) were AI/AN enrollees and 10,200 (33 percent) were non-natives (see Exhibit 4). The Tribes received $52.2 million for Medicaid health care services—$40.9 million (78 percent) for AI/AN enrollees and $11.2 million (22 percent) for non-natives. Medical services accounted for $17.7 million (34 percent), mental health services were $13.5 million (25 percent) and chemical dependency services were $12.1 (23 percent).

Medicaid AI/AN Mental Health System

Washington's current Medicaid mental health service system is complex (see Exhibit 5). There are two sets of mental health benefits and three different ways that these services are provided. The services are administered by two different state agencies—the Department of Social and Health Services and the Health Care Authority. For AI/AN people, the system is further complicated because AI/AN individuals and their family members can receive Medicaid funded outpatient mental health services directly from their IHS or 638 contract/compact Tribal programs, as well as through the RSN system and/or the Healthy Options program if they have elected to enroll in managed care.

Mental Health Service Benefits

The Medicaid program has two sets of outpatient mental health services for AI/A and non-native people enrolled in Medicaid. Currently, under what is referred to as *medical mental health services*, adult Medicaid enrollees may have access to a limited mental health benefit. Adults have access to 12 mental health therapy visits per year plus medication management—the therapy services must be provided by a psychiatrist. Child Medicaid enrollees currently may have access to outpatient services from a psychiatrist or other

[7] Source: GAO Report 05-789, "*Indian Health Services: Health Care Services Are Not Always Available to Native Americans*" (August 2005).

licensed mental health professional specializing in serving children. Unlike adults, children are eligible for up to 20 visits per year, including medication management. Adult and children's management of mental health drugs by physicians and ARNPs does not have limitations. The *medical mental health services* are administered by HCA. Beginning January 2014, Medicaid will adopt ACA parity provisions that eliminate visit limits for adults and children and expand the types of mental health providers who can provide adult mental health services.

Under what is referred to as the *rehabilitative mental health services*, Medicaid enrollees have access to 19 different "treatment or service modalities" (see Exhibit 5). Importantly, these services include crisis services. Unlike the *medical mental health benefit*, these services do not have specific limits on the number of visits. Services may be provided as long as the client presents with medical necessity for care. However, persons can only get these services if they meet *Access to Care Standards* and have a covered mental health diagnosis.[8] These services are administered by DSHS through the RSNs.

Mental Health Service Delivery

Most Medicaid enrollees are required to be enrolled in, and receive their medical care, through managed care contracted health plans (Healthy Options Program). The managed care plans are also responsible for providing limited outpatient medical mental health outpatient visits and medication through the Healthy Options plan. AI/AN Medicaid enrollees are not required to enroll in a managed care plan to receive their health care. They can go directly to their IHS/638 Tribal programs, urban Indian health programs or to any other health provider with a Medicaid contract. This includes *medical mental health services*.

While AI/AN people can get mental health services through the two urban Indian health programs, the current Medicaid program restricts the services that the urban programs can provide. In the existing system, the urban programs must contract with their local RSN to be able to provide the rehabilitative mental health services. Otherwise, they can only provide the more limited *medical mental health services*. Tribal programs can provide rehabilitative mental health services to AI/AN people and their non-native family members without having to contract with an RSN.

Medicaid enrollees must obtain *rehabilitative mental health services* through their local RSN, which is a local government managed care program. RSNs operate as Pre-Paid Inpatient Health Plans (PIHPs) and provide outpatient services to reduce the need for inpatient care. AI/AN Medicaid enrollees can also go to their IHS/638 Tribal programs to obtain outpatient mental health services. They do not have to meet the RSN *Access to Care Standards* to receive the services at IHS/638 facilities. Currently, AI/AN Medicaid enrollees can only access

[8] *Rehabilitative mental health services* provided by IHS and 638 contract/compact facilities are not subject to rehabilitative *Access to Care Standards*. Instead, they must meet the general medical necessity standard, which is less rigorous standard of acuity allowing for more persons to have access to this level of care.

inpatient psychiatric services through their RSN. This is also true for all other Medicaid enrollees in Washington.

RSNs are responsible for the inpatient mental health service costs for all Medicaid enrolled consumers living within the RSN. This includes Medicaid enrollees participating in other managed care plans, RSN enrollees and AI/AN individuals covered by Medicaid.

Unless they have contracted with Tribal or urban Indian health programs, the RSN system typically does not have culturally appropriate services for AI/AN people. In part this is due to a limited number of Indian mental health professionals, who most often work for Tribal or urban Indian programs.

