DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

October 16, 2024

Carmen Heredia
Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, Arizona 850934

Dear Director Heredia:

In accordance with section 1115(a) of the Social Security Act (the Act), the Centers for Medicare & Medicaid Services (CMS) is approving Arizona's request to amend the demonstration titled "Arizona Health Care Cost Containment System (AHCCCS)" (Project Number 11-W-00275/9) (the "demonstration"), to provide expenditure authority for coverage of traditional health care practices. This approval is effective from October 16, 2024, through September 30, 2027, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

With this amendment, Arizona will have expenditure authority to provide coverage for traditional health care practices received through Indian Health Service (IHS) facilities or facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) (here called Tribal facilities). Coverage of these traditional health care practices will be available to Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

We are pleased to approve this amendment, which is part of a groundbreaking demonstration initiative that is expected to promote the objectives of Medicaid by broadening the health coverage that can be furnished by states to Medicaid beneficiaries who are able to receive services delivered by or through IHS and Tribal facilities. This demonstration coverage is expected to be particularly impactful for American Indian and Alaska Native populations and individuals with physical or behavioral health needs because it is expected to improve their access to coverage of culturally appropriate health care. American Indian and Alaska Native traditional health care practices have historically been paid for and delivered by or through IHS or Tribal facilities but have not until now been covered or paid for by Medicaid. Medicaid payment for these services will promote access to care for American Indian and Alaska Native Medicaid beneficiaries and improve access to services at IHS and Tribal facilities.

CMS's approval is subject to the limitations specified in the attached expenditure authorities, special terms and conditions (STC), and any supplemental attachment defining the nature,

character, and extent of federal involvement in this project. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been identified in the attached expenditure authorities list as not applicable to expenditures under the amendment.

Section 1115(a) of the Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. This approval will permit CMS to evaluate the effects of providing Medicaid coverage for these traditional health care practices, which cannot currently be covered under the Medicaid state plans.

Extent and Scope of Demonstration Amendment

Background

Traditional health care practices are described by the World Health Organization as the "sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness."[1] American Indian and Alaska Natives have long recognized the contribution of traditional healers and practitioners who are valued for their role in aiding the healing process. There are 574 federally recognized Tribes in the United States,[2] each with its own traditional health care practices. Some Tribes, bands, groups, pueblos, rancherias, nations, colonies, or communities, including Native villages or Native groups, see traditional health care practices as a fundamental element of health care that can help patients with specific physical and mental ailments.

American Indians and Alaska Natives experience significantly worse health disparities as compared to the general population, including higher incidence and prevalence of obesity, diabetes, tobacco addiction, and cancer. In addition to significant physical health issues, American Indians and Alaska Natives face mental health illnesses, substance use disorders, and suicide rates that impact Tribal communities at rates significantly higher than the general population.[3] A number of factors contribute to these persistent disparities, including barriers to quality and timely medical care; geographic isolation; contemporary threats to culture, language, and lifeways; and lack of access to traditional foods.[4,5] However, several studies have demonstrated that traditional health care practices might help to improve mental health symptoms and outcomes and quality of life, including with respect to individuals with substance

[1] https://www.who.int/health-topics/traditional-complementary-and-integrative-medicine#tab=tab_1. NOTE: This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

[2] https://www.usa.gov/tribes#:~:text=The%20federal%20government%20recognizes%20574,and%20learn%20how%20to%20enroll

[3] https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf

[4] https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf

[5] https://minorityhealth.hhs.gov/american-indianalaska-native-health

use disorder.[6,7,8] Section 1115 demonstrations can therefore further test the effects of providing coverage for traditional health care practices in Medicaid.

The Indian Health Care Improvement Act (IHCIA) (25 U.S.C. 1601 *et seq*.) serves as one of the federal government's statutory authorities for IHS's provision of health care to American Indians and Alaska Natives and is based on the unique government-to-government relationship between the federal government and Indian Tribes. The United States Department of Health and Human Services promotion of traditional health care practices is authorized in the IHCIA at 25 U.S.C. 1680u.[9] Over the years, the provision of traditional health care practices has been supported primarily through IHS appropriations, Tribal resources, various pilot programs, and grant funding. Additionally, Medicaid is the largest source of third-party payment for services billed by IHS and Tribal facilities, accounting for nearly two-thirds of health coverage payments to these facilities.[10] Given the significant role of Medicaid as a payer for IHS and Tribal facility services, authorizing Medicaid payment to these facilities for traditional health care practices may potentially improve patient access to culturally appropriate practices to maintain and sustain health and otherwise support these facilities' ability to serve their patients.

