



May 2026

# How can Tribal health, Medicaid, and child welfare partner to support traditional healing and behavioral health services?

This brief was developed by the [Center for Health Care Strategies](#) in partnership with Casey Family Programs. For profiles of three services that put the strategies explored in this brief into practice, see the companion brief: [What are examples of Tribal behavioral health and traditional healing programs?](#) For background information on key systems that can work together to improve behavioral health outcomes for Native American children and families, see the companion brief: [How do Tribal health, Medicaid, and child welfare systems interact?](#)

Ensuring early access to high-quality behavioral health services can help children and families address safety challenges and reduce the need for more intensive child welfare interventions later. In Native American and Alaska Native Tribal communities, those behavioral health services need to be both holistic and culturally informed.

Many Tribes, though, have limited access to effective behavioral health care due to underfunding and a provider pool limited in both capacity and expertise tailored to their communities. When the systems of child welfare, Tribal health, Medicaid, and behavioral health work together, however, they can support traditional healing practices in behavioral health that resonate culturally with members of Tribes.

The Center for Health Care Strategies conducted interviews with staff in child welfare systems, Tribal health organizations, state Medicaid agencies, and other child- and family-serving systems — along with people with lived experience in these systems and other subject matter experts — in an effort to learn more about collaboration strategies that have been successful in advancing culturally informed behavioral health approaches in Tribal communities. These conversations have informed this brief,<sup>1</sup> which is designed to help state and Indian child welfare systems, Tribal health systems and Tribe-affiliated organizations,<sup>2</sup> and Medicaid agencies identify and create opportunities for partnership.

## Key challenges

When developing strong partnerships between child welfare systems, Tribal health care, and Medicaid, the following challenges must be addressed:

- **Each system was built separately.** As these systems evolve, limitations in how they can work together become more apparent. Medicaid, for example, has become an important payer for Tribal health services but was not originally designed with that purpose, and therefore may not always reimburse providers that work exclusively in Tribal communities, such as Indian Health Service (IHS) [community health representatives](#).
- **Partners may lack expertise in one another's systems.** Developing policy and programs that serve the behavioral health needs of Tribal members requires technical knowledge, an appreciation for system priorities, and an understanding of native populations. Close collaboration and information sharing among the three systems are needed to bridge knowledge gaps.
- **IHS is underfunded.** A system of federally run and federally funded clinics and hospitals, IHS currently is funded at [less than half](#) of its estimated need, limiting Tribal health systems' ability to hire the staff required to work across organizations and offer comprehensive services. Families in rural areas — which may include reservations and Tribal lands — are particularly impacted by this underfunding because alternative health care providers may be geographically inaccessible, unaffordable, or both.
- **Sharing data and information is complex.** Confidentiality laws — especially related to behavioral health — can restrict information sharing and working in small Tribal communities can make maintaining privacy and confidentiality even more difficult. Sharing data between Tribal and non-Tribal government entities, such as a state child protection agency or Medicaid system, also is challenging, both for technical reasons (data systems may not operate interdependently) and data ownership concerns. Understanding and supporting the Tribal value of [data sovereignty](#) is key to building trust around data and information sharing.
- **Lack of cultural familiarity can hinder collaboration.** State child welfare and Medicaid staff may not be familiar with Tribal sovereignty and cultural approaches to healing and well-being, which may hinder states from designing programs and policies tailored to Tribal communities.

## Key strategies

The following seven strategies can help child welfare systems, Tribal health organizations, and Medicaid programs work together more effectively on behavioral health programs for children and families who are members of Tribes.

### Uphold Tribal sovereignty through strengthened relationships

Tribes are sovereign nations with their own governments that provide social and support services to their members. One key facet of Tribal sovereignty is self-determination: the ability of each Tribe to determine

its own future by building policies and programs that are aligned with the culture and values of its members. To build a successful partnership and create effective cross-system initiatives, child welfare and Medicaid staff need to wholly understand the concept of Tribal sovereignty and proceed by developing a strong [government-to-government relationship](#), which involves meeting regularly as equals. This can include [formal Tribal consultation](#) and informal conversations, and should involve working at both the governmental and community levels.

