

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Review of Payment Options for Traditional Healing Services
(Resolution 106-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolution 106, which was sponsored by the Medical Student Section and asked for the American Medical Association to “study the impact of Medicaid waivers for managed care demonstration projects regarding implementation and reimbursement for traditional American Indian and Alaska Native healing practices provided in concert with physician-led healthcare teams.”

In 1883, the federal government established the Code of Indian Offenses to prosecute American Indians who participated in traditional ceremonies. The cultural identity of American Indian Tribes was restricted by such methods until 1978, when the American Indian Religious Freedom Act legalized traditional spirituality and ceremonies. As the cornerstone legal authority for the provision of health care to American Indians and Alaska Natives (AI/AN), the Indian Health Care Improvement Act (IHCA) was permanently authorized in 2010 to promote traditional health care practices, fulfill special trust responsibilities, and ensure the highest possible health status by providing all resources necessary to implement that policy.

Federal officials have called for Medicaid to improve its ability to provide culturally competent services to AI/AN beneficiaries and many Tribes have incorporated traditional healing services into their health care delivery. While Congress granted the Indian Health Service the ability to bill Medicaid, traditional healing services are not currently a Medicaid covered service. Accordingly, Section 1115 waivers provide a path forward. Currently, four states are pursuing Medicaid Section 1115 demonstration authority to cover traditional healing services furnished by Indian health providers to AI/AN Medicaid beneficiaries. The waiver requests seek the maximum amount of discretion to be given to Native and Indigenous communities to establish relevant programs for each community, while incorporating minimal federal requirements upon approval of the requests. The Council supports monitoring of Medicaid Section 1115 waivers that recognize the value of traditional AI/AN healing services as a mechanism for improving patient-centered care and health equity among AI/AN populations when coordinated with physician-led care.

For AI/AN communities, traditional healing practices are a fundamental element of Indian health care that helps individuals achieve wellness and restores emotional balance and one’s relationship with the environment. While traditional healing services are recognized by the IHCA, there is no statutory definition for traditional healing services, as they vary considerably among Tribes. The Council supports consultation with Tribes to facilitate the development of best practices and coordination of AI/AN traditional healing providers with the physician-led care team.

The value of traditional healing services is not easily quantified by a culture grounded in conventional medicine as it represents a spiritual tradition tied to lifestyle, community, sovereignty issues, and land and culture preservation. The history of AI/AN Tribes in the US involves dislocation and upheaval followed by sustained disregard for effective Indigenous practices based on a historic preference for conventional evidence-based medicine. As a result, barriers to traditional care services have been created by a lack of cultural competence among systems of care that fail to question how evidence has historically been defined.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-24

Subject: Review of Payment Options for Traditional Healing Services
(Resolution 106-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

1 At the 2023 Annual Meeting, the House of Delegates referred Resolution 106, which was
2 sponsored by the Medical Student Section. Resolution 106-A-23 asked for the American Medical
3 Association (AMA) to “study the impact of Medicaid waivers for managed care demonstration
4 projects regarding implementation and reimbursement for traditional American Indian and Alaska
5 Native (AI/AN) healing practices provided in concert with physician-led healthcare teams.”
6 Testimony was mixed for Resolution 106, with some recommending alternate language asking our
7 AMA to support Medicaid payment for traditional healing services and encourage involved
8 communities to adhere to a series of principles addressing traditional provider/facility
9 arrangements, covered services, and qualified providers. Others supported the resolution as written,
10 albeit with further study to recognize the need for cultural relevance while ensuring patient safety.
11 This report focuses on health equity and cultural competence in providing care for AI/AN
12 populations, examines coverage considerations, summarizes relevant Medicaid Section 1115
13 waiver requests, and presents new policy recommendations.

14 15 BACKGROUND

16
17 The [Office of Management and Budget](#) (OMB) defines an AI/AN individual as “a person having
18 origins in any of the original peoples of North and South America (including Central America) and
19 who maintains Tribal affiliation or community attachment.” American Indians and Alaska Natives
20 are a United States (US) census-defined racial group that also has a specific political and legal
21 classification. From 1778 to 1871, US relations with individual American Indian Nations
22 indigenous to what is now the US were established through the treaty-making process. The treaties
23 recognized unique sets of rights, benefits, and conditions for the Tribes who agreed to surrender
24 millions of acres to the U.S. in return for its protection. The US-American Indian treaties are
25 considered to be the foundation upon which federal Indian law and the [federal Indian trust
26 responsibility](#) is based. In *Seminole Nation v. United States (1942)*, the US “charged itself with
27 moral obligations of the highest responsibility and trust” toward Indian Tribes and accepted a
28 legally enforceable fiduciary obligation to protect Tribal treaty rights, lands, assets, and resources,
29 as well as a duty to carry out the mandates of federal law with respect to AI/AN Tribes and
30 villages.¹

31
32 In 1954, the [Transfer Act](#) moved responsibility for Indian health care from the Bureau of Indian
33 Affairs to the United States Public Health Service in the former Department of Health, Education,
34 and Welfare, currently known as the Department of Health and Human Services (HHS), creating
35 the Indian Health Service (IHS). The IHS was formed to provide federal health care services to

1 AI/AN populations based on the unique government-to-government relationship between the
 2 federal government and the Tribes established by treaties and codified in [Article I, Section 8 of the](#)
 3 [US Constitution](#). IHS funds and delivers health services through a network of programs and
 4 facilities, providing services free of charge to eligible individuals. IHS provides an array of direct
 5 health care services at its facilities and also refers beneficiaries to private providers for care through
 6 the Purchased/Referred Care Program when needed services are not available at IHS facilities.
 7 Eligibility is generally restricted to members of [federally recognized Tribes](#) and their descendants
 8 who live within the geographic service area of an IHS or Tribally operated facility, typically on or
 9 near a reservation or other trust land area.

