Gaps and Strategies to improve American Indian and Alaska Native Data in Medicare, Medicaid and SCHIP Data Bases

A Report for the
Center for Medicare and Medicaid Services
From the Technical Tribal Advisory Group

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I. Introduction

The purpose of the project is to improve and integrate Center for Medicare and Medicaid Services (CMS) and Indian Health Service (IHS) data so that they are useful for CMS program and policy analysis with respect to American Indian and Alaska Natives (AIAN) and IHS, tribal and urban Indian (I/T/U) providers of health care.[1] The project was funded by the CMS through a contract to the National Indian Health Board to address the need to evaluate data quality and make improvements in Medicare, Medicaid and SCHIP data related to AIAN populations and I/T/U providers.[2] The project goals as outlined in the CMS Technical Tribal Advisory Group (TTAG)[3] Strategic Plan of 2006 are:

- To evaluate gaps in the data bases for their usefulness for policy analysis and measuring performance of the CMS Medicare, Medicaid and SCHIP programs;

- To make specific recommendations on strategies for reducing gaps in data bases, generating useful program and policy reports, and training data users for AIAN populations and I/T/U providers.

- To recommend a budget for implementation of the recommendations that is to be forwarded to the CMS Administrator for implementation of recommendations in 2008.

What has been done to work on these goals between January and June 2007 with oversight provided by the Data Subcommittee of the CMS TTAG (participants listed in Appendix D) includes:

- Identification of key criteria for evaluating the extent to which CMS data bases have data useful for program performance and policy analysis from the perspective of AIAN populations and I/T/U providers;

- Systematic review of CMS data sets to assess the extent to which useful data items are available and adequate for identifying and monitoring measures of program performance and policy analysis;

- Analysis of data available in the federal CMS data bases to assess strengths and limitations of available data currently;

- Identification of gaps in the available data and current initiatives underway within IHS and CMS that may reduce these gaps, and strategies that, if implemented, could improve the availability and quality of data.

Guidance from CMS AIAN Strategic Plan

The CMS AIAN Strategic Plan gives the background for key criteria on CMS data for AIAN program performance and policy analysis**.** The key criteria for evaluating the extent to which CMS data bases have data useful for AIAN program performance and policy analysis stem from the Federal Trust Responsibility of the US Government with respect to health care,[4] as well as civil rights of US citizens, including racial minorities, to equitable health care and opportunities for equitable health status.

As a result of the Federal Trust Responsibility there are populations of AIAN who are federally recognized, and there is a unique health care system of providers for federally recognized AIAN who live on or near federally

[1] CMS AIAN Strategic Plan, 2006, page 48. www.cmsttag.org/policy.html
[2] CMS AIAN Strategic Plan, 2006, page 48. www.cmsttag.org/policy.html
[3] CMS Technical Tribal Advisory Group (TTAG) is defined on its website: www.cmsttag.org
[4] CMS AIAN Strategic Plan, 2006, page 13. www.cmsttag.org/policy.html

recognized tribal lands. The health care system is organized through the IHS of the Public Health Service, Department of Health and Human Services. The health facilities are operated either by the IHS or tribes. In addition Indian Health Organizations operate clinics in certain urban areas that are funded by IHS.

Medicaid and Medicare became part of the implementation of the Federal Trust Responsibility when in 1976 Congress authorized Medicare and Medicaid payment for services delivered by IHS and Tribal facilities through amendments to the Social Security Act made in the Indian Health Care Improvement Act of 1976 (P.L. 94-437).[5] These provisions established a role for CMS Medicare and Medicaid programs to:

- Determine eligibility and enroll eligible AIAN served by the I/T/U providers;
- Assure that the IHS-funded providers meet the standards of Medicare and Medicaid;
- See that a 100 percent Federal Medical Assistance Percentage (FMAP) to states would apply for Medicaid covered services delivered to Medicaid enrolled AIAN through IHS facilities, and later Tribal facilities;[6]
- See that IHS funded services do not substitute for those that those provided to Medicare and Medicaid eligible enrollees so that Medicare and Medicaid enhance revenues paid to IHS-funded facilities.

SCHIP became part of the implementation of the Federal Trust Responsibility when program benefits became available in 1997.

- Consistent with the Federal Trust Responsibility, IHS does not charge AI/AN who use IHS facilities for services and therefore does not charge AIAN eligible for Medicare, Medicaid, or SCHIP for co-pays or deductibles associated with that third-party coverage; Tribal and Urban providers strive to meet that responsibility as well, in spite of the further financial liability to their underfinanced services;
- AIAN who are experienced with the Federal Trust Responsibility are often perplexed by Medicare, Medicaid, or SCHIP premiums, co-pays and deductibles they face at enrollment for SCHIP, Health Plans, Supplemental Medicare coverage, or Drug Plans; or co-pays and deductibles when they need health care services not provided by I/T/U providers.

In addition to the Federal Trust Responsibility, Medicaid, Medicare and SCHIP share in the government's responsibility to see that health care that is financed by the government is equitably provided to populations within the US to eliminate racial disparities in health and access to health care.