American Indian/Alaskan Native Health & Mental Health Disparities [9]

While Washington's Tribes have achieved improvements in health status, AI/AN people continue to experience disproportionate health disparities in comparison to the states' general population.

The life expectancy of an AI/AN individual is lower than any other population in Washington.[10] In the *Washington State Vital Statistics Report of 2008*[11], mortality data was assessed over a five-year period from 2000 –2006, using ten (10) leading causes of death. The outcomes were disheartening for AI/AN people: (a) AI/AN males and females had the lowest life expectancy of any other population in Washington (71 and 75 years of age, respectively); (b) AI/AN age-adjusted mortality rates (1,187.5 per 100,000) exceeded all other groups, and was significantly higher than whites ((897.6 per 100,000); and, (c) From 1990–2006, there were significant decreases in age-adjusted mortality rates for Whites, Blacks, and Asian/Pacific Islanders, yet no significant downward trend was seen in AI/AN male rates, and AI/AN females experienced a 1.3 percent increase per year in mortality rates.

The leading causes of death for AI/AN include: (a) heart disease; (b) cerebrovascular disease; (c) unintentional injuries; (d) cancer; (e) diabetes mellitus; and, (f) chronic liver disease and cirrhosis. AI/AN people are much more likely (nearly twice) to die in middle age (25-65) than the general population. Conversely, only 45 percent of AI/AN people die after 65 compared to 74 percent of the general population.[12] Suicide is also much more common among AI/AN people than the general population.

---

[9] Source: Mental illness diagnosis and chemical dependence need is from DSHS Integrated Client Database data by the DSHS Research and Data Analysis Division.

[10] Source: American Indian Health Commission's *Tribal Analysis for Washington State Health Benefits Exchange & Health Care Authority*, report (April 1, 2012).

[11] Washington State Department of Health, Center for Health Statistics. Vital Statistics 2006 Report. November 2008.

[12] Chronic Disease Profile, Washington State Department of Health, December 2011, p. 7.

Medicaid enrolled AI/AN individuals have a significantly higher incidence of mental illness diagnoses than Medicaid non-natives. Across all ages, AI/AN (35 percent) enrollees have a 67 percent higher incidence of mental illness diagnoses than non-natives (21 percent) enrollees (see Table 2 and Exhibit 5). This is reflected in mental health prescription drug utilization, with AI/AN enrollees (31 percent) having 47 percent higher usage than non-natives (21 percent).

AI/AN Medicaid enrollees have a higher incidence of diagnosed mental illness across all age groups, including children, adults and persons 65 and older (see Table 2 and Exhibit 6).

Diagnoses of mental illness for AI/AN children (24 percent) was 125 percent higher than for non-native children (11 percent). AI/AN children (15 percent) also have an 84 percent higher usage of being prescribed psychotropic medications than non-native children (8 percent).

AI/AN Medicaid enrollees have a significant higher need for chemical dependency treatment services than non-natives. Across all ages, AI/AN (19 percent) have a 155 percent higher incidence of diagnosed chemical dependency than non-natives (8 percent). (Please see Table 2 and Exhibit 6.) Medicaid eligible AI/AN children and seniors have over twice the need than non-natives.

Table 2

SFY 2011 Statewide

Indicators (SFY 2010 - 2011)	Total All Ages			
	AI/AN		Non-Natives	
	Total	Percent	Total	Percent
Any MI diagnoses	27,339	35.4%	258,643	21.2%
Psychotic	3,712	4.8%	36,305	3.0%
Mania & Bipolar	7,666	9.9%	75,619	6.2%
Depression	14,864	19.3%	142,437	11.7%
Anxiety Disorder	15,156	19.6%	124,840	10.2%
ADHD	3,512	4.6%	29,176	2.4%
Adjustment disorder	3,792	4.9%	23,326	1.9%
Any Psychotropic Rx	23,716	30.7%	254,928	20.9%
Any MI Dx or Psychotropic Rx	33,155	43.0%	339,531	27.8%
Alcohol/drug Treatment Need	15,003	19.4%	93,079	7.6%
Co-occurring MI and AOD Tx Need	10,741	13.9%	65,867	5.4%
Population:	**77,140**		**1,220,945**	

Mental Health Treatment Utilization [13]

Given that Medicaid AI/AN enrollees have a higher incidence of being diagnosed with mental illness than non-natives, it is consistent to find that AI/AN enrollees also have a higher utilization of mental health services. In SFY 2011, Medicaid AI/AN utilization of RSN services was 333.4 units/1000 member-months (MM) compared to 194.7 units/1000 MM for non-natives —71 percent greater utilization (see Table 3 and Exhibit 7). Inpatient psychiatric hospital admissions for AI/AN were 66 percent greater than non-natives—41.9 admissions/1000 MM for AI/AN compared to 25.3 admissions/1000 MM for non-natives. Prescriptions for psychotropic medication was also 52 percent greater—244.3 prescriptions/1000 MM for AI/AN clients compared to 160.4 prescriptions/1000 MM for non-natives.