10
 11 The [Snyder Act of 1921](#) provided explicit legislative authorization for federal health programs for
 12 AI/AN individuals by mandating the expenditure of funds for “the relief of distress and
 13 conservation of health...(and) for the employment of...physicians...for Indian Tribes.” The 1976
 14 [Indian Health Care Improvement Act](#) (IHCIA) is the cornerstone legal authority for the provision
 15 of health care to AI/AN populations. It was permanently authorized in March 2010 as part of the
 16 Patient Protection and Affordable Care Act (ACA) with the goal to “promote traditional health care
 17 practices of the Indian Tribes served consistent with the Service standards for the provision of
 18 health care, health promotion, and disease prevention” and “fulfill special trust responsibilities and
 19 legal obligations to Indians...to ensure the highest possible health status for Indians and urban
 20 Indians and to provide all resources necessary to effect that policy.”² The ACA included many
 21 AI/AN-specific provisions, such as greater flexibility in health insurance enrollment in the
 22 individual marketplace exchanges, limited or elimination of cost-sharing for health plans based on
 23 income, improved payment to IHS hospitals through Medicare, and promotion of traditional
 24 healing services. The legislation additionally facilitated the expansion of Medicaid, to the benefit of
 25 many AI/AN individuals. The Snyder Act and the permanent authorization of the IHCIA provide
 26 legislative authority for Congress to appropriate funds specifically for the health care of Indian
 27 people.

28
 29 Since Indian Tribes are political entities, they are considered sovereign nations participating in a
 30 government-to-government relationship with the US separate from the state regulatory structure.
 31 The federal government honors this unique relationship by adhering to 2021 [Executive Order](#)
 32 [13175](#), which requires federal agencies to engage in meaningful Tribal consultation. As a result of
 33 the Executive Order, HHS and the Centers for Medicare & Medicaid Services (CMS) each have a
 34 Tribal consultation policy. Depending on the nature of the policy at issue, states are subject to
 35 varying levels of Tribal consultation requirements. For example, [Section 5006 of the American](#)
 36 [Recovery and Reinvestment Act](#) requires that states must seek advice from designees of Indian
 37 health programs and urban Indian organizations in the state when Medicaid and Children’s Health
 38 Insurance Program (CHIP) matters have a direct effect on Indians, Indian health programs, or
 39 urban Indian programs. States are also required to describe the process for seeking advice from
 40 Indian health programs and urban Indian organizations in the Medicaid and CHIP state plans.

41
 42 IHS does not provide insurance coverage or offer a defined benefit package. Further, because it is
 43 not an entitlement program, IHS offers services to the extent permitted by its annual federal
 44 appropriation and a limited amount of revenue from other sources (e.g., payment from insurers
 45 such as Medicaid). While IHS was previously the only federal health program without advance
 46 appropriations, HHS successfully secured advance appropriations for IHS starting in 2024, which
 47 means that the majority of IHS-funded programs, including Tribal health programs and urban
 48 Indian organizations, will remain funded and operational in the event of an expiration of
 49 appropriations. The [Indian Health Manual](#) sets forth the policies, standards, and procedures for
 50 determining who falls within the scope of the IHS health care program. Generally, in order to
 51 receive IHS services, an individual must be a member of a federally recognized Tribe or an [Alaska](#)

1 [Native Claims Settlement Act](#) shareholder. Health care services unavailable at an
 2 IHS/Tribal/Urban facility can be provided by non-IHS health care facilities through the
 3 [Purchased/Referred Care \(PRC\) program](#). Since PRC payments are authorized based on clearly
 4 defined guidelines subject to availability of funds, services obtained under PRC must be prioritized,
 5 with life-threatening illnesses or injuries being given highest priority. Although there are no
 6 deductibles, coinsurance, or copayments for IHS services, insurance allows coverage for things
 7 such as specialty care, services without IHS PRC authorization, and care when away from home.

8
 9 AI/AN individuals who are eligible for health care through the IHS are also entitled to
 10 Medicaid/CHIP coverage if they meet the categorical and financial eligibility requirements of the
 11 Medicaid/CHIP program in the state in which they reside. When AI/AN individuals enroll in
 12 Medicaid/CHIP or a qualified health plan (QHP) available through the Marketplace, they can
 13 continue to receive services from their local Indian health care provider and can also access
 14 services from non-IHS providers that are participating providers in Medicaid/CHIP or the QHP
 15 provider network, respectively. [IHS and Tribal providers can generally bill QHP issuers or](#)
 16 [Medicaid/CHIP for services](#) provided to their patients, and these revenues can be used to pay for
 17 costs such as hiring health professionals, purchasing equipment, and meeting accreditation
 18 requirements. Medicaid plays a secondary but significant role in financing health services for the
 19 AI/AN population, as it provides health insurance coverage for many AI/AN people.³ In 2020, over
 20 1.8 million AI/AN individuals were enrolled in Medicaid, meaning almost one-fifth of the AI/AN
 21 population was covered by Medicaid.⁴ Services provided by IHS and Tribal physicians are also
 22 subject to a 100 percent Federal Medical Assistance Percentage. As such, Medicaid is an essential
 23 source of revenue for the facilities and programs that make up the IHS health care delivery system.

24
 25 AMERICAN INDIAN/ALASKA NATIVE TRADITIONAL HEALING SERVICES

26
 27 The value of AI/AN traditional healing services is often measured against modern medicine, or
 28 allopathy. Allopathy is the treatment of disease by conventional means and translates to “other than
 29 the disease.” Traditional healing is holistic and spiritual, with a focus on well-being and the
 30 promotion of health through ceremony-assisted treatments. Many modern medicines and treatments
 31 have Indigenous equivalents (e.g., aspirin is closely related to salicin found in willow bark) and
 32 studies have found that traditional healing is currently in wide-spread use,⁵ with documented
 33 effectiveness in diabetes mellitus populations.⁶