“We collaborate with the Tribes. Each is different, the territories are different, and so are the needs of their members. Our approach is to connect with the Tribes and find out how we can support them. If it’s for the Tribes then we build it with them and alongside them.”

— Ashley Johnson, Tribal Relations Director, Oklahoma Health Care Authority

States with large native populations often are supported by internal staff dedicated to working with Tribes, such as Tribal liaisons. Some states operate a division of Tribal affairs. These states also act as a major payer for Tribal health and social systems, with state staff often providing technical assistance for Tribes that bill Medicaid for reimbursement of Indian health services.

Navigating this multi-pronged relationship is complex, however, and requires clear communication. State staff become better partners in this relationship when they partner with both Tribal government officials and individual members of Tribes. Gathering on-the-ground insights from members can help states build partnership programs that best meet community needs.

“We do lots of Tribal engagement in each region of the state,” said Shannel Squally-Janzen, Tribal prevention services specialist in the Office of Tribal Relations for the Washington State Department of Children, Youth, & Families (DCYF). Tribes host the engagements while DCYF presents their work and seeks feedback from Tribe members. The agency encourages community participation by sharing meals, providing gift cards to recognize the time and expertise people bring, and offering childcare and transportation to make it easier for Tribe members to participate.

### Prioritize holistic approaches that connect health care and culture

Traditional Tribal healing practices and [connection to culture](#) and community have been shown to be [protective factors](#) for children who struggle with mental health, substance use, or family relationships. Laws that [prohibited the practice of Native American religions](#), [forcibly separated children](#) from their families, and [evicted families](#) from traditional lands have disrupted that connection between health and culture, but recent federal policies are embracing the integration of religious, spiritual, and cultural health practices to enhance Indian child and family well-being.

“Native communities have always understood that health is connected to culture, spirituality, family, and our relationship to the land,” said Lacey Wind, vice president of Tribal public health programs for the National Indian Health Board. “Health in our communities has always been holistic. These things cannot be separated or compartmentalized, and we cannot truly be healthy without them. Federal policies disrupted many of those connections, and the impacts are still felt today. The growing recognition of traditional healing, including [Medicaid 1115 waivers](#) that allow reimbursement for these practices, signals an important shift toward supporting cultural approaches that help restore balance and strengthen the well-being of Native American children, families, and communities.”

A number of traditional and cultural practices support Indian health and well-being, including equine therapy, powwows, sweat lodges, smudging, and prayer or spirit naming ceremonies. Existing social-emotional therapeutic and educational programs also can be adapted with cultural practices and teachings that meet the needs of native children.

Medicaid offers several pathways for Tribal health providers to be reimbursed for healing services connected to traditional practices or culture:

- **Waivers.** States can use 1115 waivers to pilot programs to improve care and outcomes for people served by Medicaid. In October 2024, four states — Arizona, California, New Mexico, and Oregon — [received federal approval for 1115 waivers](#) that allow their Medicaid programs to reimburse Indian Health Care Providers for traditional healing practices delivered to Medicaid-eligible people. These waivers were designed to prioritize Tribal sovereignty and acknowledge differences among Tribes. In the waiver approvals, the Centers for Medicare & Medicaid Services did not define specific services that could be covered or how traditional practitioners would be defined, leaving those decisions to Tribes, in partnership with state Medicaid programs. While 1115 waivers can be powerful, design and implementation can be challenging and time-consuming. Federal administrators may need more education and support, as many are unsure about how to respond to novel requests or may approve waivers based on how proposed approaches align with their own priorities for health and well-being.
- **Value-added services.** Value-added services (VAS)<sup>3</sup> are flexible services that states allow managed care organizations to deliver, outside of typical covered services. While some states are limited in their ability to enroll [Tribe members in Medicaid managed care](#), others do have a substantial number in their programs and allow managed care organizations to design VAS tailored for this population. Some managed care organizations, for example, use VAS to support traditional healing practices, including in [New Mexico](#) and [Oklahoma](#). Practices often are defined broadly and can include spiritual or ceremonial practices.
- **Coverage of specific benefits.** Medicaid programs must offer a minimum set of services, but can add to covered benefits subject to federal approval through a [State Plan Amendment](#) (SPA). While regulations govern how Medicaid funds can be used, many eligible services may be connected to cultural healing. Some states, including [Colorado](#), cover equine therapy for select Medicaid members, for example. Equine therapy can benefit a wide variety of children from different backgrounds, and many Tribal organizations offer equine therapy programs that include cultural teachings and connection.
- **Support for flexible care models.** State Medicaid programs often prioritize increasing team-based health care, integrating different types of health services, or providing case management. States can promote these models by covering the services or providers needed through a SPA or delivery and payment mechanisms that incentivize the approaches. These models can support [Indigenous health frameworks](#), which view emotional and mental health as key components of overall well-being. Reimbursement for flexible methods of care delivery (such as group visits) or providers (such as community health workers or [doulas](#)) also can increase access to culturally competent care.