Medicaid eligible AI/AN children (age 0-20) had a 130 percent greater utilization of RSN services than non-native children (206.4 services/1000 MM as opposed to 89.8 services/1000 MM). (See Exhibit 7) They had a 106 percent greater incidence of being prescribed psychotropic medications as well—94.7 prescriptions/1000 MM compared to 45.9 prescriptions/1000 MM for non-natives. AI/AN children also had a 165 percent greater psychiatric hospital admission rate than non-natives—13.3 per 1000 MM compared to 5.0 per 1000 MM for non-natives.

AI/AN adults (age 21-64) have a 21 percent greater utilization of RSN services than non-natives—561.2 services/1000 MM for AN/AN compared to 465.6 services/1000 MM for non-natives (see Exhibit 7). AI/AN adult prescription drug utilization was 15 percent greater than for non-natives, and inpatient hospitals services utilization was 23 percent greater.

Senior (age 65 and older) Medicaid AI/AN enrollees used slightly less RSN services than non-natives, while having a 17 percent higher mental health prescription drug and a 95 percent higher inpatient hospitalization rate (see Exhibit 7).

[13] Source: Analysis of DSHS Integrated Client Database data by the DSHS Research and Data Analysis Division

Table 3

SFY 2011 MEDICAID MENTAL HEALTH SERVICE UTILIZATION

Service Category	Total All Ages			
	AI/AN		Non-Natives	
	Total Served	Units Per 1000 MM	Total Served	Units Per 1000 MM
Any DBHR-MH Service	12,009		104,461	
Any RSN Outpatient Service	11,873	333.4	103,343	194.7
Psychiatric Inpatient	894	41.9	7,613	25.3
Any HCA-paid MH Service	19,801	507.4	218,995	335.5
Tribal MH Encounters	3,458	63.4	5,195	4.6
Medical Benefit OP Visits	2,569	18.8	29,770	14.6
Any Psychotropic Rx	19,083	244.3	208,916	160.4
Any DBHR-MH or HCA-paid MH Service	24,128		256,298	
Total Population Size	77,140		1,220,945	
Total Member Months (Medicaid only)	774,351		12,099,136	
Total Member Months (Medicaid + SMH)	774,659		12,102,529	

As described above, Medicaid AI/AN enrollees had a higher utilization of RSN services than non-natives—15.4 percent of Medicaid AI/AN enrollees used RSN services compared to 8.5 percent of non-natives. This could have been attributed to the population group only using crisis services. However, this was not the case. Only 495 (4.2 percent) of the 11,873 AI/AN who used RSN services received only crisis services; 1,991 (16.8 percent) services both crisis services and other RSN services; and, 9,387 (79.1 percent) of the total AI/AN user group received outpatient services other than crisis services (see Table 4).

Table 4

SFY 2011 AI/AN RSN USER POPULATION

Service Category	Total All Ages			
	Total Served	% of Total Pop.	% of Total RSN User Pop.	Units Per 1000 MM
Any RSN Outpatient Service	11,873	15.4%	100.0%	333.37
Used Crisis Services alone without other outpatient	495	0.6%	4.2%	0.90
Used other outpatient services without Crisis services	9,387	12.2%	79.1%	229.64
Used both Crisis and other outpatient services	1,991	2.6%	16.8%	102.82
Total Population Size	77,140			
Total Member Months (Medicaid only)	774,351			
Total Member Months (Medicaid + IMD SMH months)	774,659			

Prior geo-network analysis indicates most Medicaid AI/AN enrollees do not live on the reservations. However, they do reside in the Tribes' IHS Contract Health Services District Areas (CHSDA). Given this geographic diversity, it is important to know where they receive mental health services in order to know where to focus system improvements. Based on SFY 2011 utilization, 76 percent of Medicaid AI/AN enrollees received their outpatient services through the local RSN, while 6 percent received outpatient services through both Tribal programs and RSN services, and 18 percent received care only at Tribal programs (see Table 5). This suggests that improving RSN access to care and requiring the RSNs to provide culturally appropriate services is critical. This is even more the case because the RSN system is currently responsible for providing crisis and inpatient psychiatric care.