34
 35 A scoping review of the literature provides robust data regarding the utilization of AI/AN
 36 traditional healing services, integration of traditional and Western medicine systems, ceremonial
 37 practice for healing, and traditional healer perspectives.⁷ However, published systematic reviews
 38 appear limited to determining the effectiveness of AI/AN traditional healing in treating mental
 39 illness or substance use disorders. A 2016 systematic review searched four databases and reference
 40 lists for papers that explicitly measured the effectiveness of traditional healers on mental illness
 41 and psychological distress. While there was some evidence that traditional healers can provide an
 42 effective psychosocial intervention by helping to relieve distress and improve mild symptoms in
 43 common mental disorders such as depression and anxiety, they found little evidence to suggest that
 44 traditional healers change the course of severe mental illnesses such as bipolar and psychotic
 45 disorders.⁸ A 2023 systematic review assessed the feasibility of AI/AN traditional ceremonial
 46 practices to address substance use disorders in both reservation and urban settings. Between
 47 September 2021, and January 2022, culturally specific review protocols were applied to articles
 48 retrieved from over 160 electronic databases, with 10 studies meeting the criteria for inclusion in
 49 the review. While all 10 studies reported some type of quantitative data showing a reduction of
 50 substance use associated with traditional ceremonial practices, the fact that the current status of the
 51 literature is emerging did not allow for meta-analysis of existing studies.⁹

1 For AI/AN communities, traditional healing practices are a [fundamental element](#) of Indian health
2 care that helps individuals achieve wellness and restores emotional balance and one’s relationship
3 with the environment. While traditional healing services are recognized by the IHCIA, there is no
4 statutory definition for traditional healing services. Some Tribes believe that a health problem is an
5 imbalance between an individual and the community and there are seven natural ways of emotional
6 discharge and healing to address that imbalance: shaking, crying, laughing, sweating, voicing (i.e.,
7 talking, singing, hollering, yelling, screaming), kicking, and hitting, all of which must be done in a
8 constructive manner so as to not harm another spirit.¹⁰ Accordingly, Traditional AI/AN healing
9 services might include a range of services such as (but not limited to):

- 10
- 11 • Sweat lodges
- 12 • Healing hands
- 13 • Prayer
- 14 • Smudging and purification rituals
- 15 • Song and dance
- 16 • Use of herbal remedies
- 17 • Culturally sensitive and supportive counseling
- 18 • Shamanism
- 19

20 Traditional healers are often identified in their Tribal community by their innate gift of healing.
21 They typically work informally but may continue to uncover their unique gift through
22 apprenticeship and by observing more experienced healers. Many traditional healers do not charge
23 for their services but are given gifts as an expression of gratitude. Some healers will not accept
24 payment at all, especially when originating from a third-party.

25 HEALTH EQUITY CONSIDERATIONS

26
27
28 In 1883, the federal government established the [Code of Indian Offenses](#) to prosecute American
29 Indians who participated in traditional ceremonies in order to replace them with Christianity.¹¹
30 This was one of several methods utilized to restrict the cultural identity of American Indian Tribes
31 throughout US history. In 1978, the [American Indian Religious Freedom Act](#) (AIRFA) was a
32 pivotal turning point in addressing concerns regarding separation of church and state, legalizing
33 traditional spirituality and ceremonies, and overturning local and state regulations that had banned
34 AI/AN spiritual practices. In 1994, AIRFA was expanded to increase access to traditional healing
35 services such that “when an Indian Health Service patient requests assistance in obtaining the
36 services of a native practitioner, every effort will be made to comply...such efforts might include
37 contacting a native practitioner, providing space or privacy within a hospital room for a ceremony,
38 and/or the authorization of contract health care funds to pay for native healer consultation when
39 necessary.”

40
41 More recently, Congress recognized “provid[ing] the resources, processes, and structure that will
42 enable Indian Tribes and Tribal members to obtain the quantity and quality of health care services
43 and opportunities to eradicating health disparities between Indians and the general population of
44 the United States,” as a top national priority. After President Biden issued [Executive Order 13985](#)
45 in 2021 to establish equity as a cornerstone of Administration policy, the National Indian Health
46 Board (NIHB), supported by CMS and the CMS Tribal Technical Advisory Group (TTAG),
47 convened AI/AN leaders to consider what health equity means from a Tribal perspective. The
48 resulting [2022 NIHB report](#) similarly concluded that traditional healing is essential to advancing
49 health equity. The federal government issued a [second Executive Order](#) in 2023, to further build
50 equity into the business of government.

1 The 2022 NIHB report established that in pursuit of honoring Indigenous knowledge, traditional
 2 healing services should be paid utilizing paths to credentialing and billing that are Tribally led and
 3 approached with sensitivity and cultural humility. In [September 2023](#), the CMS TTAG wrote to the
 4 CMS Administrator urging the Biden-Harris Administration to develop CMS policy in support of
 5 funding and payment for traditional healing, which would “allow Tribes to use the additional third-
 6 party revenue to expand traditional healing services, coordinate the services within the facility, hire
 7 additional healers as appropriate, and create a space for ceremonial practices.”

8
 9 LESSONS LEARNED IN FOSTERING CULTURAL COMPETENCE

10
 11 In January 1952, two anthropologists and a physician from Cornell Medical College learned that
 12 tuberculosis raged untreated on the Navajo Reservation in Arizona. Recognizing a valuable
 13 opportunity for medical research, they designed and administered a ten-year demonstration to
 14 evaluate the efficacy of new antibiotics and test the power of modern medicine to improve the
 15 health conditions of a marginalized rural society. In 1970, they published a book detailing the
 16 demonstration and deeming the project a success, as it established a mechanism for effective,
 17 continued community control and elicited full participation by community members who expressed
 18 satisfaction with the care they received.¹² A 2002 analysis of the demonstration drew different
 19 conclusions, where “researchers exploited the opportunities made possible by the ill-health of a
 20 marginalized population...(and) erected an intrusive system of outpatient surveillance that failed to
 21 reduce the dominant causes of morbidity and mortality...(where) every act of treatment became an
 22 experiment (and) risked undermining the trust on which research and clinical care depended.”¹³
 23 However, the demonstration’s exploration of AI/AN traditional healing is perhaps the only
 24 semiquantitative approach to the subject and provides insights that remain useful today, as the
 25 demonstration recognized that “First, it must be realized that this is not a situation of compromising
 26 alternatives. Rather, there is belief on the part of patients that both systems have something to offer,
 27 they both ‘work.’”¹⁴

28
 29 Humility, which is at the core of AI/AN traditional healing, requires commitment to cultural
 30 connectedness, particularly when traditional healing services are provided in concert with
 31 allopathic/osteopathic care. While validated cultural connectedness measurement scales are
 32 available,¹⁵ there are tenets of traditional healing that can be successfully incorporated into any care
 33 coordination paradigm, such as providing multigenerational visits and home visits to reinforce the
 34 value of community-and family-based care or supporting a holistic approach to care through hands-
 35 on healing, physical body manipulation, and use of Indigenous diets to promote food as medicine.
 36 More AI/AN patients are embracing the opportunity to benefit from coordination between
 37 traditional healing and allopathic/osteopathic care. For example, in the Navajo Tribe, use of healers
 38 overlaps with use of medical providers for common medical conditions and patients rarely perceive
 39 conflict between the Native healer and conventional medicine.¹⁶ If traditional healing services are
 40 allied with the health system, care can be coordinated to accommodate individuals’ needs, leading
 41 to improved health outcomes.¹⁷ Furthermore, coordination, open communication, and transparency
 42 are critical to overcoming medical mistrust in modern medicine among AI/AN individuals.