Guidance from the Indian Health Care Improvement Act

The Indian Health Care Improvement Act of 2007 calls for on-going annual report with CMS data for AIAN program performance and policy analysis that includes:[7]

- Eligibles Enrolled
- Enrollees Served

[5] Memorandum of Agreement between the Indian Health Service and the Health Care Financing Administration, 1976. Available at: www.nihb.org/staticpages/index.php?page=200403301344371708

[6] A Memorandum of Agreement in 1996 clarified that this 100 percent FMAP to states also applies to tribally-operated P.L.93-638 facilities under contracts, grants or compacts. Urban facilities were not included in the Memo.

[7] Indian Health Care Improvement Act introduced for reauthorization 2007: HR1328, S1200: Section 209. Available at: www.nihb.org/article.php?story=20070426181149951

- Provider compliance with standards
- Benefits (includes Services provided and payments for services)
- Health Status

Opportunities with CMS Data

CMS already regularly collects, processes, analyzes and reports on data for program and policy analysis from three primary sources: 1) the people who apply and are established as eligible for a CMS program, and eligibles who use any services of a CMS program; 2) providers who are certified (licensed), and providers who submit claims for payment for any of the services of a CMS program provided to an eligible person; and 3) claims from providers for payment for services provided to an eligible person. The major categories of data collected for program and policy analysis through either surveys or administrative activities are routinely categorized as:

1. Eligibles Enrolled and Enrollees Served data (also called 'Enrollees,' 'Beneficiaries,' and 'Persons Served')
2. Providers data (health care professional people, facility types, and durable equipment suppliers)
3. Services data (hospital, outpatient, prescription, laboratory, etc.)
4. Payments data (fee-for-service, case management, administrative, etc)
5. Health Status data (days of stay, diagnoses, procedures, days of disability, etc)

This information could be used to answer program and policy questions that press upon AIAN and I/T/U providers such as:

> What percent of AIAN who use I/T/U providers are eligible for Medicare, Medicaid and SCHIP? How does this proportion vary with different state and federal policies? How has this proportion changed over the years?
>
> How do services paid by Medicare, Medicaid and SCHIP vary for AIAN who use I/T/U providers? Do I/T/U providers provide comparable levels of services to AIAN as providers to other Medicare, Medicaid and SCHIP enrollees? Are tribal and urban providers able to provide the AIAN who use their services comparable levels to those of IHS providers?
>
> What Medicare, Medicaid and SCHIP payments are lowest for AIAN who use I/T/U providers? Is this because it is harder to bill Medicare, Medicaid and SCHIP for these services than to use IHS funds?

On-going annual data reports could be developed for AIAN beneficiaries and I/T/U providers with useful measures for monitoring such program and policy impacts as thee over time if the data that CMS already collects were properly analyzed for AIAN and I/T/U.[8] In addition to routine annual reports, there are special reports tailored to specific program and policy questions that could be developed for AIAN and I/T/U, such as: determining the impact of Medicare Part D on prescription drug utilization.

Challenges with CMS Data

While CMS data resources are rich and promising, AIAN and I/T/U are often invisible in the data bases and the data reports. A recently completed analysis of gaps and strategies for improving AIAN data in DHHS

[8] For example see *CMS Statistics 2005.* Available at: www.cms.hhs.gov/CapMarketUpdates/Downloads/2005CMSStats.pdf

data bases listed the following widely recognized reasons that complicate AIAN data in DHHS data bases generally, and CMS data bases in particular:[9]

- Small total population sizes that result in inadequate sample sizes for surveys and some analyses;
- Misclassification of race on administrative data sets;
- Concentration of populations in rural areas and tribal lands that produce especially small samples;
- Privacy or confidentiality protection rules that limit use of small samples in geographically identified areas with scarce population;
- Lower participation in data collection methods due to language barrier, higher mobility, lack of telephones and cultural issues;

Overview of this Report

The report to follow first describes the data issues for identifying the AIAN populations and I/T/U providers that CMS TTAG recommended for Medicare, and then Medicaid and SCHIP data bases. Recommendations are made as to how the CMS TTAG definitions for AIAN and for I/T/U providers be implemented in data bases over time.

The report then applies the definitions for AIAN enrollees and I/T/U providers currently available in Medicare, Medicaid and SCHIP data bases, to present their Enrollment, Services, and Payments data useful for program and policy reports that we were able to tabulate for AIAN and I/T/U. For Medicaid we had access to actual electronic data and analyzed the data for AIAN and I/T/U providers. For Medicare we had tabulated data for AIAN Enrollment, but not Services or Payments, and not for I/T/U providers. We provide a review of Medicare data sets from which Provider, Service, Payment and Health Status data could be obtained. For SCHIP we had no electronic data for AIAN or for I/T/U providers, and we assess the extent to which useful data is available.

Finally the report provides a list of recommended strategies to improve and integrate CMS data bases with IHS data so that CMS data is more useful for program and policy reporting with respect to AIAN populations and I/T/U health care providers.