Table 5

SFY 2011 Medicaid AI/AN, Statewide, All Ages

(Unduplicated Count)

	Number	% Received MH Service	% Total AI/AN Pop
AI/AN Who Only Received RSN Outpatient Services	11,042	76.2%	14.3%
AI/AN Who Only Received Tribal Program MH Outpatient Services	2,627	18.1%	3.4%
AI/AN Who Received Tribal & RSN Outpatient Services	831	5.7%	1.1%
AI/AN Who Received Any Outpatient MH Service	14,500	100.0%	18.8%
Total AI/AN Medicaid Clients	77,140		100.0%

NOTE: MH outpatient services do not include mental health drugs or medication management.

NOTE: Any MH outpatiet service includes services provided by a Tribal program, RSN, Medicaid FFS or Health Options program.

Tribal Centric Workgroup History

The Tribal Centric Behavioral Health Workgroup has met twice monthly since August 2012. Prior to that, meetings were held monthly and bi-monthly, beginning in 2009. During these meetings Workgroup members identified mental health delivery system strengths and deficits and developed strategies for problem resolution.

System Strengths

One of the major system strengths cited by the Workgroup is the State's implementation of mental health services through the IHS encounter rate. Workgroup members emphasized Washington's institution of the *Clinical Family* designation as a significant system asset.

This designation allows non-Native members of AI/AN families to receive mental health services from Tribal providers at the IHS encounter rate. The designation helps address those situations in which successful treatment of a AI/AN client may need to include treatment of non-Native family members.

Workgroup members also emphasized as a system strength, that, for the IHS mental health encounter rate, there is no limitation on the frequency, intensity and duration of services as long as medical necessity is present. Additionally, they cited that Tribes have the flexibility in how they serve their clients, and are able to develop programs so that they can meet the enrollee where they are; mentally, physically, emotionally and spiritually.

Workgroup members also stated that they wanted this report to call-out and identify as a strength the longstanding strong working relationship with the Tribes and the DSHS Division of Behavioral Health for chemical dependency services.

System Deficits

A review of past and current concerns and complaints about the mental health system demonstrated that the problems typically revolve around RSN services and access to those services—primarily crisis services, involuntary treatment services and voluntary hospitalization.

In response to these and other concerns DSHS undertook the following changes:

- DSHS (OIP and DBHR) worked with Tribes and AIHC in the development of a Tribal Attestation process for mental health programs. This became essential to address because both the Memorandum of Agreement between IHS and the Healthcare Financing Administration (currently known as the Center for Medicare and Medicaid Services) and federal statute stipulates that while states may not require tribal provider programs to be licensed through the state, those programs must meet applicable state law for providing Medicaid services.
- DBHR established Tribal Liaison access with its toll-free line so that Tribes could easily access the Liaison to request intervention in access issues related to RSN services, focusing on crisis access, hospitalization and involuntary treatment act services.
- DSHS and HCA responded to billing and Medicaid concerns from Tribal Mental Health programs by conducting multiple trainings on billing mental health services, Medicaid rules, state plan services and documenting medical necessity.

Planning Process

During the months of July and August 2013, the Tribal Centric Workgroup membership identified a group of consistently attending Workgroup members who had expertise in Tribal behavioral health and the public mental health service delivery system. On August 20, 2013 a full day planning meeting was held. During this highly structured meeting, participants wrote an outline for this report and identified the Workgroup recommendations and strategies for change. A follow-up meeting was held on August 21 with available group members. The report was then drafted and distributed to the planning group members for feedback. Edits were incorporated into the report and a fuller draft was distributed to the entire Tribal Centric Workgroup for feedback. After the brief feedback period the draft document was disseminated to the Office of Indian Policy's Tribal leadership and behavioral health distribution list for feedback and comment. That draft was discussed at the first Roundtable.

DSHS conducted a second Roundtable and again incorporated the comments and feedback into the report. A third draft was distributed to the Tribes for the October 12 Consultation. A final Tribal feedback review session was held at the November 5 Tribal Centric Behavioral Health meeting. This report includes comments and guidance that were voiced during the Consultation Meeting and subsequent Tribal Centric Workgroup meeting, as well as any feedback and document revisions received through November 7, 2013.

Implementation

There are multiple unknown and unknowable factors confounding the Tribal Centric Behavioral Health planning process. The major unknown is the communication received from the Center for Medicare and Medicaid Services (CMS) regarding concerns as to the way in which Washington State procures Medicaid managed care mental health services through its 1915 (b) waiver. An additional significant unknown is the impact of the implementation of the Affordable Care Act January 1, 2014. The ACA brings two huge variables into play: the Medicaid expansion and the implementation of parity. Finally there are the pending recommendations of the State Health Care Innovation Plan (SHCIP) which is investigating improving Washington's health outcomes by better integrating physical and behavioral health care.