43
 44 There are two areas where it is particularly important to further cultural sensitivity in the provision
 45 of traditional healing services:

- 46
 47 (1) Collecting data: While Indigenous Peoples need health data to help identify populations at risk
 48 and monitor the effectiveness of programs, health care centers and public health institutions
 49 [regularly overlook the AI/AN community when collecting data](#) and conducting research. Because
 50 some AI/AN patients are hesitant to allow the collection of their health care data by non-
 51 Indigenous individuals due to a lack of trust in how it might be used, this underrepresentation can

1 be magnified. Additionally, because Western research protocols do not prioritize providing benefits
 2 to the entire community, randomized clinical trials are often perceived as unacceptable and unfair
 3 as true randomization is difficult to apply when investigators have legacy relationships with certain
 4 individuals over others. The perception that control-group communities are receiving a lesser
 5 intervention, or none at all, can result in an ethical and cultural, and often stressful, struggle for
 6 both academic and community investigators.¹⁸

7
 8 (2) Credentialing traditional healers: As non-AI/AN protocols cannot be easily applied in
 9 determining necessary qualifications when it comes to traditional healing services, many Tribes
 10 have established distinct processes for credentialing traditional healers. A Tribal credentialing
 11 process might involve a multi-level training program where applications are reviewed by Tribal
 12 Elders, who then interview candidates before being considered by the Council of Elders. Given the
 13 wide variation among Tribes, many agree that it would be impractical to standardize the
 14 credentialing process. Furthermore, if traditional healing is governmentally regulated and licensed,
 15 then licensing boards will tell traditional healers what conditions they can and cannot treat, what
 16 methods are acceptable, and determine who is qualified, possibly challenging Tribal sovereignty.

17
 18 EFFORTS TO INTEGRATE TRADITIONAL HEALING SERVICES AND CONVENTIONAL
 19 MEDICINE

20
 21 Due to the fact that traditional healing services exist outside the paradigm of conventional medicine
 22 and vary across Tribes, they do not necessarily adhere to a conventional evidence-based standard of
 23 care. Ensuring patient safety and quality of care through the delivery of evidence-based medicine
 24 remains a top priority for the AMA. Accordingly, when it comes to traditional healing services or
 25 integrative medicine services, it is important to distinguish between welcoming the benefits of
 26 culturally competent/sensitive care as adjunctive or supportive and full acceptance of non-
 27 evidence-based medicine practices as substitutes for evidence-based medicine-derived treatments.
 28 In Canada and the US, there is a growing movement toward combining traditional healing services
 29 with conventional medicine. The “[wise practices](#)” model incorporates local knowledge, culture,
 30 language, and values into program design, implementation, and evaluation. This ensures that the
 31 local context is a formal component of determining program success, allowing for improved
 32 community engagement and increased community acceptance of programs. Wise practices allow
 33 Indigenous knowledge and principles to be incorporated into public health, academic, and policy
 34 settings.

35
 36 In 2020, the University of North Dakota launched the first of its kind [doctoral program in](#)
 37 [Indigenous health](#), offering students a deeper understanding of the unique health challenges faced
 38 by Indigenous communities. The training is focused on getting to know the community and its
 39 history to allow the provision of health care on reservations that is both evidence-based and
 40 culturally competent. That same year, [KFF](#) reported that IHS facilities were actively seeking job
 41 applicants for traditional healers toward rebuilding trust and recouping Indigenous expertise. In
 42 2022, a Federal Indian Health Insurance Plan was proposed in *Preventive Medicine Reports* that
 43 would offer a culturally competent, comprehensive health insurance product that would include
 44 payment for traditional healing services and eliminate premiums and all other forms of cost-sharing
 45 regardless of income.¹⁹ To-date, its legislative status is unknown.

46
 47 LEARNING FROM PAST CONSIDERATIONS OF ALTERNATIVE TREATMENT OPTIONS

48
 49 Developing an infrastructure to allow coverage for AI/AN traditional healing services could be
 50 informed by coverage considerations for other types of traditional healing services or integrative

1 medicine services, which have varying degrees of success in being covered by insurance and
2 differing evidence bases, many of which are still evolving as coverage expands.

3
4 Considerations surrounding coverage and payment for other types of alternative treatment include:

- 5
6
 - Patient safety/quality and outcomes oversight
 - 7 • Training, licensing, credentialing of providers
 - 8 • Benefit design and payment structure
 - 9 • Utilization uptake

10
11 Due to these and other considerations, insurance plans often have measures in place to ensure
12 patient safety and clinical effectiveness in exchange for payment. For example, many plans only
13 cover these services if prescribed by a physician or licensed practitioner as a demonstration of
14 clinical benefit to the patient. Most insurance plans utilize a team of clinical experts to review
15 which services meet their requirements for safety and effectiveness before offering coverage.

16
17 PURSUING PAYMENT FOR AI/AN TRADITIONAL HEALING SERVICES

18
19 Payment for the provision of AI/AN traditional healing services offers pathways for
20 complementary practices, improvements in safety of care coordination, and trust-building between
21 physicians and patients rooted in cultural sensitivity. Allowing payment for traditional healing
22 services will likely increase access for AI/AN patients. In situations where traditional healers are
23 unable to accept payment directly from patients, the payment can be given to the IHS facility,
24 which can utilize the funds to procure medical supplies, invest in capital (e.g., build a Navajo
25 Hogan), and pay the healers and other health care providers employed by the IHS.