[9] Westat. Gaps and Strategies for Improving AI/AN/NA Data: Final Report. Under direction of the DHHS Office of the Assistant Secretary for Planning and Evaluation, Office of Human Services Policy. January 2007. Available at: http://aspe.hhs.gov/hsp/07/AI-AN-NA-data-gaps

II. CMS Data Gap Identifying AIAN

The extent to which CMS data is useful in measures of program performance and policy analysis from the perspective of AIAN depends first and foremost on how AIAN are identified. We present the recommended definitions for identifying AIAN suggested by the CMS TTAG, and then the gaps in defining AIAN in Medicare, Medicaid and SCHIP data bases given these definitions, followed by recommendations on how to reduce the data gaps for each CMS program.

CMS TTAG Recommended Definitions of 'AIAN'

The 2006 Strategic Plan of the CMS TTAG makes clear that there are three relevant definitions of AIAN useful in CMS program performance and policy analysis (Table 1).

Tribal AIAN. Enrolled members of federally-recognized tribes of American Indians and corporations of Alaska Natives have federal trust rights to health care. This is a political designation stemming from legal history and government-to-government relationships that is distinct from a racial group. These particular tribes and corporations numbering more than 560 are updated and published in the Federal Register in a list every year.[10] In addition, specified descendants of American Indians also have rights to health care.[11] Enrolled members of these federally-recognized tribes may or may not live near their tribal lands. To obtain health care they may have to return to their tribal homeland because IHS is a health care system related to tribal lands, not a third-party payer of care.

IHS AIAN. The second relevant population of AIAN is the IHS user population of active patients documented by the National Patient Information Registry System (NPIRS). These AIAN are registered locally with I/T/U facilities and therefore live on or near tribal lands, or in an urban area. Those AIAN registered locally (Active Registrants) are verified nationally by NPIRS and then annually assigned to one and only one facility to derive an allocated Active User Population.[12] It is the IHS user population of active patients verified by NPIRS, and not strictly the Active User population that is relevant to CMS, since the assignment of an active patient to only one facility nationally occurs regardless of any other facilities that provided them a CMS covered service during the year.

Census AIAN. The third relevant population is that of AIAN who self-identify with a Census racial classification of AIAN.[13] In the 2000 Census, people could indicate multiple races with which they identified themselves, therefore there are two groups of Census AIAN: those who self-identified their 'race' as only AIAN, and those who self-identified their 'race' as AIAN either alone, or in addition with one or more other racial categories.[14] The AIAN group with multiple races is 55% larger than the AIAN only group, but only 0.97% of the US population. Those included in the Census AIAN categories include American Indians born outside the US in North, South or Central America. AIAN born in or out of the US

[10] Bureau of Indian Affairs, Department of the Interior. "Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs." *Federal Register* March 22, 2007; Vol. 72, No. 55: pages 13648-52.
[11] There are also special groups of American Indians in California, certain Alaska Natives in Alaska, and other American Indians elsewhere with federal trust rights to health care that have been legally established as a result of special historic circumstances.
[12] The 'IHS Active User Population' is a more restrictive definition of AIAN than 'IHS user population of active patients' since the former obtains an annual unduplicated count for all I/T/U providers by assigning each AIAN who has had a medical or dental reportable visit within the last three fiscal years to the last Service Unit they used, regardless of any other Service Units that provided a third-party covered service to the user. The IHS Active User Population is used for allocating IHS funds to I/T/U facilities.
[13] Ogunwole SU. American Indian and Alaska Native Population: 2000. Census 2000 Brief February 2002. This report is available on the U.S. Census Bureau's Internet site at www.census.gov/prod /2002pubs/c2kbr01-15.pdf.
[14] Jones N. We the People of More Than One Race in the United States. Census 2000 Special Reports, April 2005. This report is available on the U.S. Census Bureau's Internet site at www.census.gov/prod /2005pubs/censr-28.pdf

can self-identify their Hispanic (Latino) ethnicity separately from their race. These are the 1997 Office of the Management of the Budget (OMB) standards for collecting racial information.

Table 1. AIAN definitions recommended for CMS by TTAG Strategic Plan.

Definition	Who is Included	How Inclusion Determined	Estimated Population in 2006
Tribal	Enrolled member of federally-recognized Tribes	Tribes	1.8 million
Indian Health Service	IHS user population of active patients (AIAN who live close to I/T facilities and are enrolled members of federally-recognized Tribes)	I/T Facilities and IHS NPIRS	1.6 million
Census	Self-identified 'race' as only AIAN*	Person completing Census	2.9 million
	Self-identified 'race' as AIAN* alone or in addition to other racial categories	Person completing Census	4.5 million

*Race is separate from Ethnicity (Hispanic/Latino) in the Census following the 1997 standards of the Office of the Management of the Budget (OMB).

While the definitions of AIAN that are desirable for program performance and policy analysis are based on tribal membership, I/T/U facility utilization, and Census racial definitions (described in Table 1), the definitions of AIAN in CMS data bases are only racial, and are not the same as in the Census (Table 2). Neither Medicare nor Medicaid/SCHIP data bases collect AIAN tribal membership information. Medicare and Medicaid/SCHIP data bases each has a different way of including AIAN IHS User and AIAN racial information.