These unknowns present the Workgroup with an opportunity to weigh in with those tasks and to ensure that as the responses to CMS and the SHCIP grant are developed, providing appropriate services to AI/AN Medicaid consumers as well as interfacing effectively with Tribes and Tribal programs is an integral feature to the proposed systems as opposed to an afterthought.

HCA staff from the SHCIP grant team have been especially engaging in assuring that the Tribal Centric Planning Process and the SHCIP will inform one another in affording the

Tribes and the state the opportunity to leverage the strengths of both activities in developing a comprehensive system.

Tribal Centric Behavioral Health Workgroup Recommendations

The Workgroup identified multiple major milestones to measure progress in the implementation of Tribal Centric Behavioral Health. These high-level milestones are as follows:

> Establish an ongoing Workgroup for clear communication with Tribes, Tribal Provider Agencies, HCA and DSHS as regards billing, encounter reporting, service documentation and compliance with Medicaid rules. Anticipated start date for Workgroup: January 21, 2014.
>
> Establish a standing committee to meet with the DSHS, including representatives from the Behavioral Health Service Integration Administration (BHSIA), the Indian Policy Advisory Committee (IPAC) and the American Indian Health Commission (AIHC) and selected representatives from RSNs to review and revise RSN contract terms to ensure equitable and consistent access to all levels of mental health treatment and RSN network comportment to the values of Tribal Centric Behavioral Health. Anticipated start date: January 15, 2014.
>
> Require that all RSNs who have Tribal land within their catchment area have at least one Tribal representative on the RSN's governing board with full voting rights. Anticipated implementation date: July 1, 2014.
>
> Establish a team, which will include BHSIA staff, and representatives from IPAC and AIHC to review RSN compliance with new contract terms and recommend corrective action to the Department as needed. Anticipated implementation date: March 1, 2014.
>
> Develop a mechanism to coordinate planning activities between the Tribal Centric Behavioral Health Workgroup and the SHCIP Team, HCA staff and BHSIA staff. Implementation: Immediate and ongoing.

As illustrated in the Background Section of this report, the RSN managed care system is the primary source of outpatient mental health services for AI/AN enrollees and currently is the only source of inpatient services for all Medicaid enrollees. There is currently no viable, economically feasible, statewide alternate existing service system for AI/AN people. In this context, the Tribal Centric Behavioral Health System Workgroup recommends that the project work to leverage and improve the RSNs, or their successor's, ability to provide equitable and timely access to culturally appropriate mental health services for AI/AN Medicaid enrollees.

The Tribal Centric Behavioral Health System Project's Workgroup identified the following additional strategies to improve the working of the RSN system with Washington's AI/AN population. These strategies include:

- Require RSNs to have Tribal Liaisons who are trained by the Tribe, Indian Policy Advisory Committee or the American Indian Health Commission. The Tribal Liaison function would be an additional duty assigned to an already existing RSN staff.
- Review and revise the RSN *Access to Care Standards* list of covered diagnoses to insure coverage for historical trauma and its resultant disorders, in all their complexity for AI/AN people.
- Require RSNs to provide timely and equitable access to crisis services. This would include requiring RSNs to contract with Tribal and urban Indian mental health programs that are willing and able to provide crisis services.
- Require RSNs to develop protocols, in conjunction with each Tribe in their catchment area, for accessing tribal land to provide crisis and Involuntary Treatment Act (ITA) services. These protocols would include coordinating the outreach and debriefing the crisis/ITA review outcome with the tribal mental health provider within twenty four hours.
- Require DSHS to assist tribal programs to train and have Designed Mental Health Professionals (DMHP) who can detain AI/AN for involuntary (ITA) commitments.[14]
- Require RSNs to contract with Tribal DMHPs, when a Tribal provider is willing and able, or if a Tribal practitioner can be recruited, to serve AI/AN people.[15]
- Obtain necessary statutory and/or regulatory changes that will allow Tribal Courts to make ITA commitments for Tribal members of other AI/AN on Tribal lands.
- Require RSN contracted and DBHR credentialed licensed psychiatric care hospitals and Evaluation & Treatment (E&T) facilities to notify and coordinate AI/AN discharge planning with the Tribes and urban Indian health programs.
- Require state psychiatric hospitals to notify and coordinate discharge planning with Tribes and urban Indian health programs.
- As part of 2SSB 5732, Tribal representatives will participate in developing culturally appropriate evidence-based and promising AI/AN practice treatments that RSNs will be required to provide.
- Obtain state funding to conduct a feasibility study for one or more E&T/crisis triage facilities to service AI/AN people needing inpatient psychiatric care.
- Require that all RSNs and their provider networks that provide services to AI/AN consumers meet minimal cultural competency standards to be established through a joint AIHC/OIP/Washington Behavioral Health Council and Departmental Workgroup.