26
27 During the August 2023 [Traditional Medicine Global Summit](#), the World Health Organization
28 (WHO) presented results from the third global survey on traditional medicine, which included
29 questions on financing of traditional medicine, health of Indigenous Peoples, evidence-based
30 traditional medicine, integration, and patient safety. In addition to informing the development of
31 [WHO's 2025-2034 traditional medicine strategy](#), these findings outline how standardization of
32 traditional medicine condition documentation and coding in routine health information systems is a
33 pre-requisite for effective implementation of traditional medicine in health care systems.

34
35 Payment for any health service usually requires establishing a coding infrastructure to allow
36 reporting in a standardized manner. The infrastructure includes both procedural and diagnosis
37 codes to answer the “what” and “why” of patient encounters, respectively. While there are
38 currently no procedure codes for AI/AN traditional healing services, in May 2023, Blue Cross Blue
39 Shield of Minnesota (BCBS MN) submitted an application for a [Healthcare Common Procedural
40 Coding System \(HCPCS\) Level II code](#) to allow AI/AN Medicaid and dual-eligible members to
41 receive and bill the health plan for traditional healing services. While approval of the code is
42 currently pending a decision by CMS, BCBS MN will plan to pilot it with four Native-led clinics
43 using an Indigenous evaluator to determine patient satisfaction, leaving it up to each clinic as to the
44 level of physician involvement. Each Native-led clinic will validate the traditional healing services
45 through its Elder in Residence, Elders Council, or Elders Advisory Board. The HCPCS Level II
46 code will be used to pay a capitated fee, viewed as administrative remuneration to offset the grant
47 amount. BCBS MN is currently required to use an unlisted Current Procedural Terminology
48 (CPT®) code to allow reporting of traditional healing services, which necessitates review of each
49 paper claim submission. The HCPCS Level II nomenclature includes code *S9900, Services by a
50 journal-listed Christian science practitioner for the purpose of healing, per diem*, which may serve
51 as a precedent to assist CMS in its decision. Another option could be a standard encounter fee, such

1 as the IHS [All Inclusive Rate](#) (AIR), which is the amount paid to IHS and Tribal facilities by CMS
 2 for Medicaid covered services per encounter (not per specific service). IHS reviews annual cost
 3 reports before submitting recommended rates to OMB for final approval through HHS. The
 4 approved AIRs are published in the *Federal Register* to allow annual updates to IHS systems. In
 5 lieu of a discrete HCPCS/CPT code, traditional healing services could be paid using an AIR.

6
 7 The WHO's *International Classification of Diseases, 11th Edition* (ICD-11) allows reporting of
 8 traditional medicine diagnoses, representing a formative step for the integration of traditional
 9 medicine conditions into a classification standard used in conventional medicine. As a tool for
 10 counting and comparing traditional medicine conditions, the ICD-11 [Traditional Medicine Chapter](#)
 11 can provide the means for doing research and evaluation to establish efficacy of traditional
 12 medicine and collect morbidity data (e.g., payment, patient safety, research).²⁰

13
 14 Additionally, the *International Classification of Diseases, 10th Edition, Clinical Modification*
 15 (ICD-10-CM), which is the Health Insurance Portability & Accountability Act diagnosis code set
 16 standard, includes social determinants of health (SDOH)-related Z codes (Z55-Z65). The Z codes
 17 can be reported when documentation specifies that a patient has an associated problem or risk
 18 factor that influences their health (e.g., housing insecurity or extreme poverty), thereby helping to
 19 improve equity in health care delivery and research by:

- 20
 21 • Empowering physicians to identify and address health disparities (e.g., care coordination
 22 and referrals)
 23 • Supporting planning and implementation of social needs interventions
 24 • Identifying community and population needs
 25 • Monitoring SDOH intervention effectiveness for patient outcomes
 26 • Utilizing data to advocate for updating and creating new policies

27
 28 Payment processes for traditional healing services should be culturally sensitive, to allow
 29 individuals to “recover one’s wholeness.” [The Anti-Deficiency Act](#) prevents the IHS from
 30 participating in risk-based contracts, as it prohibits expenditures in excess of amounts available in
 31 appropriations. Furthermore, a bundled payment model would not be logical as healers cannot be
 32 put at risk based on outcomes in an environment where collection of demographic-based outcome
 33 data is suspect. There are several possible options for a payment model, including:

- 34
 35 • Standard Encounter Fee: IHS, Tribal, or Urban Indian health facilities paid at the AIR per
 36 encounter rate available for Medicaid inpatient and outpatient hospital services for covered
 37 traditional healing services, with hospital services billed on a Uniform Billing Form (UB-
 38 04) at the OMB AIR using with the current rate published in the *Federal Register*.
 39 • Fee-for-Service: Payment based on traditional healing services provided to an individual
 40 AI/AN patient and reported by a HCPCS/CPT code(s) (e.g., BCBS MN pilot)
 41 • Member Benefit Allowance: Each eligible AI/AN patient receives an added value benefit
 42 to be spent on traditional healing services at their determination. This option could
 43 circumvent some Tribes’ inability to accept payment from a third party. The self-directed
 44 community benefit is currently utilized by the New Mexico Centennial Care 2.0 Medicaid
 45 Section 1115 waiver. Native American Healers is among the specialized therapies under
 46 the member-managed annual \$2,000 budget, allowing Tribal members to have access to an
 47 annual sum to use for traditional healing services.
 48 • Medicaid Section 1115 Waivers.

1 MEDICAID SECTION 1115 WAIVER REQUESTS

2
 3 Medicaid Section 1115 waivers may provide another path forward for payment of traditional
 4 healing services through conventional health care systems. While federal officials have called for
 5 state Medicaid programs to improve their ability to provide culturally competent services to AI/AN
 6 beneficiaries²¹ and Congress granted IHS the ability to bill Medicaid, traditional healing services
 7 are not currently a Medicaid nationally covered service. However, [Section 1115\(a\) of the Social](#)
 8 [Security Act](#) (SSA) authorizes the Secretary of HHS to waive provisions of Section 1902 of the
 9 SSA and grant expenditure authority to treat demonstration costs as federally matchable
 10 expenditures under Section 1903 of the SSA. The Secretary’s approval of experimental, pilot, or
 11 demonstration projects is discretionary and must be based on a finding that the demonstration is
 12 likely to assist in promoting the objectives of the Medicaid program.