### Explore multiple entry points to support

Medicaid, child welfare, and behavioral health systems can work together to [provide braided funding](#) targeted to the behavioral health needs of children and families involved with the child welfare system — helping prevent challenging situations from escalating and reducing the need for family separation and foster care. Identifying which systems can pay for which services often is complex, making effective cross-sector collaboration necessary. Bringing together staff from different organizations who focus on billing and reimbursement helps ensure the right people are identifying financing opportunities and addressing barriers to timely and seamless access to care.

Partnerships between school and health systems, such as [school-based services](#), can increase access to health care and connect educational success with health and well-being. The Osage Nation Health System provides school-based counseling services as part of its focus on early childhood outcomes. The Osage

Nation notes that working in schools is especially valuable in rural areas, where long distances between home, school, and clinics can create challenges in accessing care.

Additional systems, including Tribal and state social services, court or juvenile justice systems, and programs for youth like Boys and Girls Clubs, may be valuable partners for Medicaid and Tribal providers or health systems. Care management programs, like the Sacred Child Project, a program of the Turtle Mountain Band of Chippewa Indians in North Dakota, provide comprehensive mental health and substance use disorder treatment services for youth with justice system involvement. Partnering with court systems, including Tribal courts, can identify youth who can benefit from behavioral health services. Medicaid can provide reimbursement for programs that address high-needs children, older youth, and their families, including [targeted case management](#) using the [Wraparound approach](#).

### Take time to cultivate relationships

Cultivating relationships across organizations helps build trust and collaboration. There are often more opportunities for Medicaid to support behavioral health services than Tribal leaders and providers may realize. Medicaid already may cover some services that Tribal programs offer but do not bill for (such as Wraparound), and it may be possible to expand Medicaid coverage to support specific Tribal priorities. Developing ongoing relationships affords Tribe and state Medicaid staff opportunities to meet regularly, educate each other about their work, and identify opportunities.

Building connections with Medicaid can be challenging for Tribal providers and leaders, however. Engaging with Medicaid requires providers to invest in technology to meet Medicaid billing and documentation requirements, learn new systems, and prepare for audits and other compliance-related requirements. Meeting in-person, showing respect for cultural differences, and being a consistent source of support can help mitigate these challenges.

State Medicaid staff should understand that people working in Tribal behavioral health or Indian child welfare place a high value on serving their communities and may have personal or family experiences with the programs. Showing respect for these connections and honoring [lived experience as a form of evidence](#) can help to build trust and create open conversations across organizations.

“I have some really good contacts in Medicaid in North Dakota. I’ve been to state meetings, and I know the Medicaid people, and they know me. They help me as much as they can.”

— Jan Birkland, Project Coordinator, Sacred Child Project

### Strengthen internal agency communication

Within health systems or behavioral health organizations — including those run by Tribes, Tribe members, and IHS — there may be a disconnect between staff who identify community needs and design programs, and staff who manage finance and reimbursement. Program staff may work with external partners, including state agencies, to identify sustainable financing opportunities for new, eligible services, but this information may not always reach their fiscal counterparts. Regular communication allows program staff to share opportunities for Medicaid to cover group therapy visits, helping fiscal staff identify what information is needed to submit claims. Conversely, fiscal staff may identify ongoing challenges in receiving timely reimbursement for certain services, prompting program staff to strengthen training to ensure accurate documentation and claims submission.