---

[14] Each Tribal behavioral health program has different capacities. Under a government-to-government relationship, each Tribe will determine whether or not the Tribe is willing and/or has the capacity to provide crisis or DMHP services.

[15] DSHS may be requested by individual Tribes to facilitate and monitor the process to insure that the process and product comports with government-to-government standards.

The Tribal Centric Behavioral Health System Project's Workgroup additionally identified several strategies to maintain, support and improve Tribes and urban Indian health programs ability to serve their members and other AI/AN individuals. These include:

- Continuing to use the IHS encounter rate to reimburse tribal mental health and chemical dependency programs.
- Continuing to allow Tribal and urban Indian health programs to directly provide mental health services to clinical family members of Tribal members.
- DSHS/HCA should contract with adult and child consulting psychiatrists to provide medication consultation services to tribal and urban Indian health programs.
- Developing and promoting a system for tribal mental health providers to obtain specialty psychiatric consultations with: child psychiatrists, psychiatrists certified in addictionology and geriatric psychiatrists.
- DSHS and HCA should establish an ongoing project with Tribes and urban Indian health programs to develop culturally appropriate evidence-based and promising AI/AN practice treatments. Program development should include a plan for reimbursement for providing the service.
- DSHS and HCA should work with the Tribes to develop treatment modalities and payment policies for persons with co-occurring conditions.
- DSHS should seek state funds to pay Tribal programs for chemical dependency services provided to non-natives.

In addition to the above strategies and recommendations, the Workgroup membership requested that this report emphasize three critical concerns regarding the interface between Tribes, Tribal providers and the RSN system: voluntary inpatient authorization, a lack of DMHP responsiveness, and the lacking of a mutual respect for Tribal mental health professionals on the part of the RSN provider networks.

Tribal Workgroup members report that there are occasions when RSN authorization for hospitalization occurs and the RSNs pays for the hospitalization, but there are an equal number of occasions when the authorization does not occur. Regrettably, the outcome when hospitalization does not occur usually results in tragedy. While Tribes have experienced and skilled mental health professionals, often Tribal programs do not have the staffing resources for twenty four hour crisis service coverage. Frequently RSN crisis responders do not explain that the RSN inpatient authorization process is for payment only and that RSNs do not have the authority to deny access to medical and behavioral health hospitalizations. In other words, RSNs can only authorize or deny payment, they cannot make admission decisions for hospitals.

As mentioned above, the relationship between the Tribes and the RSNs and state hospitals is disjointed. This is most readily evidenced by the lack or delay of response from DMHPs. Challenges include accessing hospitalization from referrals, limited beds, culturally responsive services, and lack of discharge coordination. There is a lack of a comprehensive model of

care for delivery of services. It is recognized that there is a lack of psychiatrists for tribal communities, and many are too small to employ one full time.

It is essential that whatever the Behavioral Health System for Washington State becomes, there needs to be a recognition or Tribal Mental Health professionals, programs and the services they provide. There is a need for continued education of the public to address the stigma that Mental Health clients receive for their condition that could be from illness or historical trauma.

The new system should include an orientation or training to educate RSN provider networks and State Hospitals as regards the nature of the government-to-government relationships when working with Tribes, cultural competency and the importance of mutual respect for tribal mental health professionals.

DSHS and HCA should establish an ongoing Workgroup to ensure that clear and consistent communication between the state and Tribes helps to define the new Tribal-Centric approach.

The State should work with the Tribes to conduct a feasibility study to explore the development of two regional Tribal residential programs with the capacity to function as Evaluation and Treatment Centers (E&T) and/or crisis triage center to serve AI/AN people needing emergency psychiatric inpatient care. Appropriate and early intervention will greatly decrease the need for long-term hospitalization at our state hospitals.

Culturally Appropriate Evidence Based Practices and Promising Practices

There are limited Evidence Based Practices (EBPs), Promising Practices or Research Based Practices that have been tested in tribal communities. The range of Washington's tribal communities—urban, rural and frontier—adds another level of complexity to finding EBPs that have been adequately normed for tribal communities. What is known is that a "cut and paste" approach to services does not work. EBPs are expensive to implement and maintain. For any EBP to be effective there has to be ongoing fidelity monitoring and technical assistance—this is an additional cost to the actual service provision. For those practices that may exist, other barriers come into play including conflicts with the primary funding streams that Tribes use for providing behavioral health services, including; Indian Health Services, Medicaid, Tribal and State.