As noted above, with this amendment, Arizona will have expenditure authority to provide coverage for traditional health care practices received through IHS or Tribal facilities by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.[11] CMS expects that this amendment will broaden the health coverage that can be furnished by states to these Medicaid beneficiaries. The amendment is also expected to expand utilization of these traditional health care practices and improve access to culturally appropriate care; support these facilities' ability to serve their patients; maintain and sustain health; improve health outcomes and the quality and experience of care; and reduce existing disparities in access to and quality of care and health outcomes. This amendment also aligns with this Administration's policy priorities articulated in the 2022 guidance and implementation memorandum for Federal Agencies on recognizing and including Indigenous Knowledge in Federal research, policy, and decision making.[12] Furthermore, this approval supports the CMS Tribal Technical Advisory Group (TTAG) Strategic Plan 2020-2025 Objective 1C, Task 4, which states that CMS will

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[6] https://ncuih.org/research/third-party-billing/
[7] https://pubmed.ncbi.nlm.nih.gov/26851329/
[8] https://pubmed.ncbi.nlm.nih.gov/24842541/
[9] 25 U.S.C. 1680u specifically provides that "the Secretary may promote traditional health care practices, consistent with the [IHS] standards for the provision of health care, health promotion, and disease prevention under [title 25, chapter 18 of the U.S. Code]."
https://uscode.house.gov/view.xhtml?req=(title:25%20section:1680u%20edition:prelim)%20OR%20(granuleid:USC-prelim-title25-section1680u)&f=treesort&edition=prelim&num=0&jumpTo=true.
[10] Assistant Secretary of Planning and Evaluation (ASPE),
How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives, Report No. HP-2022-21, (Washington, DC, 2022),
https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf
[11] Whether a beneficiary is able to receive services from a qualifying facility will be determined by the applicable facility. Under IHS authorities, IHS and Tribal facilities serve Medicaid and CHIP beneficiaries who are able (authorized) to receive services from the facility under IHS regulations at 42 CFR part 136, and also may serve other Medicaid and CHIP beneficiaries under 25 U.S.C. 1680c.
[12] https://www.whitehouse.gov/ceq/news-updates/2022/12/01/white-house-releases-first-of-a-kind-indigenous-knowledge-guidance-for-federal-agencies/

support work to evaluate, use, and inform states on how the use of state plan amendments, section 1115 demonstrations, or other demonstrations can improve access for Tribal citizens and other IHS-eligible individuals to timely health care services.[13] Lastly, Medicaid and CHIP provide health coverage for approximately 35 percent of all American Indian and Alaska Native nonelderly adults and more than 60 percent of American Indian and Alaska Native children.[14] Given the scope of the American Indian and Alaska Native population covered by Medicaid, this demonstration approval can play a key role in enhancing health equity for these populations.

Scope of Approval

Traditional health care practices vary widely by Tribe, facility, and geographic area. Under this amendment, traditional health care practices received through IHS or Tribal facilities will be covered when provided to a Medicaid beneficiary who is able to receive services delivered by or through these qualifying providers. Whether a beneficiary is able to receive services from a qualifying provider will be determined by the applicable provider. Purchased/referred care under 25 U.S.C. 1603(5) and 42 CFR 136.21(e) is included in this coverage. To be covered, the traditional health care practices must be provided by practitioners or providers who are employed by or contracted with one of these facilities (which could include an urban Indian organization contracted with an IHS or Tribal facility), in order to ensure that the practices are provided by culturally appropriate and qualified practitioners at facilities that are enrolled in Medicaid. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to the state, upon request. Each qualifying facility is responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices 1) is qualified to provide traditional health care practices to the qualifying facility's patients; and 2) has the necessary experience and appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request.

Because some of the traditional health care practices covered under this demonstration may be considered religious or may contain elements of religious or spiritual practices, the state must attest, as a condition of receiving federal matching funds for its expenditures under this approval, to: 1) providing adequate access to secular alternatives, including but not limited to preventive services, primary care, pharmacy services, mental health and substance use disorder services, as approved in its state plan, 1115 demonstration(s), or 1915 waiver(s), and in compliance with federal laws and regulations; 2) for any condition(s) addressed by and through covered traditional health care practices, ensuring beneficiaries have a genuine, independent choice to use other Medicaid- and CHIP-covered services; and 3) assuring that traditional health care practices may not be used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered under the state plan, 1115 demonstration(s), or 1915 waiver(s) and that the state will not

[13] https://www.cms.gov/files/document/ttag-strategic-plan-2020-2025.pdf
[14] https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/

deny access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. Provided that all other applicable requirements for claiming FFP have been met, the state may begin claiming FFP for its expenditures on traditional health care practices only after submitting this attestation to CMS. The state must notify beneficiaries of their rights to file grievances, complaints, and appeals related to this attestation and take any needed actions or monitoring, consistent with federal laws and regulations regarding grievances, complaints, and appeals. As per the STCs, the state must report any such grievances, complaints, and appeals to CMS in Monitoring Reports. CMS will review all reports and will follow up on credible concerns in those reports, as well as any credible concerns raised by members of the public. If the state is found to be out of compliance with the attestation and related STCs, CMS may: 1) require the state to submit a corrective action plan, 2) issue a deferral, or 3) withdraw authority for traditional health care practices.