### Embrace creativity in program and policy design

The Medicaid program was not explicitly designed to support Tribal health systems or child welfare priorities, so there are not always clear answers to questions about coverage of programs designed for

members of Tribes. Staff in Medicaid and child protection agencies need to be aware of differences in rules, regulations, and evidence-based services for Tribes compared to non-Tribal providers. They also should consider how flexible interpretation of Medicaid policy, where possible, can help overcome challenges. David Simmons, director of government affairs and advocacy for the National Indian Child Welfare Association, said policy interpretation is sometimes outdated and may not reflect how policies *can* work. Oklahoma Medicaid, for example, does not directly reimburse [community health aides](#), but facilities that employ them can bill for their work under an existing Medicaid policy that allows billing under a supervising physician. Medicaid can make other creative changes by exploring waivers or state plan amendments.

“There is a real need for people to re-learn policy. There is discretion to do things differently and with more flexibility than they realize.”

— David Simmons, Director of Government Affairs and Advocacy, National Indian Child Welfare Association

James Baker, senior supervisor of Healing Horse Ranch, an equine therapy program of the Mandan, Hidatsa, Arikara Nation (MHA Nation) in North Dakota, said there is often a lack of understanding from people outside his community about the value of his work. Limited formal research on effective programs for Tribal communities means communities struggle to identify Medicaid-allowable programs that meet their needs. In the absence of robust research, use of lived experience and [community-defined evidence practice](#) can help inform reimbursement policy and decisions.

States also can help Tribes build their own evidence. DCYF in Washington state, for example, supports 10 pilot programs run by Tribes or Tribal organizations designed to serve children and families in their communities. Participating Tribes have explored many options for these pilot projects, including modifying existing programs like the [Positive Parenting Program](#) or [Positive Indian Parenting](#) to meet specific needs and dynamics, developing home visiting programs such as [Family Spirit](#), or creating social-emotional curriculum based on cultural practices such as [Healing of the Canoe](#). These pilot programs came about because state child welfare staff who work closely with and/or are Tribal members understood challenges and partnered with Tribes to pursue creative solutions.

### Promote intergenerational connections

Forced assimilation, erasure of Indigenous cultures and languages, and policies that promoted separation of Native American families have contributed to historical and [intergenerational trauma](#) and are precursors to the high levels of behavioral health conditions in Tribal communities. Legal and legislative remedies — like the [Indian Child Welfare Act](#), which recognizes the imperative to keep Native American children who are removed from their parents in their community, within their family, and within their culture — can help address these challenges.

Behavioral health programs can help address the community’s struggles by promoting culturally relevant care practices like intergenerational connections, peer support, and family support. Intergenerational relationships also play a particularly valuable role. [Elders and experienced community members](#) can serve as mentors to children and their families, and connect them to cultural and spiritual practices that promote resilience and support well-being.

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<sup>1</sup> The content of 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; Ashley Johnson, Tribal Relations Director, Oklahoma Health Care Authority, on September 5, 2025; Shannel Squally-Janzen, Tribal Prevention Services Specialist, Office of Tribal Relations, Washington State Department of Children, Youth, and Families, on September 26, 2025; Tara Reynon, Senior Program Director, and David Simmons, Director of Government Affairs and Advocacy,

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National Indian Child Welfare Association, October 10, 2025; James Baker, Senior Supervisor, Healing Horse Ranch, on October 21, 2025; and Jan Birkland, Project Coordinator, Sacred Child Project, on October 28, 2025.

<sup>2</sup> Although IHS and Urban Indian Organizations are key components of the Indian health care delivery system, this brief primarily focuses on programs run by Tribes or Tribal members on reservations or Tribal lands. These programs require strong government-to-government relationships between sovereign Tribal governments and the states they work with. Many lessons highlighted in this brief, however, may be applicable across all Indian Health Care Providers.

<sup>3</sup> Hinton, E. and Diana, A. (2024). [Medicaid Authorities and Options to Address Social Determinants of Health](#). KFF.

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