Medicare is primarily a health benefit to people with Social Security benefits (both aged and disabled). Racial information on enrollees is obtained when people apply for a Social Security number or card, usually long before they are eligible for Medicare. Medicaid and SCHIP are health benefits primarily determined by state programs for low income, aged, and disabled individuals with some terms of coverage that are federally mandated and others that are optional features. In neither case does CMS directly register the beneficiaries in the CMS program, and therefore in neither case does CMS have an opportunity to have the individual enrolling in the program identify to the federal CMS their Census race category, let alone their tribal membership or I/T/U utilization.

Table 2. Current CMS Data Base definitions of AIAN Beneficiaries, and possible CMS Data Sources for TTAG recommended definitions in Table 1.

Definition	Who is Included	How Inclusion Determined	Possible CMS Data Source	
			Medicare	**Medicaid, SCHIP**
Tribal	Enrolled member of federally-recognized Tribes	Tribes (age of enrollment varies by tribe)	Enrollment Data Base (EDB): Eligibility or IHS-Medicare Exchange new data item	Medicaid Statistical Information System (MSIS): new Eligibility data item
Indian Health Service	IHS active user population (AIAN who live close to I/T facilities and are enrolled members of federally-recognized Tribes)	I/T/U Facilities and IHS NPIRS	EDB: already collected in IHS-Medicare Exchange, Race Code Source	MSIS: New Claims data item to indicate AIAN user of I/T/U facility
Census	Self-identified 'race' as only AIAN	Person completing Census	New fields in Social Security Administration, or Medicare Enrollment data sources	MSIS already collects this Race Code
	Self-identified 'race' as AIAN alone or in addition to other racial categories	Person completing Census		MSIS: use available Race Code questions to make new Multi-Race Code data item
Current Medicare	Enrollment Data Base (EDB) Race Code = North American Native, and not Hispanic/Latino Ethnicity.	Person Completing Forms	EDB	Not Applicable
Current Medicaid, SCHIP	MSIS State Summary online data mart Race Code = AIAN, and not Hispanic/Latino Ethnicity.	Person Completing Forms	Not Applicable	MSIS State Summary Data Mart online

We next describe for Medicare and Medicaid how data that defines AIAN beneficiaries is obtained, and how data gaps in defining AIAN beneficiaries arise as a result. We also suggest strategies for data collection efforts that could reduce the gaps.

Medicare Data Gaps Defining AIAN Beneficiaries

The Medicare Enrollment Data Base (EDB) is the sole source of beneficiary race information included in any Medicare data base. The current definition for AIAN on the Enrollment Data Base is a race code, but it is not classified in a way consistent with Census race categories. The main problem is that racial information is not collected by Medicare in a consistent way. Another problem is that the final race code for AIAN is, 'North American Native.' This designation technically includes Canadian, and excludes Central and South American. Mexican and southwest US indigenous Indians must choose between Hispanic/Latino and North American Native. Only 33% of beneficiaries self-identified as AIAN in the Medical Beneficiary Survey were identified as AIAN in Medicare data bases in 2002.[15]

Medicare relies to a great extent on the Social Security Administration for racial data on its beneficiaries in the Enrollment Data Base. The Social Security Administration remains responsible for certifying that an individual is eligible for Medicare and for transmitting demographic information about that individual, including race, to Medicare. To understand the data gap that this creates for AIAN it is important to outline the acquisition of race data by the Social Security Administration:

[15] McBean AM. Medicare Brief: Improving Medicare's Data on Race and Ethnicity. National Academy of Social Insurance. No. 15. October 2006.

The racial data that the Social Security Administration *routinely* obtains and provides Medicare has only four racial categories: White, Black, Other and Unknown. Prior to 1980 when most current Medicare beneficiaries applied for a Social Security card, they completed a form (Form SS-5) with only these choices for indicating their race. If race was left unchecked, the Social Security Administration Master Beneficiary Record for every person categorized the person as of 'Unknown' race. The Social Security Administration uses the Master Beneficiary Record to transmit a record to CMS for each new Medicare beneficiary. In turn, Medicare creates a record in its Enrollment Data Base with this limited race information. For the vast majority of current Medicare beneficiaries who applied for a Social Security card before 1980 this is the primary source of race information. As a further compromise of the validity of racial information, spouses and other 'auxiliary' beneficiaries who do not apply for their own Social Security benefits are assigned the race of the wage earner. Nearly 18 percent of Medicare beneficiaries fell under the category of 'auxiliary' beneficiaries in 2001.[16] After being assigned a Social Security number, a person submits a new Form SS-5 only when seeking a replacement Social Security card or changing personal information (for example, changing a name because of marriage).

Even though in 1980 the 'Other' category of Form SS-5 was replaced by three additional race and ethnicity categories two of which were 'North American Native' and 'Hispanic,' the Social Security Administration Master Beneficiary Record did not establish new data codes for this information. Therefore the Master Beneficiary Record continues to provide Medicare the new racial data collapsed into the old "Other" data code, and loses even this limited racial information identifying AIAN.

