ISSUE BRIEF

SAFESTRONGSUPPORTIVE

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How do Tribal health, Medicaid, and child welfare systems interact?

This brief is part of a series developed by the Center for Health Care Strategies in partnership with Casey Family Programs. For strategies that Tribes and states can use to deliver behavioral health services for Native American children and families, see the companion strategy brief: How can Tribal health, Medicaid, and child welfare partner to support traditional healing and behavioral health services? For profiles of three services, see the companion brief: What are examples of Tribal behavioral health and traditional healing programs?

When the various systems serving children and families in Tribes work together, they can build and support prevention-focused programs and services that focus on improving the well-being of Tribal members. These include the Tribal health, Medicaid, behavioral health, and child welfare systems. Ensuring access to high-quality behavioral health services can help address safety challenges and reduce the need for more intensive child welfare interventions.

This brief describes how these systems intersect, providing basic background information that can lay the groundwork for effective cross-system collaboration that benefits Native American and Alaska Native children and families.[1] Developing policy and programs within each of these systems is complex; working across these systems requires close collaboration that can bridge knowledge gaps and lead to creative approaches.

Tribal health systems

Tribes are sovereign nations that have established their own governments and provide social and support services to their members. Members of federally recognized Tribes (sovereign Tribal governments) have a

right to health care due to treaty and trust obligations of the federal government. Tribe members can receive free health care from Indian Health Care Providers (IHCPs), including: the Indian Health Service (IHS), a system of federally run and funded clinics and hospitals; Urban Indian Organizations, which provide care for Tribe members in cities; and Tribe-operated health systems authorized by the Indian Self-Determination and Education Assistance Act of 1975.

This law enabled Tribes to compact with the federal government to manage their own health systems. Prior to this law, the federal government ran all IHS-funded health systems and health care sites for members of Tribes. Compacting allows Tribes to receive federal funding allocated for their health care and apply it with sovereignty to manage part or all of their health systems in the way they see best for serving their community. Today, over half of federally recognized Tribes operate part or all of their own health systems.

IHCPs provide a variety of health care services covering physical, oral, and behavioral health needs. But due to staffing shortages within IHS and in rural areas, as well as a recognition of the value of preventive care, most IHCPs primarily offer outpatient primary and preventive care. Other health services may be accessed through Purchased/Referred Care (IHS's budget for outside providers), collaboration with other healthcare providers, and additional health coverage, including Medicaid.

Leaders of Tribes often work with the federal and state governments to achieve cross-system and cross-program collaboration — and in turn, better serve their members. Lacey Wind, vice president of tribal public health for the National Indian Health Board, explained that when states make efforts to truly understand Tribes, they are better situated to put Tribal leaders and programs "in the driver's seat" for program and policy design, when possible.

> "When we have effective collaboration, children and families fare better. Success comes from talking to one another, breaking down silos, and going back to our traditional teachings of being interdependent as a community."
>
> — Tara Reynon, Senior Program Director, National Indian Child Welfare Association

Medicaid

Medicaid, a state-federal partnership, is a key source of funding for the Tribal health system (IHS clinics, Urban Indian Organizations, and Tribally-operated and affiliated health systems) — providing almost 13% of the funding in 2025.[2] Both state and federal governments contribute to Medicaid funding, with the federal government setting core requirements and standards and states designing and running the Medicaid program to meet the unique needs of their populations.

Medicaid programs cover a defined set of comprehensive health services that contracted providers deliver to Medicaid-eligible recipients. Medicaid programs also may offer additional services or test new ways to deliver care using a State Plan Amendment or waivers, which must be approved by the federal government. Medicaid is the largest payer of children's health care, including mental health, in the country.

Members of federally recognized Tribes may enroll in Medicaid if they meet the program's eligibility requirements. When Tribal members with Medicaid receive care from IHCPs, Medicaid reimburses those providers. Tribal health systems that partner with states to bill Medicaid often report increased flexibility and revenue, which can support sustainability and the expansion of services.