13
 14 Medicaid Section 1115 waivers are initially approved for five years and renewable for three years
 15 at a time. The waivers are required to be budget-neutral, meaning that federal spending under the
 16 waiver cannot exceed what it would have been in absence of the waiver. Although not defined by
 17 federal statute or regulations, this requirement has been in practice for many years. Over time, CMS
 18 has allowed states to calculate budget neutrality in multiple ways, although [in 2018 it provided](#)
 19 [states with additional information](#) on agency policies regarding calculating budget neutrality.

20
 21 To date, four states (i.e., Arizona, California, New Mexico, and Oregon) have pursued Medicaid
 22 Section 1115 demonstration authority to cover traditional healing services furnished by Indian
 23 health providers to AI/AN Medicaid beneficiaries. In general, the waiver requests seek that the
 24 maximum amount of discretion be given to Native and Indigenous communities to establish
 25 relevant programs for each community, while allowing HHS to enact certain federal oversight
 26 requirements to ensure patient safety and program requirements are being met (e.g., background
 27 checks, verification of training, etc.) upon approval of the requests. The Center for Medicaid &
 28 CHIP Services (CMCS) is the agency charged with reviewing the state waiver requests with the
 29 goal of supporting cultural alignment of providers and patients toward reducing health disparities in
 30 the AI/AN community. CMCS has acknowledged the importance of incorporating Tribal
 31 leadership into the review process since traditional healing services vary across Tribes. Below is a
 32 summary of the current status of each state’s waiver application request.

33
 34 Arizona

35 It is expected that the Arizona waiver application will be considered by CMCS first – and then
 36 serve as the template for the other three states. The Arizona Health Care Cost Containment System
 37 (AHCCCS) initially submitted its [waiver request](#) in 2015 and then again in 2020, consulting with
 38 Tribal leadership prior to each submission. AHCCCS is requesting permission to pay for traditional
 39 healing services using [Title 19](#) dollars, maximizing individual Tribal communities’ discretion to
 40 define traditional healing services and qualifications for traditional healers. The request limits
 41 services to individuals served by the IHS and urban Indian facilities and proposes paying the AIR,
 42 which is annually established by the federal government. It also includes specific service
 43 parameters toward maximizing patient benefit and safety.

44
 45 California

46 The California Department of Health Care Services (DHCS) has requested authority to cover
 47 Traditional Healer and Natural Helper services under the Drug Medi-Cal Organized Delivery
 48 System (DMC-ODS) in 2017, 2020, and again in 2021. The most recent request includes
 49 Traditional Healer and Natural Helper services under the DMC-ODS as part of the comprehensive
 50 [California Advancing and Innovating Medi-Cal](#) initiative. The purpose of the request is to provide
 51 culturally appropriate options and improve access to substance use disorder (SUD) treatment for

1 AI/AN Medi-Cal members receiving SUD treatment services through Indian health care providers.
2 Meanwhile, DHCS provides funding and technical assistance resources to Tribal and urban Indian
3 health programs through the [Tribal MAT Project](#), including the [Tribal and Urban Indian](#)
4 [Community Defined Best Practices](#) program. Described by its lead entities as “a unified response to
5 the opioid crisis in California Indian Country,” the Tribal MAT Project was designed to meet the
6 specific opioid use disorder prevention, treatment, and recovery needs of California’s Tribal and
7 Urban Indian communities with special consideration for Tribal and urban Indian values, culture,
8 and treatments.

9
10 New Mexico

11 Since 2019, New Mexico’s [Centennial Care 2.0](#) Section 1115 demonstration has provided a self-
12 directed community budget for specialized therapies to members with a nursing-facility level of
13 care need (NF LOC) and who receive home and community-based services (HCBS). Native
14 American Healing is among the specialized therapies under the member-managed annual
15 \$2,000/member budget. All Tribal members with an NF LOC need are mandatorily enrolled in a
16 health plan. Tribal members ineligible for HCBS and who have enrolled in a health plan may have
17 access to an annual sum to use for traditional healing services; this arrangement is considered a
18 “value-added service”²² subject to the health plan to provide or place parameters on the benefit. In
19 2022, the New Mexico Human Services Department (HSD) submitted a waiver renewal application
20 seeking federal approval to renew and enhance the Centennial Care 2.0 waiver to expand the
21 availability of culturally competent, traditional healing benefits to AI/AN members enrolled in
22 managed care, up to \$500/member for traditional healing services to each Tribal member enrolled
23 in managed care and lacking an NF LOC need. HSD has hosted Tribal Listening Sessions to gather
24 feedback on the new Member-Directed Traditional Healing Benefits for Native Americans.

25
26 Oregon

27 In 2022, the [Oregon Health Plan](#) (OHP) submitted a Section 1115 waiver request to continue
28 foundational elements of the OHP with a substantial refocus on addressing health inequities,
29 including expanding benefits for AI/AN OHP members to include Tribal-based practices as a
30 covered service, and waive prior authorization criteria for Tribal members. The Oregon Health
31 Authority and the Oregon Tribes implemented a process by which [Tribal-based practices](#) are
32 developed and approved by the Tribal-Based Practice Review Panel, which is comprised of Tribal
33 representatives.

34
35 In reviewing the applications across the four states, CMCS’ goal is to identify commonality of
36 services that can be covered under Medicaid, provided by traditional healers who have been
37 credentialed within their communities. CMCS plans to pay for traditional healing services through
38 certified IHS facilities, who will then decide how the traditional healers are paid. It is not
39 anticipated that traditional healing will require a referral or prior authorization, as this limits access
40 to the service. CMCS is currently undergoing robust consultation with Tribes and IHS to identify
41 common traditional healing services, facilities where those services are being provided, and
42 providers who will provide them. Pending approval of the waivers, CMCS has expressed that it
43 would require each state to develop and report on benchmarks to demonstrate how it is improving
44 outcomes and reducing disparities, thereby requiring demonstration of value while allowing for
45 variation by state and by Tribe.

