

Report to the Legislature

Tribal Centric Behavioral Health

2SSB 5732, Section 7 Chapter 388 Laws of 2013

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and
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Executive Summary

In September 2009, during the Washington State Tribal Mental Health Conference, the vision of a Tribal Centric Mental Health System began. It was during this meeting that then Assistant Secretary Doug Porter acknowledged what the tribes of Washington had known and experienced since the inception of the Regional Support Networks (RSNs)—a Managed Care system without the requirement to acknowledge and constructively work with Tribal Governments cannot adequately respond to and appropriately serve Tribal members. Since that meeting, the Tribes and the Department of Social and Health Services (the Department) have strived to address these matters through the formation of a Tribal Centric Workgroup. Over the years the work has grown to move from a mental health focus to an integrated behavioral health model which encompasses both mental health and chemical dependency treatment. A summary of the cumulative work of this workgroup can be found in Attachment (A).

Planning activities identified system strengths and deficits. The Tribal Centric workgroup proposes to enhance systemic strengths and surmount its inherent gaps. One of the major system strengths cited by the workgroup is the State's implementation of mental health services through the Indian Health Services (IHS) encounter rate. Chief among these is the *Clinical Family* designation, which provides for the mental health treatment in which successful treatment of a native client may need to include non-native family members. This designation allows for a non-native family member to be served and billed for as part of a family treatment. It also allows for the individual to self-identify to their tribal affiliation. No limitation on frequency and duration of services as long as medical necessity is present. Tribes have the flexibility in the areas of serving clients, developing programs so that they can meet the client where they are; mentally, physically, emotionally and spiritually. There are no limits to the number of visits that can be provided. Since 1994 the tribes have had the ability to bill the all-inclusive encounter rate. This does have a benefit for the State as well since these visits are 100% reimbursed by the federal government.

Some of the milestones that have been accomplished since 2009 that will remain as assets as Tribal Centric Behavioral Health progresses include the following: The Department worked with the tribes in the development of a Tribal Attestation process for mental health programs. This became essential to address because both the Memorandum of Agreement (MOA) between IHS and the Healthcare Financing Administration (HCFA) 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. Tribes can if they prefer become a Federally Qualified Health Center (FQHC). There is a longstanding strong working relationship with the tribes and Division of Behavioral Health for chemical dependency services. Tribes have the ability although limited with the number of staff available for technical assistance from both the Department and Health Care Authority (HCA). (list more accomplishments: Tribal access line, facilitating disputes between Tribes and RSNs, providing Medicaid training to tribal providers, clinical case consultation when requested)

Recent data analysis indicates that while 19 percent of American Indian/Alaskan Native (AI/AN) 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. Given the

geographic distribution of AI/AN Medicaid eligibles across the state, the RSNs are the primary source of outpatient mental health services for AI/AN Medicaid clients.

Based on SFY 2011 data, an estimated 14,500 (19 percent) of the 77,140 AI/AN Medicaid clients received mental health services through the RSNs. The Tribes provided services to 3,458 (4 percent) of all Medicaid AI/AN who received mental health services during the period. Of this number, 831 (1 percent) received services from both Tribal and RSN provider programs. Of those who received mental health services, 11,042 (14 percent) AI/AN received mental health services only through the RSN system.¹

Over the last eighteen months the Tribal Centric Behavioral Health workgroup has identified issues, reviewed problems and explored multiple solutions to not only the issues surfaced at the 2009 meeting, but also has identified emerging concerns regarding the provision of mental health services and the interface between tribal providers, Tribes, individual AI/AN, and the RSN system.

After this multi-year process, the workgroup identified and defined the hallmarks/traits/values that should define a Tribal Centric Behavioral Health System:

Individual choice should be a strong value of any future system. Those AI/AN 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 **having to opt-in to the RSN** system.

However, 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, both **technically and in spirit**. 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 actual government-to-government relationship.

The 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.

The Department 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.

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.

The State should invest in two regional Tribal Evaluation and Treatment Centers (E&T) to serve AI/AN people needing psychiatric inpatient care. Appropriate and early intervention will greatly decrease the need for long-term hospitalization at our state hospitals.

The Tribes, the Department and HCA are reviewing the barriers and strategies for removing those barriers to tribal members receiving equitable access to publicly funded behavioral health services. Some examples of these are the inconsistent recognition for tribal court orders and Tribal Designated Mental Health Providers (TDMHP) being consistently utilized or recognized by the RSNs. Further review of this will be expanded in a June 2014 report.

There are 29 Federally Recognized Tribes in Washington State. The American Indian/Alaska Native population is comprised of members from federally recognized tribes across the country. Additionally, there are two Urban Indian facilities that provide behavioral health services to AI/AN residing outside of the tribal service areas. They are located in Spokane and Seattle. The demographics of these members will be included as attachment (B).