There needs to be an explicit acknowledgement that each Tribe knows what works best in a tribal community and that a pilot project or study that works in one tribal community may not necessarily be easily replicated in another. Each Tribe in Washington has its own rich and unique history, culture and traditions. It is essential for the development of culturally appropriate and responsive providers for behavioral health services that includes interaction with the Tribes directly.

DSHS Recommendations

DSHS recommends that its participation in, and commitment to, the development and implementation of a Tribal Centric Behavioral Health system continue for the foreseeable future. Additionally, if the legislature determines that DSHS conduct a procurement for mental health services as a result of the CMS letter, DSHS recommends that the Tribal Centric Workgroup be involved in the procurement process. DSHS also recommends that the Tribes be formally involved in developing the procurement through the formal consultation process.

The Behavioral Health and Service Integration Administration requests one full time staff at DBHR to respond to Tribal concerns regarding access to RSN services, including crisis and inpatient, and issues with state hospitals. This position would also be responsible for monitoring RSN implementation of contract changes identified in this report. The position would also work with OIP, IPAC and AIHC to provide training for RSNs and state hospital employees to work with Tribes. The position would also work with government-to-government partners in developing training and implementing a process for credentialing provider agencies as being proficient in working with AI/AN population.

DSHS requests funding to conduct a Feasibility Study with the Tribes to determine the most appropriate vehicle for decreasing hospitalizations. This could take the form of regional Tribal E&Ts, regional crisis/triage centers or a combination of the two. The outcome should be based on working with Tribes to accurately identify the need and to develop a strategy to create the structure to meet those needs.

Fiscal Impacts

The fiscal impact will be relatively limited. Behavioral health services provided to AI/AN Medicaid consumers through Tribal providers is 100 percent FMAP. RSN services are included in the RSNs' Medicaid rate, given that all of a given RSN's Medicaid eligibles are included in the PMPM payment, whether or not the Medicaid eligible is AI/AN or living on Tribal land. Please see the following tables for Fiscal Impact.

Additional costs would revolve around RSN contract monitoring and the position requested in the previous section of this report. If crisis triage and/or E&T programs were established, there would be start-up costs with capital expenditures and ongoing operational costs for non-Native consumers. The E&T costs would be offset by a projected decrease in the number of AI/AN inpatient psychiatric services provided through the RSN system and a decrease in long-term stays at the state hospitals. Additionally, given that freestanding E&T services are considered as an outpatient service in the Medicaid State Plan, services could be billed as IHS Medicaid encounters under the encounter rate for AI/AN Medicaid eligibles, if the facility was on Tribal land or an urban Tribal program on the IHS facility list. For patients

with co-occurring chemical dependency disorders, the potential exists for billing both a mental health and a chemical dependency encounter for the two separate treatment interventions.

Milestones, Fiscal Impacts and Implementation Dates

The following tables depict the overall recommendations, with proposed timeframe and estimated fiscal impacts.

RSN Related Tribal Workgroup Recommendations

	Timeframe	Currently in RSN State Rate	Currently in RSN Medicaid Rate	Fiscal Impact
Define and clarify role and scope of RSN governing boards. Require RSNs to include Tribal representatives in their decision and policy making boards.	7/1/2014	No	No	No
Require RSNs to identify an RSN staff member as a Tribal Liaison.	7/1/2014	N0	No	No
Review and revise the RSN *Access to Care Standards* and list of covered diagnoses to insure that historical trauma and its resultant disorders, in all their complexity for AI/AN people.	3/1/2014	No	Yes[16]	No
Require RSNs to provide timely and equitable access to crisis services for AI/AN. This would include requiring RSNs to contract with Tribal and urban Indian mental health programs that are willing and able to provide crisis services.	7/1/2014	Yes	Yes	Potential
Require RSNs to contract with Tribal DMHPs to serve AI/AN people on Tribal Land. (If Tribal DMHPs available and willing to contract with RSN)	7/1/2014	Yes	Yes	Yes
Require RSN contracted and DBHR credentialed licensed psychiatric care hospitals and Evaluation & Treatment (E&T) facilities to notify and coordinate AI/AN discharge planning with the Tribes and urban Indian health programs.	3/1/2014	No	No	Yes
As part of 2SSB 5732, Tribal representatives will participate in developing culturally appropriate evidence-based and promising AI/AN practice treatments for that RSNs will be required to provide.	3/1/2014	No	No	Potential
Require that all RSNs and their provider networks who provide Medicaid encounters to AI/AN consumers meet minimal cultural competency standards to be established through a joint AIHC/OIP/Washington Behavioral Health Council and departmental Workgroup.	9/1/2014	No	No	Potential

[16] Mental disorders resulting from historic trauma are already included in the list of covered diagnoses. However, the disorder must be severe enough to meet test of medical necessity.