The Osage Nation, for example, found that compacting to run its own healthcare system and incorporating third-party billing, which includes billing Medicaid, allowed for an expansion of health care services. Running its own healthcare system meant the Tribe could hire additional finance and billing staff who were

able to use their expertise to increase revenue, which in turn supported the new services as well as increased salaries for staff.

How states operate their Medicaid programs

Medicaid programs tend to operate in two ways: (1) a "fee-for-service delivery system," where states directly administer their own programs, including functions such as credentialing providers, developing reimbursement rates, managing the provider network, paying claims, and managing the utilization of care; and (2) "Medicaid managed care," where states set goals and policies but contract with managed care organizations (insurance providers) to organize health care access and delivery.

Most states enroll their Medicaid-eligible population primarily through a managed care system in which the state holds the managed care organization accountable for coordinated and timely access to high-quality care. Federal guidance limits the ability of states to mandate enrollment of Tribe members in managed care, therefore many receive their Medicaid services through the fee-for-service system — though enrollment in Medicaid managed care for members of Tribes members varies across the country. The federal guidance also creates certain protections for members of Tribes enrolled in Medicaid managed care, including guarantees that they can receive care from IHCPs, even if the provider is not in the managed care network.

This guidance is designed to preserve Tribal sovereignty to oversee health care for its own citizens and ensure access to culturally appropriate care for Tribe members. States, however, rely on managed care to cover the vast majority of their Medicaid populations and implement most policy changes through managed care organizations. As a result, this structure may unintentionally limit access to innovative services and supports for Medicaid-eligible Tribe members who receive care through the fee-for-service system. Some state Medicaid agencies are trying to mitigate this disparity by exploring ways to create an equilibrium between the managed care and fee-for-service systems.

Child welfare

Medicaid has long been responsible for providing health services to children in foster care, who experience greater health care needs than children not involved in foster care. The 2018 passage of the Family First Prevention Services Act expanded the use of child welfare funding to focus more on maltreatment prevention, promoting services that can keep children and families safely together. Medicaid also can cover many of the services included in Family First, such as intensive in-home services, peer supports for families, intensive care coordination, and crisis response services. Combining child welfare prevention funding and Medicaid dollars can help states and Tribes expand the array of services available for children and families involved with, or at risk of becoming involved with, the child welfare system.

How Tribal governments can braid and blend funds

Braiding and blending is the use of various funding sources to finance a program or service. Braided funds have specific reporting requirements and must be tracked separately to ensure compliance and accountability with how funds are used, while blended funds do not require separate reporting. **Tribal behavioral health services can leverage Medicaid, Family First, federal block grants, philanthropy, and other sources, to braid and blend funds to sustain and expand services.** In a state that covers equine therapy, for example, a program could employ therapists who are eligible to bill Medicaid for their services and non-licensed individuals from the Tribes for non-billable activities, such as cultural education and connection. Such an approach might sustain the program by braiding Medicaid reimbursement for certain therapist-provided services with grant funding for services that Tribe members offer.

[1] This brief was informed by interviews with: Lacey Wind, Vice President, Tribal Public Health Programs, National Indian Health Board, on August 22, 2025; Kirk Shaw, COO/Clinic Administrator, Osage Nation Health System, Tara

McKinney, Wahzhazhe Early Learning Academy Director, Osage Nation, and other members of the Osage Nation Health System, on September 3, 2025; and Tara Reynon, Senior Program Director, and David Simmons, Director of Government Affairs and Advocacy, National Indian Child Welfare Association, on October 10, 2025.

[2]Indian Health Service. (2024). *Indian Health Service FY 2025 Performance Budget Submission to Congress*. Department of Health and Human Services.

Casey Family Programs

Casey Family Programs is the nation's largest operating foundation focused on safely reducing the need for foster care and building Communities of Hope for children and families in the United States. By working together, we can create a nation where Communities of Hope provide the support and opportunities that children and families need to thrive. Founded in 1966, we work in all 50 states, Washington, D.C., Puerto Rico, the U.S. Virgin Islands and with tribal nations across North America to influence long-lasting improvements to the well-being of children, families and the communities where they live.

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