46
47 AMA POLICY

48
49 AMA Policy H-290.987 generally supports Section 1115 waivers that assist in promoting the goals
50 of the Medicaid program and have sufficient payment levels to secure adequate access to providers.

1 Policy H-350.949 encourages Medicaid managed care organizations to follow the CMS TTAG's
2 recommendations to improve care coordination and payment agreements with Indian health care
3 providers.
4

5 The AMA has several policies outlining the integral and culturally necessary role that traditional
6 healing services play in delivering health care to AI/AN individuals, including:
7

- 8 • Policy H-350.948, which advocates for increased funding to the IHS Purchased/Referred
9 Care Program and the Urban Indian Health Program to enable the programs to fully meet
10 the health care needs of AI/AN patients;
- 11 • Policy H-350.976, which recognizes the “medicine man” as an integral and culturally
12 necessary individual in delivering health care to American Indians and Alaska Natives; and
- 13 • Policy H-350.977, which supports expanding the role of the American Indian in their own
14 health care and increased involvement of private practitioners and facilities in American
15 Indian care.
16

17 The AMA has long-standing policy identifying, evaluating, and working to close health care
18 disparities, including:
19

- 20 • Policy D-350.995, which calls for a study of health system opportunities and barriers to
21 eliminating racial and ethnic disparities in health care;
- 22 • Policy D-350.996, which calls for the AMA to continue to identify and incorporate
23 strategies specific to the elimination of minority health care disparities in its ongoing
24 advocacy and public health efforts;
- 25 • Policy H-200.954, which supports efforts to quantify the geographic maldistribution of
26 physicians and encourages medical schools and residency programs to consider developing
27 admissions policies and practices and targeted educational efforts aimed at attracting
28 physicians to practice in underserved areas and to provide care to underserved populations;
29 and
- 30 • Policy H-350.974, which encourages the development of evidence-based performance
31 measures that adequately identify socioeconomic and racial/ethnic disparities in quality and
32 supports the use of evidence-based guidelines to promote the consistency and equity of
33 care for all persons.
34

35 Further, Policy H-480.973 encourages the National Center for Complementary and Integrative
36 Health to determine by objective and scientific evaluation the efficacy and safety of practices and
37 procedures of unconventional medicine.
38

39 DISCUSSION

40
41 Resolution 106-A-23 calls for the AMA to study the impact of using Medicaid Section 1115
42 waivers for demonstration projects regarding payment for AI/AN traditional healing services. The
43 Council recognizes the value of traditional healing services for AI/AN patients and understands the
44 need for state flexibility to design Medicaid programs that best respond to the health care needs of
45 their enrollees. The purpose of Section 1115 waivers, which give states additional flexibility to
46 design and improve their Medicaid programs, is to demonstrate and evaluate state-specific policy
47 approaches to better serving that state's unique population of Medicaid enrollees, including AI/AN
48 individuals. The Council acknowledges the importance of cultural competence, particularly with
49 regard to understanding traditional healing and its economic impact in the Section 1115 waiver
50 program, as it requires regular monitoring and independent evaluation of outcomes, which is

1 challenging to do while respecting Tribal data sovereignty. Additionally, it is uncertain how
2 generalizable outcomes might be given the vast differences among Tribes.

3 The Council understands the importance of distinguishing between culturally competent/sensitive
4 care as adjunctive or supportive and full acceptance of non-evidence-based medicine practices as
5 substitutes for evidence-based medicine-derived treatments. Further, with the Medicaid Section
6 1115 waiver demonstrations, we may find novel programs that are based on evidence. While
7 support of guidelines for coordinating traditional healing services as part of the physician-led
8 health care team was requested by Resolution 106-A-23 and is consistent with AMA policy,
9 decisions should be made in concert with Tribes in order to ensure inclusive and culturally relevant
10 care. Experts with whom the Council agrees have recommended that each Tribe be responsible for
11 verifying that valid traditional healing services have been performed by credentialed healers, taking
12 into account the “medical necessity” of the service along with the appropriate site of service (e.g.,
13 hogan versus hospital).

14
15 With many AI/AN patients utilizing traditional healing services,²³ patient safety will be maximized
16 if there is care coordination between Indigenous healers and physicians. The Council appreciates
17 the value of traditional healing services for AI/AN patients when provided in coordination with
18 evidence-based conventional medicine, and believes such coordination may allow the culturally
19 competent physician-led health care team to address Tribal social determinants of health while
20 building trust in conventional care systems among the AI/AN community. What cannot be
21 overlooked, however, is the substantial shortage of physicians [identifying as AI/AN](#). As of 2021,
22 fewer than 3,000 physicians – or 0.4 percent of total physicians – identified as American Indian or
23 Alaska Native, according to the latest statistics from the Association of American Medical Colleges
24 [Physician Specialty Data Report](#). The [US Government Accountability Office](#) published a report
25 outlining an average vacancy rate for IHS physicians, nurses, and other care providers of 25
26 percent. There would need to be more physicians who identify as AI/AN if the U.S. is to provide
27 culturally sensitive care implemented by a physician-led team utilizing a traditional healing model.
28

29 AI/AN traditional healing represents a spiritual tradition tied to lifestyle, community, sovereignty
30 issues, and land and culture preservation not easily explained by Western medicine. The history of
31 AI/AN Tribes in the US involves dislocation and upheaval followed by sustained disregard for
32 effective Indigenous practices based on a historic preference for conventional evidence-based
33 medicine. Barriers to care have been created by a lack of cultural competence among systems of
34 care that fail to question how evidence is defined.
35

36 It is critically important to remember that the US has a special responsibility to AI/AN populations
37 due to treaty obligations and sovereign nation status which differentiate AI/AN traditional healing
38 from other forms of traditional healing. The IHClA and resulting creation of the IHS establish clear
39 federal law plus a mandate to ensure the highest possible health status and to provide all resources
40 necessary for AI/AN populations.
41

42 RECOMMENDATIONS

43
44 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
45 106-A-23, and the remainder of the report be filed:

- 46
47 1. That our American Medical Association (AMA) amend Policy H-350.976 by addition and
48 deletion, and modify the title by addition, as follows:

