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 (IHCIA) 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 IHCIA, 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

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

BACKGROUND

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

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

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

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

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

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

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

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

AMERICAN INDIAN/ALASKA NATIVE TRADITIONAL HEALING SERVICES

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

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

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 IHCIA, there is no statutory definition for traditional healing services. Some Tribes believe that a health problem is an imbalance between an individual and the community and there are seven natural ways of emotional discharge and healing to address that imbalance: shaking, crying, laughing, sweating, voicing (i.e., talking, singing, hollering, yelling, screaming), kicking, and hitting, all of which must be done in a constructive manner so as to not harm another spirit.[10] Accordingly, Traditional AI/AN healing services might include a range of services such as (but not limited to):

- Sweat lodges
- Healing hands
- Prayer
- Smudging and purification rituals
- Song and dance
- Use of herbal remedies
- Culturally sensitive and supportive counseling
- Shamanism

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

HEALTH EQUITY CONSIDERATIONS

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

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

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

LESSONS LEARNED IN FOSTERING CULTURAL COMPETENCE

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

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

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

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

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

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

EFFORTS TO INTEGRATE TRADITIONAL HEALING SERVICES AND CONVENTIONAL MEDICINE

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

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

LEARNING FROM PAST CONSIDERATIONS OF ALTERNATIVE TREATMENT OPTIONS

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

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

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

- Patient safety/quality and outcomes oversight
- Training, licensing, credentialing of providers
- Benefit design and payment structure
- Utilization uptake

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

PURSUING PAYMENT FOR AI/AN TRADITIONAL HEALING SERVICES

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

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

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

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

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

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

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

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

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

MEDICAID SECTION 1115 WAIVER REQUESTS

Medicaid Section 1115 waivers may provide another path forward for payment of traditional healing services through conventional health care systems. While federal officials have called for state Medicaid programs to improve their ability to provide culturally competent services to AI/AN beneficiaries[21] and Congress granted IHS the ability to bill Medicaid, traditional healing services are not currently a Medicaid nationally covered service. However, Section 1115(a) of the Social Security Act (SSA) authorizes the Secretary of HHS to waive provisions of Section 1902 of the SSA and grant expenditure authority to treat demonstration costs as federally matchable expenditures under Section 1903 of the SSA. The Secretary's approval of experimental, pilot, or demonstration projects is discretionary and must be based on a finding that the demonstration is likely to assist in promoting the objectives of the Medicaid program.

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

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

Arizona

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

California

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

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

New Mexico

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

Oregon

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

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

AMA POLICY

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

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

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

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

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

- Policy D-350.995, which calls for a study of health system opportunities and barriers to eliminating racial and ethnic disparities in health care;
- Policy D-350.996, which calls for the AMA to continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts;
- Policy H-200.954, which supports efforts to quantify the geographic maldistribution of physicians and 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; and
- Policy H-350.974, which encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality and supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

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

DISCUSSION

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

challenging to do while respecting Tribal data sovereignty. Additionally, it is uncertain how generalizable outcomes might be given the vast differences among Tribes.
The Council understands the importance of distinguishing between culturally competent/sensitive care as adjunctive or supportive and full acceptance of non-evidence-based medicine practices as substitutes for evidence-based medicine-derived treatments. Further, with the Medicaid Section 1115 waiver demonstrations, we may find novel programs that are based on evidence. While support of guidelines for coordinating traditional healing services as part of the physician-led health care team was requested by Resolution 106-A-23 and is consistent with AMA policy, decisions should be made in concert with Tribes in order to ensure inclusive and culturally relevant care. Experts with whom the Council agrees have recommended that each Tribe be responsible for verifying that valid traditional healing services have been performed by credentialed healers, taking into account the "medical necessity" of the service along with the appropriate site of service (e.g., hogan versus hospital).

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

AI/AN traditional healing represents a spiritual tradition tied to lifestyle, community, sovereignty issues, and land and culture preservation not easily explained by Western medicine. 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. Barriers to care have been created by a lack of cultural competence among systems of care that fail to question how evidence is defined.