Consistent with CMS's longstanding interpretation of section 1905(b) of the Act, the state will receive a 100 percent federal medical assistance percentage (FMAP) for its expenditures on the services for which coverage is authorized under this approval when those services are received through IHS or Tribal facilities by Medicaid beneficiaries who are American Indians or Alaska Natives.[15] State expenditures for these services when delivered by or through qualifying facilities to Medicaid beneficiaries who are not American Indians or Alaska Natives will be federally matched at the otherwise applicable state service match. Arizona is approved to cover traditional health care practices for any Medicaid beneficiary who is able to receive services delivered by or through IHS or Tribal facilities. Implementation of the amendment will be subject to the approval of the state legislature if the state is required to secure non-federal share for the expenditures authorized by this amendment.

As discussed in State Health Official letter #16-002, IHS facilities and facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act "may enter into care coordination agreements with [non-IHS or Tribal] providers to furnish certain services for their patients who are [American Indian and Alaska Native] Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching…of 100 percent."[16]

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a

[15] Section 1905(b) of the Social Security Act (third sentence). Under CMS's longstanding interpretation of this statutory language, the 100 percent FMAP applies only when services are received through IHS and Tribal facilities by American Indian or Alaska Native Medicaid beneficiaries.

[16] https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf.

balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 demonstration approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration, the "without waiver" (WOW) costs.

As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to-government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authority. This expenditure authority is not likely to increase overall expenditures beyond what those expenditures could have been without the demonstration. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid payment rate for most of these services will be the IHS All-Inclusive Rate that is published annually in the Federal Register.[17] CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral and will not require a specific budget neutrality expenditure sub-limit. The state will be held to the general monitoring and reporting requirements, as per the STCs, and will continue to be held accountable to the overall budget neutrality expenditure limit of the demonstration (for more information on CMS's current approach to budget neutrality, see State Medicaid Director letter #24-003). Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in the budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 6.

Requests Not Being Approved at this Time

Arizona requested to change the FMAP for services received through urban Indian organization facilities from the applicable state service match to 100 percent FMAP, without the use of a care coordination agreement as described in State Health Official letter #16-002. While section 1115 of the Act permits CMS to treat otherwise non-matchable expenditures as federally matchable, it does not permit CMS to alter the FMAP set forth in federal statute. Accordingly, CMS does not have authority under section 1115 of the Act to waive, modify, or make not applicable the parameters established under section 1905(b)'s third sentence with respect to the 100 percent FMAP for services received through IHS or Tribal facilities.

[17] See https://www.ihs.gov/businessoffice/reimbursement-rates/.

Monitoring and Evaluation

The state is required to conduct systematic monitoring and robust evaluation of the demonstration amendment in accordance with the STCs. In collaboration with CMS, the state must update its demonstration Monitoring Protocol to incorporate how it will monitor the amendment components, including relevant metrics data as well as narrative details describing progress with implementing the amendment.

The state is required to incorporate the amendment into its evaluation to support a comprehensive assessment of whether the initiatives are effective in producing the desired outcomes for beneficiaries and the state's overall Medicaid program. Evaluation of the amendment is expected to assess beneficiary awareness and understanding of traditional health care practices; access to, utilization and cost of traditional health care practices; quality and experience of care; and physical and behavioral health outcomes. Additionally, the state's monitoring and evaluation efforts must facilitate understanding the extent to which the amendment might support reducing existing disparities in access to and quality of care and health outcomes.

Consideration of Public Comments

Arizona met the requirements for public notice for the demonstration application and CMS deemed the application complete. The state's public comment period for the AHCCCS traditional health care practices request was held from October 2, 2020, through November 30, 2020. The federal comment period for this request was open from January 4, 2021, through February 3, 2021. A total of 12 comments were received through the federal comment period related to the traditional health care practices request. These comments came from a variety of advocacy organizations and Tribal government and health advocacy entities. All 12 comments supported the proposal's traditional health care practices provision given the health disparities faced by American Indian and Alaska Natives and emphasized the importance of providing culturally appropriate and responsive health care to these populations. Two commenters explained that traditional health care practices would be complementary to allopathic medicine. Another noted that this proposal would help fulfill the federal responsibility for American Indian health. Two commenters supported allowing each IHS, Tribal, or urban Indian organization facility to determine its traditional health care practices as a recognition of Tribal sovereignty. Another commenter noted that traditional health care practices are specifically authorized in section 831 of the Indian Health Care Improvement Act.