49
50 Improving Health Care of American Indians and Alaska Natives H-350.976

- 1 (1) Our AMA recommends that: (1) All individuals, special interest groups, and levels of
2 government recognize the American Indian and Alaska Native people as full citizens of the
3 US, entitled to the same equal rights and privileges as other US citizens.
- 4 (2) The federal government provide sufficient funds to support needed health services for
5 American Indians and Alaska Natives.
- 6 (3) State and local governments give special attention to the health and health-related needs of
7 nonreservation American Indians and Alaska Natives in an effort to improve their quality of
8 life.
- 9 (4) American Indian and Alaska Native religious and cultural beliefs be recognized and
10 respected by those responsible for planning and providing services in Indian health programs.
- 11 (5) Our AMA recognize practitioners of Indigenous medicine as an integral and culturally
12 necessary individual in delivering health care to American Indians and Alaska Natives.
- 13 (6) Our AMA support monitoring of Medicaid Section 1115 waivers that recognize the value
14 of traditional American Indian and Alaska Native healing services as a mechanism for
15 improving patient-centered care and health equity among American Indian and Alaska Native
16 populations when coordinated with physician-led care.
- 17 (7) Our AMA support consultation with Tribes to facilitate the development of best practices,
18 including but not limited to culturally sensitive data collection, safety monitoring, the
19 development of payment methodologies, healer credentialing, and tracking of traditional
20 healing services utilization at Indian Health Service, Tribal, and Urban Indian Health
21 Programs.
- 22 ~~(68)~~ Strong emphasis be given to mental health programs for American Indians and Alaska
23 Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and
24 accidents.
- 25 ~~(79)~~ A team approach drawing from traditional health providers supplemented by psychiatric
26 social workers, health aides, visiting nurses, and health educators be utilized in solving these
27 problems.
- 28 ~~(810)~~ Our AMA continue its liaison with the Indian Health Service and the National Indian
29 Health Board and establish a liaison with the Association of American Indian Physicians.
- 30 ~~(911)~~ State and county medical associations establish liaisons with intertribal health councils in
31 those states where American Indians and Alaska Natives reside.
- 32 ~~(1012)~~ Our AMA supports and encourages further development and use of innovative delivery
33 systems and staffing configurations to meet American Indian and Alaska Native health needs
34 but opposes overemphasis on research for the sake of research, particularly if needed federal
35 funds are diverted from direct services for American Indians and Alaska Natives.
- 36 ~~(1113)~~ Our AMA strongly supports those bills before Congressional committees that aim to
37 improve the health of and health-related services provided to American Indians and Alaska
38 Natives and further recommends that members of appropriate AMA councils and committees
39 provide testimony in favor of effective legislation and proposed regulations. (Modify HOD
40 Policy)
- 41
- 42 2. That our AMA reaffirm Policy D-350.996, which states that the AMA will continue to identify
43 and incorporate strategies specific to the elimination of minority health care disparities in its
44 ongoing advocacy and public health efforts. (Reaffirm HOD Policy)
- 45
- 46 3. That our AMA reaffirm Policy H-200.954, which supports efforts to quantify the geographic
47 maldistribution of physicians and encourages medical schools and residency programs to
48 consider developing admissions policies and practices and targeted educational efforts aimed at
49 attracting physicians to practice in underserved areas and to provide care to underserved
50 populations. (Reaffirm HOD Policy)

- 1 4. That our AMA reaffirm Policy H-350.949, which encourages state Medicaid agencies to follow
2 the Centers for Medicare & Medicaid Services Tribal Technical Advisory Group’s
3 recommendations to improve care coordination and payment agreements between Medicaid
4 managed care organizations and Indian health care providers. (Reaffirm HOD Policy)
5
6 5. That our AMA reaffirm Policy H-350.977, which supports expanding the American Indian role
7 in their own health care and increased involvement of private practitioners and facilities in
8 American Indian health care through such mechanisms as agreements with Tribal leaders or
9 Indian Health Service contracts, as well as normal private practice relationships. (Reaffirm
10 HOD Policy)

Fiscal Note: Less than \$500.

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Council on Medical Service Report 3-A-24
Review of Payment Options for Traditional Healing Services
Policy Appendix

Strategies for Eliminating Minority Health Care Disparities D-350.996

Our American Medical Association (AMA) will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

Res. 731, I-02 Modified: CCB/CLRPD Rep. 4, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22

US Physician Shortage H-200.954

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
- (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
- (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
- (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
- (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
- (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
- (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
- (8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
- (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
- (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
- (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
- (12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
- (13) will work to augment the impact of initiatives to address rural physician workforce shortages.

(14) supports opportunities to incentivize physicians to select specialties and practice settings which involve delivery of health services to populations experiencing a shortage of providers, such as women, LGBTQ+ patients, children, elder adults, and patients with disabilities, including populations of such patients who do not live in underserved geographic areas

Res. 807, I-03 Reaffirmation I-06 Reaffirmed: CME Rep. 7, A-08 Appended: CME Rep. 4, A-10 Appended: CME Rep. 16, A-10 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 922, I-13 Modified: [CME Rep. 7, A-14 Reaffirmed: CME Rep. 03, A-16](#) Appended: Res. 323, A-19 Appended: [CME Rep. 3, I-21](#) Reaffirmation: I-22 Appended: Res. 105, A-23 Reaffirmed: BOT Rep. 11, A-23

Medicaid Waivers for Managed Care Demonstration Projects H-290.987

(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package. (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

Medicaid Managed Care for Indian Health Care Providers H-350.949

Our AMA will: (1) support stronger federal enforcement of Indian Health Care Medicaid Managed Care Provisions and other relevant laws to ensure state Medicaid agencies and their Medicaid managed care organizations (MCO) are in compliance with their legal obligations to Indian health care providers; and (2) encourage state Medicaid agencies to follow the Centers for Medicare and Medicaid Services Tribal Technical Advisory Group's recommendations to improve care coordination and payment agreements between Medicaid managed care organizations and Indian health care providers.

Res. 208, A-23

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the US, entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce

the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

CLRPD Rep. 3, I-98 Reaffirmed: Res. 221, A-07 Reaffirmation A-12 Reaffirmed: Res. 233, A-13 Reaffirmed: BOT Rep. 09, A-23

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

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