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

RECOMMENDATIONS

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

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

   Improving Health Care of American Indians <u>and Alaska Natives</u> H-350.976

(1) Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian and Alaska Native people as full citizens of the US, entitled to the same equal rights and privileges as other US citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians and Alaska Natives.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians and Alaska Natives in an effort to improve their quality of life.
(4) American Indian and Alaska Native religious and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize practitioners of Indigenous medicine as an integral and culturally necessary individual in delivering health care to American Indians and Alaska Natives.
(6) Our AMA support monitoring of Medicaid Section 1115 waivers that recognize the value of traditional American Indian and Alaska Native healing services as a mechanism for improving patient-centered care and health equity among American Indian and Alaska Native populations when coordinated with physician-led care.
(7) Our AMA support consultation with Tribes to facilitate the development of best practices, including but not limited to culturally sensitive data collection, safety monitoring, the development of payment methodologies, healer credentialing, and tracking of traditional healing services utilization at Indian Health Service, Tribal, and Urban Indian Health Programs.
(~~6~~8) Strong emphasis be given to mental health programs for American Indians and Alaska Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(~~7~~9) 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~~10) 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~~11) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians and Alaska Natives reside.
(~~10~~12) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian and Alaska Native 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 and Alaska Natives.
(~~11~~13) 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 Alaska Natives and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. (Modify HOD Policy)

2. That our AMA reaffirm Policy D-350.996, which states that the 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. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-200.954, which supports efforts to quantify the geographic maldistribution of physicians and 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. (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.

REFERENCES

[1] Allen, C, US Department of the Interior, Indian Affairs, "What is the Federal Trust Responsibility?" November 2017. Available at: https://www.bia.gov/faqs/what-federal-indian-trust-responsibility
[2] Declaration of national Indian health policy, U.S. Code 25 (2022), § 1602. https://www.govinfo.gov/app/details/USCODE-2022-title25/USCODE-2022-title25-chap18-other-sec1602.
[3] Medicaid's Role in Health Care for American Indians and Alaska Natives (IssueBrief) Medicaid and CHIP Payment and Access Commission; Washington, D.C.: 2021. Advising Congress on Medicaid and CHIP Policy. Available at: https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf
[4] Smith, H, National Council of Urban Indian Health, "An Overview of the Impact of Medicaid on Health Care of American Indians and Alaska Natives," June 2023. Available at: https://ncuih.org/2023/06/12/resource-an-overview-of-the-impact-of-medicaid-on-health-care-of-american-indians-and-alaska-natives/#:~:text=Medicaid%20Coverage%20in%20AI%2FAN%20Communities&text=In%202020%2C%20over%201.8%20million,the%20ages%20of%2019%2D64
[5] Redvers N, Blondin B (2020) Traditional Indigenous medicine in North America: A scoping review. PLoS ONE 15(8): e0237531. https://doi.org/10.1371/journal.pone.0237531
[6] Oster, R.T., Grier, A., Lightning, R. et al. Cultural continuity, traditional Indigenous language, and diabetes in Alberta First Nations: a mixed methods study. Int J Equity Health 13, 92 (2014). https://doi.org/10.1186/s12939-014-0092-4
[7] Redvers N, Blondin B (2020) Traditional Indigenous medicine in North America: A scoping review. PLoS ONE 15(8): e0237531. https://doi.org/10.1371/journal.pone.0237531
[8] Nortje G, Oladeji B, Gureje O, Seedat S. Effectiveness of traditional healers in treating mental disorders: a systematic review. Lancet Psychiatry. 2016 Feb;3(2):154-70. doi: 10.1016/S2215-0366(15)00515-5. PMID: 26851329.
[9] Chase-Begay DM, Peterson JC, Liddell J, Belcourt A. Traditional Ceremonial Practices as a Strategy to Reduce Problem Substance Use in American Indian Communities: A Systematic Review. J Integr Complement Med. 2023 Jun-Jul;29(6-7):408-419. doi: 10.1089/jicm.2022.0655. Epub 2023 Apr 10. PMID: 37229620; PMCID: PMC10280199.
[10] Hill, G, Lyle S. Hallman Faculty of Social Work, "A holistic aboriginal framework for individual healing," 2014. Available at: https://scholars.wlu.ca/cgi/viewcontent.cgi?article=1023&context=scwk_faculty#:~:text=There%20are%20seven%20natural%20ways,)%2C%20kicking%2C%20and%20hitting.
[11] Price, Hiram. Rules Governing The Court of Indian Offenses. March 30, 1883. https://commons.und.edu/indigenous-gov-docs/131/.
[12] Adair J, Deuschle KW, Barnett CR. The People's Health—Anthropology and Medicine in a Navajo Community. Albuquerque, NM: University of New Mexico Press; 1988.