One of the groups contributing to the Unknown category is that of former railroad workers who enroll with Social Security and Medicare through the Railroad Retirement Board.[17] The Railroad Retirement Board does not collect information on race.

Starting in 1989 Social Security Administration policy was to enable parents to register infants at birth. When applying for a birth certificate, parents are also given an application for a Social Security number for their newborn. Race collected on these forms reverts to the four racial categories: White, Black, Other and Unknown.

To reduce the incompleteness of the Social Security Administration racial data, Medicare has undertaken updates of the Enrollment Data Base. One update was a one-time survey begun in 1995 of beneficiaries with data codes of 'Other' or 'Unknown' for the 'Beneficiary Race Code' data item and to those with a Hispanic surname.

Another update of the Enrollment Data Base is that of the Numerical Identification (Numident) file of the Social Security Administration. The Numident file is the Master File of Social Security Number Holders and Applications and contains the expanded race codes of the 1980 version of Form SS-5 in which AIAN are categorized as 'North American Native.' As a result of these updates there was a redistribution of people from the Other and the Unknown categories to the three additional race and ethnicity categories, including a 68% increase in 'North American Natives' from 1996 to 1997.[18] Medicare continues to use the Numident file periodically to update the their Enrollment Data Base even though the regular system for transferring information from the Social Security Administration to Medicare is still the Social Security Administration Master Beneficiary Record (in which AIAN are collapsed into 'Other').

[16]Arday SL, et al. "HCFA's Racial and Ethnic Data: Current Accuracy and Recent Improvements," *Health Care Financing Review* 21 (Summer 2000):107–108.
[17]Railroad Retirement Board, Benefit Information, Forms and Instructions. Avaliable at: www.rrb.gov/default.asp
[18]McBean AM. Medicare Brief: Improving Medicare's Data on Race and Ethnicity. National Academy of Social Insurance. No. 15. October 2006.

To further reduce the incompleteness of AIAN racial data, Medicare began to conduct periodic updates of the Enrollment Data Base with data from the IHS in 1999. Through an interagency agreement for data file exchange,[19] IHS identifies in a file sent by Medicare to IHS which of its beneficiaries meet the IHS criteria for AIAN in their National Patient Information Registry System (NPIRS).[20] As a result of the file exchange there was nearly a three-fold increase in AIAN beneficiaries in the Medicare Enrollment Data Base from 54,000 to 152,000 by 2003.[21]

Medicare uses this IHS "Indian-only" file for the purpose of improving the racial classification of AIAN in its Race data item (Beneficiary Race Code). If the beneficiary race code in the Medicare Enrollment Data Base is updated with information from the IHS, then a special data code in the 'Beneficiary Race Code Source' indicates the source of the racial information. Medicare does not update data in the Beneficiary Race Code with the Numident race data if it has already been updated with information from the IHS (or the 1995 special beneficiary survey described above which is also tracked by the 'Beneficiary Race Code Source'). The intent is to perform this Exchange four times a year, however, it usually takes longer to complete the multiple steps of the Exchange and therefore it is done less frequently.

Table 3. Medicare Eligibles Enrolled in 50 states by Race-Ethnicity Categories in the Enrollment Data Base.

		Medicare Eligibles Enrolled	
Race-Ethnicity	**Code**	**Number**	**Percent of Total**
White - non-Hispanic	1	36,234,731	83.6%
Black - non-Hispanic	2	4,320,124	10.0%
'North American' Indian - non-Hispanic = 'AIAN'	3	179,794	0.4%
Asian/Pacific Islander - non-Hispanic	4	759,763	1.8%
Hispanic	5	1,045,902	2.4%
Other Race-ethnicities(s)	6	722,110	1.7%
Unknown	9	76,147	0.2%
Total		43,338,571	100.0%

Data Source: *Medicare Enrollment Tables 2006*, Table 2: Data as of July 1, 2006, Job Name MC29TAB1, page 1-04; CMS Office of Research, Development and Information.

While Medicare improves the racial classification of AIAN in its Enrollment Data Base with this information, the IHS uses the exchange to verify the Medicare enrollment of people served by I/T/U providers in each of their 12 administrative Areas (Figure 1). Two files for every Area are sent to the Area offices for them to use as desired. At the national level, the records in the Enrollment Data Base extract file are matched to the NPIRS CHART table. A new record is written for each user found in the Enrollment Data Base extract file and written to the IHS Area Update File.

[19] The intent of HCFA IA # IA-00-38 agreement is to facilitate an exchange of goods services, and information between IHS and CMS. IHS receives Medicare enrollment data to establish an accurate data base for IHS. In return, IHS provides CMS with detailed AIAN specific information to help better identify AIAN beneficiaries in the Enrollment Data Base.

[20] Begay N, Petrakos. Indian Health Service, Information Technology Support Center. The National Patient Information Registry System NPIRS – HCFA Medicare Eligibility Match Requirements Document (Revision 1.1). March 2001.

