Notice of Intent to Participate

Required Opt-In Template for Participating Traditional Health Care Practice Providers

Background

The New Mexico Health Care Authority (HCA), through the Medical Assistance Division (MAD), received approval from the Centers for Medicare & Medicaid Services to cover Traditional Health Care Practices (THCP) under the state's 1115 Demonstration Waiver.

THCP are delivered by or through Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (Tribal facilities), and facilities operated by Urban Indian Organizations under Title V of the Indian Health Care Improvement Act (UIO facilities).

HCA issued Letter of Direction (LOD) #69 to guide Turquoise Care Managed Care Organizations (MCOs) on THCP billing, reimbursement, and service delivery. LOD #69 establishes participating facilities' responsibilities, provider types, covered services, and reimbursement requirements. This Notice of Intent to Participate aligns THCP providers' participation with the policies in LOD #69.

Eligibility

To provide Traditional Health Care Practices and receive Medicaid payment under the 1115 Demonstration Waiver, an IHS or tribal facilities must:

1. Be enrolled as a New Mexico Medicaid provider;

   Note: If the facility is not currently enrolled as a Medicaid provider, complete enrollment first through the YesNM Portal at https://yes.nm.gov/nmhr/s/providers-and-ped?language=en_US before submitting this form.

2. Follow all requirements to provide THCP as described in LOD #69;
3. Submit and obtain HCA approval for an opt-in package using this template; and
4. Provide services as a Traditional Healer (TH) or Natural Helper (NH), as defined in LOD #69.

Note: THCP may be provided outside of New Mexico's 1115 authority (e.g., by Tribal or community programs), but this opt-in process specifically authorizes billing and reimbursement under the 1115 Demonstration Waiver.

Submission

Submit opt-in packages on tribal facility letterhead to: TCinfo@hca.nm.gov

HCA will review each opt-in package and determine approval. Only facilities whose opt-in submissions are approved by HCA may provide THCP services under the 1115 Demonstration Waiver and claim Medicaid reimbursement using the IHS All-Inclusive Rate (AIR).

Approved facilities should retain their approved opt-in package and HCA approval letter for their records.

Opt-In Template

1. Participating Site Information
Provide the following information for each site seeking to deliver TH or NH services:

Name of facility: _____

Facility address: _____

Organization NPI (Type 2): _____

Primary contact name: _____

Primary contact email: _____

Primary contact phone: _____

2. Medicaid Enrollment Status
Indicate whether the facility is enrolled as a Medicaid provider:

☐ **Yes.** Effective date: _____

☐ **No.** The facility cannot claim for TH or NH services without Medicaid enrollment.

3. Provider Types the Facility Will Offer
Please indicate which provider types your facility will offer (select all that apply):

❑ **Traditional Healer (TH):** A person recognized as a spiritual leader who is in good standing with a Native American Tribe, Nation, Band, or community and has at least 2 years of experience practicing in a Tribal-recognized setting.

❑ **Natural Helper (NH):** A health advisor who provides health, recovery, and social support services in the context of Tribal cultures and typically works in collaboration with or under the guidance of a TH.

Note: Both TH and NH practitioners must be employed or contracted by the participating IHS, Tribal, or UIO facility. Each participating facility is responsible for determining practitioner qualifications. Full definitions, scope, and qualification requirements are provided in LOD #69.

4. Policy Documentation Requirements
Participating facilities must provide documentation demonstrating their compliance with the 1115 Demonstration Waiver's Special Terms and Conditions and LOD #69. These requirements apply to all TH and NH practitioners providing THCP. Attach relevant policies for each area listed below. If a final policy is not yet in place, submit the draft policy and indicate the anticipated date of finalization.

a. **Practitioner Qualifications.** Policy or process for determining, reviewing, and approving qualifications for TH and NH.

   Document name/policy #: _____

   Copy attached: ☐

   Date of expected finalization (if draft):_____

a. **Care Coordination.** Policy or process ensuring that beneficiaries receiving THCP have access to other Medicaid services.

   Document name/policy #: _____

   Copy attached: ☐

   Date of expected finalization (if draft):_____

b. **Referral Processes.** Policy or process outlining referral or provision of additional services as needed.

   Document name/policy #: _____

   Copy attached: ☐

   Date of expected finalization (if draft): _____

5. Attestation

I, the authorized officer of _____ (facility name), attest under penalty of perjury that the information provided is accurate, complete, and truthful. I understand that HCA may request supporting documentation at any time, including during or after a review.

Facility Name: _____

Date: _____

Authorized Officer Name:_____

Print Title: _____

Authorized Officer Signature: _____

Date: _____