[13] Jones DS. The health care experiments at Many Farms: the Navajo, tuberculosis, and the limits of modern medicine, 1952-1962. Bull Hist Med. 2002 Winter;76(4):749-90. doi: 10.1353/bhm.2002.0186. PMID: 124469g78.
[14] Virtual Mentor. 2009;11(10):793-798. doi: 10.1001/virtualmentor.2009.11.10.mhst1-0910. Available at: https://journalofethics.ama-assn.org/article/indian-health-service-and-traditional-indian-medicine/2009-10
[15] King J, Masotti P, Dennem J, Hadani S, Linton J, Lockhart B, Bartgis J. The Culture is Prevention Project: adapting the cultural connectedness scale for multi-tribal communities. Am Indian Alsk Native Ment Health Res. 2019:104–35. https://doi.org/10.5820/aian.2603.2019.104.
[16] Kim C, Kwok YS. Navajo Use of Native Healers. Arch Intern Med. 1998;158(20):2245–2249. doi:10.1001/archinte.158.20.2245. Available at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/210290
[17] Krah E, de Kruijf J, Ragno L. Integrating Traditional Healers into the Health Care System: Challenges and Opportunities in Rural Northern Ghana. J Community Health. 2018 Feb;43(1):157-163. doi: 10.1007/s10900-017-0398-4. PMID: 28681282; PMCID: PMC5767209. Available at: https://pubmed.ncbi.nlm.nih.gov/28681282/
[18] DL. Dickerson, J. Baldwin, A. Belcourt, L. Belone, J. Gittelsohn, K. Kaholokula, N. Wallerstein, Encompassing cultural contexts within scientific research methodologies in the development of health promotion interventions, Prevention Science (2018), 10.1007/s11121-018-0926-1, (PMCID: PMC6311146 doi: 10.1007/s11121-018-0926-1).
[19] Khetpal V, Roosevelt J Jr, Adashi EY. A Federal Indian Health Insurance Plan: Fulfilling a solemn obligation to American Indians and Alaska Natives in the United States. Prev Med Rep. 2021 Dec 16;25:101669. doi: 10.1016/j.pmedr.2021.101669. PMID: 34976706; PMCID: PMC8688870. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8688870/
[20] Reddy B, Fan AY. Incorporation of complementary and traditional medicine in ICD-11. BMC Med Inform Decis Mak. 2022 Jun 30;21(Suppl 6):381. doi: 10.1186/s12911-022-01913-7. PMID: 35773641; PMCID: PMC9248085. Available at: https://pubmed.ncbi.nlm.nih.gov/35773641/
[21] MACPAC Issue Brief, "Medicaid's Role in Health Care for American Indians and Alaska Natives," February 2021. Available at: https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf
[22] Additional specialized therapies include acupuncture, biofeedback, chiropractic services, hippotherapy, massage therapy, and naprapathy.
[23] Buchwald D, Beals J, Manson SM. Use of traditional health practices among Native Americans in a primary care setting. Med Care. 2000 Dec;38(12):1191-9. doi: 10.1097/00005650-200012000-00006. PMID: 11186298.

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.
CLRPD Rep. 3, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmation A-12 Reaffirmed: Res. 233, A-13 Appended: Res. 305, A-23 Reaffirmed: BOT Rep. 09, A-23