[21] McBean AM. Medicare Brief: Improving Medicare's Data on Race and Ethnicity. National Academy of Social Insurance. No. 15. October 2006.

The IHS definition of 'AIAN' in the data file that is returned to Medicare involves three data items from their Registry: 'Tribe' is federally recognized,[22] or 'IHS Beneficiary Classification' code is "Indian or Alaskan Native," or the 'Blood Quantum' code indicates any amount of blood relationship that is a descendant of an AIAN.[23] Any Medicare beneficiary identification number may belong to multiple records in the IHS Registry data base because most IHS beneficiaries are registered at more than one I/T/U provider facility. If *any* of the person's registration records meet the IHS definition requirements of an AIAN, IHS returns to Medicare a file that includes no information from the Registry except the IHS identification code, the Verified Social Security Number and Gender from the Registry.

- ***Recommendations to Reduce Medicare Data Gaps Defining 'Tribal AIAN'***

  - IHS and CMS should work together to expand the CMS-IHS Data Exchange so that the 'IHS code' in the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base is expanded to indicate 'Tribal AIAN.' In the Medicare Return File of the data exchange, IHS should include a data item on whether or not each Medicare beneficiary is a Tribal AIAN or their descendant entitled to health care through federal trust, and government-to-government derived rights.

  - CMS should include the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base in all linkages of the Enrollment Data Base to other Medicare data bases so that any Medicare data base intended for analysis of beneficiary information could be analyzed for Tribal AIAN beneficiaries.

  - CMS should examine the feasibility, costs and relative effectiveness of having a question added to the following to obtain Tribal AIAN information conforming to IHS Tribe codes that indicate tribes entitled to health care through federal trust, and government-to-government derived rights:
    - At time of application for birth certificate, and arrange for information to be exchanged with the Social Security Administration during the Enumeration at Birth
    - At time of application for Social Security card (Form SS-5) [and specify evidence required to document the information]
    - At time of application to enroll in Medicare [and specify evidence required to document the information]
    - Add Question to Medicare Beneficiary
    - Perform a special Medicare Beneficiary survey of AIAN designated by Medicare Beneficiary Race Code

- ***Recommendations to Reduce Medicare Data Gaps Defining 'IHS AIAN'***

  - CMS should make available the Beneficiary Race Source Code data item with the Medicare Enrollment Data Base for use of the current 'IHS code' in designating IHS AIAN beneficiaries in Medicare.

  - CMS should include the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base in all linkages of the Enrollment Data Base to other Medicare data bases so that any Medicare

[22] Through the Indian Health care Improvement Act of 1976 a special classification of American Indians was federally recognized in California.

[23] IHS Tribe code values and Indian Flag values (available at: www.ihs.gov/CIO/scb/index.cfm?module=W_TRIBE&option=list&order=indian_fg); IHS Beneficiary Classification Codes available at: www.ihs.gov/CIO/scb/index.cfm?module=W_BENEF_CLASS&option=list&num=80&newquery=1); IHS Blood Quantum Codes available at: www.ihs.gov/CIO/scb/index.cfm?module=W_BLOOD_QUANTUM&option=download&row=1).

data base intended for analysis of beneficiary information could be analyzed for IHS AIAN beneficiaries.

- IHS and CMS should work together to expand the 'IHS code' in the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base to indicate IHS AIAN according to the CMS TTAG definition. In the Medicare Return File of the data exchange with the IHS registry system, CMS should include a data item on whether or not each Medicare beneficiary is in the IHS user population of active patients and all the I/T/U providers with whom the beneficiary is registered.

- ***Recommendations to Reduce Medicare Data Gaps Defining 'Census AIAN'***

  - CMS should examine the feasibility, costs and relative effectiveness of having questions added to the following to obtain Race and Ethnicity conforming to 1997 OMB standards allowing beneficiaries to self-declare their identification with multiple races, and to additionally indicate their Hispanic/Latino ethnicity:
    - At time of application for birth certificate, and arrange for information to be exchanged with the Social Security Administration during the Enumeration at Birth
    - At time of application for Social Security card (Form SS-5) the Social Security Administration should collect information on race and ethnicity on Form SS-5 and through the Enumeration at Birth process.
    - At time of application to enroll in Medicare.
    - Add Question to Medicare Beneficiary Surveys
    - Perform a special Medicare Beneficiary survey of AIAN designated by Medicare Beneficiary Race Code to obtain this information
    - Medicare prepaid health plans (which enroll 12 percent of beneficiaries) should be required to collect and report to CMS the race and ethnicity of all enrolled Medicare members.

Medicaid and SCHIP Data Gaps Defining AIAN Beneficiaries

Since 1999 states are required to submit their Medicaid and SCHIP eligibility and claims data to CMS as a result of provisions in the Balanced Budget Act of 1997. States vary considerably in the types of information collected and the way the data is categorized. Therefore CMS requests states to extract certain data items from their systems and submit them in a standardized format, known as the Medicaid Statistical Information System (MSIS). States submit individual eligibility data and claims tapes to Medicaid in five file formats on a quarterly basis. These files must meet the specifications outlined in the MSIS Tape Specification and Data Dictionary. The data is aggregated into a Medicaid State Summary Data Mart which is accessible online to designated partners.