CMS also consulted with Tribal governments consistent with Executive Order 13175 and the CMS Tribal Consultation Policy by seeking advice and input from Tribal leaders on CMS policies that have Tribal implications. CMS obtained advice and input from the CMS Tribal Technical Advisory Group on July 26, 2023, and March 6, 2024. In addition, CMS held an All Tribes Consultation Webinar on April 3, 2024, and presented on this request during the Department of Health and Human Services Annual Budget Tribal Consultation Session on April 10, 2024. CMS requested Tribal comments from March 6, 2024, through May 3, 2024. A total of 26 comments were received through these consultation efforts that related to the traditional health care practices request.

Comments received through these consultations with Tribes were supportive of Medicaid coverage of traditional health care practices. However, some commenters advised CMS to be flexible in developing its approach to reviewing these demonstration proposals. The most prevalent themes in the comments supporting the demonstration amendments were that CMS needs to be flexible to honor Tribal sovereignty and that urban Indian organization facilities need to be included as they are a vital piece of the Indian health system and are sometimes the only facility accessible to American Indians or Alaska Natives. CMS has made efforts to be inclusive and flexible in its approach to approving traditional health care practices demonstrations and states may choose to include urban Indian organizations in these demonstrations.

During Tribal consultation, most commenters urged CMS to continue consulting with Tribes and conferring with urban Indian organizations on the design and implementation of demonstrations that would provide coverage of traditional health care practices. Commenters expressed concerns about CMS limiting coverage to only those services delivered by or through IHS or Tribal facilities because it would exclude services provided by urban Indian organization facilities. Commenters relayed during Tribal consultation that Tribal sovereignty requires CMS to let Tribal Nations decide what should be considered an appropriate traditional health care practice provided to their Tribal community. Commenters also wanted to clarify that traditional health care practices should include services provided outside of the four walls of a clinic. After receiving this feedback during the consultation process, CMS decided that urban Indian organizations could be a qualifying provider type option for states. Medicaid coverage and payment for clinic services furnished outside the four walls of a clinic is the topic of a separate CMS rulemaking and we will address comments on that topic as part of that rulemaking.[18] The services that can be covered under this approval are not "clinic services" within the meaning of section 1905(a)(9) of the Act, 42 CFR 440.90, or the pending separate CMS rulemaking; there is no requirement under this demonstration approval that, to be covered, traditional health care practices must be provided in the four walls of a qualifying facility. CMS will also permit IHS and Tribal facilities to determine the scope of services that they provide under this amendment, based on facilities' knowledge of these services and their patient populations.

During Tribal consultation, commenters agreed that using general standards to determine who is a qualified practitioner, including using a high-level position description, is important so that each facility can tailor provider qualifications for their traditional health care practitioners. Commenters expressed interest in how the traditional health care practices approved in demonstrations would align or deviate from the IHCIA and what is currently delivered by or through IHS, Tribal, or urban Indian organization facilities. CMS has developed an approach to approving traditional health care practices demonstration proposals that is intended to be as flexible as possible to allow qualifying facilities to determine practitioner qualifications and scope of practices. Consistent with the IHCIA, IHS, Tribal, and urban Indian organization

[18] https://www.federalregister.gov/documents/2024/07/22/2024-15087/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical

facilities currently furnish traditional health care practices consistent with the IHS "standards for the provision of health care, health promotion, and disease prevention."[19]

Commenters were highly supportive of providing implementation funding for evaluation activities. However, commenters recommend having Tribes and their practitioners direct demonstration evaluation activities so that they align with the cultural protocols for sharing information for each Tribe, in addition to providing flexibility to design the performance evaluations and customer service satisfaction surveys that are culturally appropriate. With this approval, states are encouraged to consult with Tribes and qualifying facilities on the development of evaluation activities.

Consistent with the government-to-government relationship, CMS is available to continue its dialogue with Tribal governments and the CMS Tribal Technical Advisory Group and to provide technical assistance, as needed.

Other Information

CMS's approval of this amendment is conditioned upon compliance with the enclosed amended set of expenditure authorities and STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Kate Friedman. She is available to answer any questions concerning this amendment. Ms. Friedman's contact information is as follows:

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We appreciate your state's commitment to improving the health of people in Arizona, and we look forward to partnering with you on the AHCCCS section 1115(a) demonstration. If you have questions regarding this approval, please contact Ms. Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

[19] 25 U.S.C. 1680u, at https://uscode.house.gov/view.xhtml?req=(title:25%20section:1680u%20edition:prelim)%20OR%20(granuleid:USC-prelim-title25-section1680u)&f=treesort&edition=prelim&num=0&jumpTo=true.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

Enclosures
cc: Brian Zolynas, State Monitoring Lead, Medicaid and CHIP Operations Group