Tribal 638 Program and Urban Program Recommendations

	Timeframe	State Funded	Medicaid Funded	Estimated Cost
Continue to use the IHS encounter rate to reimburse Tribal mental health and chemical dependency programs.	Ongoing	No	Yes	No
Continue to allow Tribal and urban Indian health programs mental health services to clinical family members of Tribal members.	Ongoing	No	Yes	No
DSHS/HCA should contract with an adult and child consulting psychiatrists to provide medication consultation services to Tribal and urban Indian health programs.	Not Determined	Yes	No	Yes
DSHS and HCA should establish an ongoing project with Tribes and urban Indian health programs to develop and reimburse for culturally appropriate evidence-based and promising AI/AN practice treatments.	Begin 7/1/2014	Yes	No	Yes
DSHS and HCA should work with the Tribes to develop treatment modalities and payment policies for persons with co-occurring conditions.	Begin 7/1/2014	No	Yes through separate encounter rates.	No
DSHS should seek state funds to pay Tribal programs for chemical dependency services provided to non-natives.	Ongoing	Yes	Yes After Medicaid Expansion	Potential
Require state psychiatric hospitals to notify and coordinate discharge planning with Tribes and urban Indian health programs.	3/1/2014	Yes	No	No
Obtain necessary statutory and/or regulatory changes that will allow Tribal Courts to make ITA committals for Tribal members.	Submit to 2015 Legislature	No	No	No
DSHS should assist Tribal programs to train and have Designed Mental Health Professionals (DMHP) who can detain AI/AN for involuntary (ITA) commitments.	7/1/2014	Yes	No	Yes

DSHS Recommendations

	Timeframe	State Funded	Medicaid Funded	Fiscal Impact
DBHR dedicated FTE to provide technical assistance to Tribes and monitor Tribal relations in RSN contracts.	7/1/2014	Yes	No	Yes
DBHR use 2SSB 5732 appropriations to contract or employ a dedicated FTE to assist with implementation of the report's recommendations.	1/1/2014	Yes	Yes	2013-2015 Appropriation
Obtain state funding to conduct a feasibility study for one or more E&T facilities to service AI/AN people needing inpatient psychiatric care.	7/1/2014	Yes	No	Yes

Conclusion

Given that there will be a number of reports received from November 2013 through June 2015, the Department, Health Care Authority and Tribes note that this report is the first

submission. There remain many unknowns that are currently being worked on; therefore we collectively commit to submit a subsequent report on June 30, 2014 and June 30, 2015 to report on developments, progress and any additional legislative action that is necessary.

Workgroup Members

Alison Ball (Colville Tribes)
Bob Cox (Yakama Nation)
David Reed (DBHR)
Colleen Cawston (OIP)
Roger Gantz (American Indian Health Commission)
Mervyn Chambers (Lower Elwha Tribe)
Charlene Abrahamson (Chehalis Tribe)
Steve Kutz (Cowlitz Tribe)
Cindy Robison (NATIVE Project)
Coleen Bowls (Stillaguamish Tribe)
Dorothy Flaherty (Quinault Indian Nation)
Elizabeth Tail (Cowlitz Tribe)
Jim Roberts (Northwest Portland Indian Health Board)
Jo Anne Walker (Yakama Nation)
Darrell Toulou (OIP),
Liz Mueller (Jamestown S'KlallamTribe)
Sharon Grier (Lummi Nation)
James Sherrill (Cowlitz Tribe)
Stephanie Tomkins (Squaxin Tribe)
Zekkethal Vargas
Joe Valentine (North Sound Mental Health Administration)
Bob Welch
Rhonda Martinez-McFarland (Lummi Nation)
Marilyn Scott (Upper Skagit Tribe)
Nancy Dufraine (Chehalis Tribe)
Ann Dahl (Spokane Tribe)
Daryl Toulou (OIP)
Laura Allen
Janet Gone (OIP)
Suzie McDaniels (Spokane RSN)
Helen Fenrich (Tulalip Tribe)
Karol Dixon (HCA)
Elizabeth Tail (Cowlitz Tribe)