The MSIS eligibility data includes AIAN racial information. Currently states submit the race of each eligible enrolled in their Medicaid program through 5 separate race data items each with a Yes or No coded value (White, Black AIAN, Asian, Native Hawaiian) provided by the states. These may be self reports of race, or reports of an eligibility worker as to the race of the eligibility applicant. Ethnicity information is provided in a separate data item (Hispanic/Latino). Multiracial AIAN can be represented by more than one race. AIAN from the Southwest can indicate their Hispanic/Latino ethnicity.

In the Medicaid State Summary Data Mart, however, the race and ethnic information is aggregated by the Medicaid program and becomes a single Race-Ethnicity data item with 9 possible coded values. The Census classifications of race as 'only AIAN' and race as 'AIAN alone or in addition to other racial categories' are

not mutually exclusive in these Medicaid State Summary Data codes, nor is ethnicity exclusive of race. Race-Ethnicity codes of the Medicaid State Summary Data Mart spread AIAN racial categories across three codes, in addition to the 'Unknown and Multiple Responses' category (Table 4), though not all states provide MSIS data for all 9 categories:

Race-Ethnicity Code 3 = AIAN Race only, excluding AIAN who indicated Hispanic/Latino Ethnicity

Race-Ethnicity Code 7 = Hispanic/Latino and any Race(s) including AIAN who indicated Hispanic/Latino Ethnicity; but these AIAN are mixed with people of other racial categories who indicated Hispanic/Latino Ethnicity

Race-Ethnicity Code 8 = More than one Race including AIAN who also indicated any additional Race, but excluding AIAN who indicated Hispanic/Latino Ethnicity, and mixing AIAN multiracial people with other multiracial people

Because of the way race and ethnicity data in MSIS is aggregated for the Data Mart, there is no data on Census AIAN as defined in Table 1. However, MSIS data provided in data files by the states to CMS could be used to construct both Census AIAN groups in Table 1.

Table 4. Medicaid Race-Ethnicity codes for Eligibles Enrolled in 50 states in the MSIS State Summary Data Mart.

Race-Ethnicity	Code	Medicaid Eligibles Enrolled	
		Number	Percent of Total
White & non-Hispanic	1	25,372,759	44.0%
Black & non-Hispanic	2	13,309,415	23.0%
AIAN & non-Hispanic	3*	834,503	1.4%
Asian & non-Hispanic	4	1,504,894	2.6%
Hispanic & No Race	5	12,524,880	21.6%
Native Hawaiian/ Pacific Islander	6	544,085	0.9%
Hispanic & One or More Races	7*	296,631	0.5%
More than One Race & non-Hispanic	8*	44,145	0.1%
Unknown or Multiple Responses	9*	3,569,609	6.2%
Total		58,000,921	100.0%

*AIAN can be in any of four codes 3, 7, 8 and 9.Data Source MSIS State Summary Data Mart, Federal Fiscal Year (FFY) 2004. We exclude Washington DC from all Medicaid Data Mart calculations. Accessed June 2007.

While 0.97% of the US population are estimated to be AIAN (one race only, Hispanic and non-Hispanic, Table 1), 1.4% of Medicaid enrollees are estimated to be AIAN (one race and non-Hispanic, Table 4). The impact on the AIAN number (834,503 eligibles enrolled) and proportion of the total (1.4%) of all eligibles enrolled of any AIAN in Race-Ethnicity Codes 7, 8 and 9, is not likely to be large unless the 'Unknown or Multiple Responses' category contains a disproportionate number of AIAN. While the Race-Ethnicity Codes 7 and 8 account for 0.6% of Medicaid eligibles enrolled, the Race-Ethnicity Code 9 'Unknown and Multiple Responses' includes 6.2% or 3.57 million eligibles enrolled. More AIAN indicate multiple races

on the Census than other major racial groups, and therefore AIAN may be disproportionately represented in Race-Ethnicity Code 9.

There is no Medicaid data in MSIS or the MSIS State Summary Data Mart on 'Tribal AIAN' or 'IHS AIAN' as defined in Table 1. By cross-tabulating IHS provider data with AIAN beneficiary data, however, it is possible to get some information on the latter group (see Table 8 below).

- ***Recommendation to Reduce Medicaid and SCHIP Data Gaps Defining 'Tribal AIAN'***

  - CMS should examine the feasibility, costs and relative effectiveness of having a question added to MSIS to obtain Tribal AIAN information conforming to IHS Tribe codes to identify Tribal AIAN who are not in the Indian Health Service registry system but are entitled to health care through federal trust, and government-to-government derived rights, federal

- ***Recommendation to Reduce Medicaid and SCHIP Data Gaps Defining 'IHS AIAN'***

  - While there is no Medicaid data at the national level on 'IHS AIAN' as defined in Table 1, Racial AIAN defined by the Race-Ethnicity codes of the MSIS Eligible File can be cross-tabulated with IHS Program (provider) information in MSIS Claims files to analyze information on racially coded 'AIAN only' who have paid claims with an IHS program provider. Many, if not most, of these AIAN are likely to also meet the IHS definition of federally recognized AIAN living on or near tribal lands, but they are not necessarily identical to the 'IHS AIAN' verified user active patients.