Implementation Dates

There are multiple unknowns confounding the Tribal Centric Behavioral Health planning process. The major unknown is the communication received from the Center for Medicaid and Medicare 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 Affordable Care Act brings two huge variables into play: the Medicaid expansion and the implementation of parity. Finally there are the pending recommendations of the State Innovation Models Grant (SIM) which is investigating improving the health outcomes by better integrating physical and behavioral health care. With the many unknowns at this time, the Tribal Centric Behavioral Health Workgroup, has determined that it is not possible to set clear implementation dates at this time.

Major Milestones

Major milestones would include:

Establishing 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.

Setting up a standing committee to meet with the Department, including representatives from the Behavioral Health System 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.

Requiring that all RSNs have at least one Tribal representative on the RSN's governing board with full voting rights.

Establishment of a team, which will include BHSIA, IPAC and AIHC representatives to review RSN compliance with the new contract terms and recommend corrective action to the Department as needed.

Develop a mechanism to coordinate planning activities between the Tribal Centric Behavioral Health Workgroup and the SIM Team.

Fiscal Estimates

The fiscal impact will be limited, given that behavioral health services provided to AI/AN consumers through Tribal providers is 100 percent FMAP. Additional costs would revolve around RSN contract monitoring. If an E&T 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.

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 cookie cutter 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 and that includes 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 tribes know 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.

Access, Crisis Services, Outpatient Services, Voluntary and Involuntary Hospitalization, and Behavioral Health Coordination

Given that the RSN managed care system is the primary source of outpatient mental health services for AI/AN clients and currently is the only source of inpatient services for all Medicaid

clients, and that there is no viable, economically feasible, statewide alternate existing service system for AI/AN people, the Tribal Centric Behavioral Health System Workgroup recommends that the project work to improve the RSNs', or their successor's, ability to provide timely access to culturally appropriate mental health services for AI/AN Medicaid clients.

The Tribal Centric Behavioral Health System Project's Workgroup identified the following strategies to improve the RSN system. These include:

- Require RSN governing boards include Tribal representatives.
- Require RSNs have Tribal Liaisons that are trained by the Tribe, Indian Policy Advisory Committee or the American Indian Health Commission.
- Revise that the Department work with CMS to revise the RSN *Access to Care Standards* list of covered diagnoses to include 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 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 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 the Department to assist tribal programs to train and have Designed Mental Health Professionals (DMHP) who can detain AI/AN for involuntary (ITA) commitments.
- Require RSNs to contract with Tribal DMHP to serve AI/AN people in their Contract Health Service Delivery Areas (CHSDA).
- Obtain necessary statutory and/or regulatory changes that will allow Tribal Courts to make ITA committals for Tribal members of other AI/AN in their CHSDA.
- 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 for that RSNs will be required to provide.
- Obtain state funding to conduct a feasibility study for one or more E&T facilities to service AI/AN people needing inpatient psychiatric care.
- Develop and promote a system for tribal mental health providers to obtain specialty psychiatric consultations with: child psychiatrists, psychiatrists certified in addictionology and geriatric psychiatrists.
- Require that all RSNs and their provider networks that 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 work group.

The Tribal Centric Behavioral Health System Project's workgroup had identified several strategies to support and improve Tribes and Urban Indian Health Programs ability to service their members and other AI/AN they service. These include:

- Continue to use the IHS encounter rate to reimburse tribal mental health and chemical dependency programs.
- Continue to allow tribal and Urban Indian Health Programs mental health services to clinical family members of Tribal members.
- The Department/HCA will contract with an adult and child consulting psychiatrists to provide medication consultation services to tribal and Urban Indian Health Programs.
- The Department and HCA will 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.
- The Department and HCA will work with the Tribes to develop treatment modalities and payment policies for persons with co-occurring conditions.
- The Department will seek state funds to pay Tribal programs for chemical dependency services provided to non-natives.

There are occasions when authorization to hospitalization is occurring and the RSNs are paying for them, there is an equal amount of time when this does not occur. Regrettably, the outcome when there is not hospitalization usually results in tragedy. Tribes have experienced the ability to access mental health professionals that they do not have on staff for their clients, and some crisis services.

There remains a disjointed relationship with state partners such as the RSNs and state hospitals. This is evidenced by the lack or delay of response from County DMHP. Challenges in accessing hospitalization from referral, 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.

Statutory Changes needed to implement

Access to RSN Governing Boards;
Establishing Tribal Designated Mental Health Professionals independent of County Designation;
Reciprocity between Tribal Courts and Superior Courts in ITA related-hearings.

Consultation Schedule

August 13, 2013 First Roundtable;
September 12, 2013 Second Roundtable;
October 11, 2013 Consultation;

November 30, 2013 Report due to the legislature.

Agreements

The Department and Health Care Authority have entered into Intergovernmental Agreements, Local Area Agreements and Core Provider Agreements with the Tribes and RAIO's, therefore the process is in place to continue with these as the TCBH program unfolds.

Identified Contracts

Significant changes will need to be incorporated into the current RSN contracts, or be included with the model developed in the future.

Conclusion

Given that there will be a number of reports received from November 2013 through June 2015. The Department, Health Care Authority and Tribes would like the legislature to know 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 the development, progress and any additional legislative action that is necessary.

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