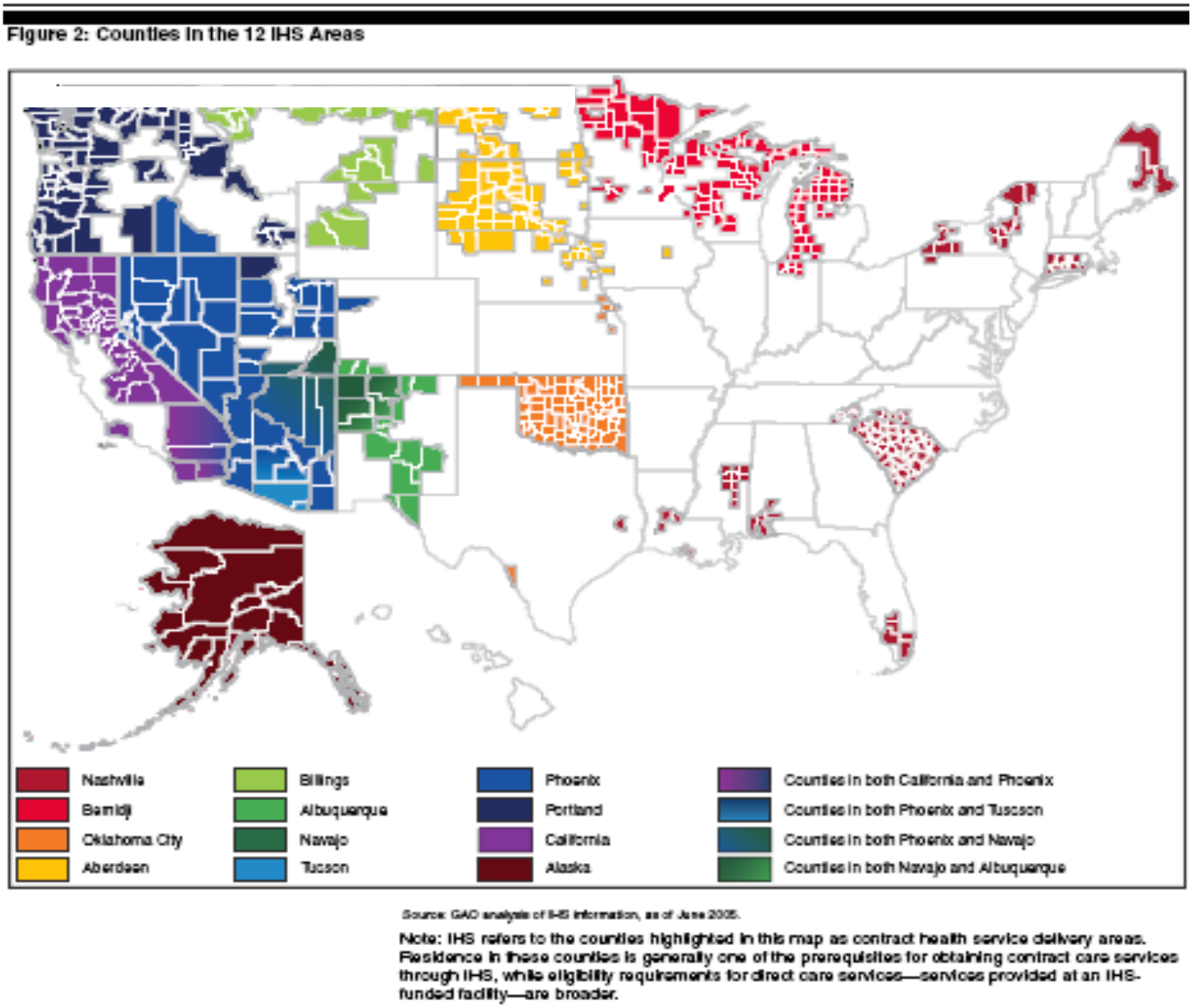
- ***Recommendation to Reduce Medicaid and SCHIP Data Gaps Defining 'Census AIAN'***

  - There is Race-Ethnicity data in the MSIS electronic Eligible File that would allow construction of the Census AIAN groups recommended by the CMS TTAG (see Table 1), but not in the data that has been aggregated for the MSIS State Summary Data Mart that is available online. Therefore to perform analyses of AIAN according to Census AIAN definitions, it is important to use MSIS electronic files and not State Summary online data.

III. CMS Data Gap Identifying I/T/U Providers

The extent to which CMS data is useful in measures of program performance and policy analysis from the perspective of IHS, tribal and urban Indian (I/T/U) providers depends on how well they are identified in CMS data bases. We present the definitions recommended by the CMS TTAG for identifying I/T/U providers, and then the gaps in defining them in Medicare, Medicaid and SCHIP data bases given these definitions, followed by recommendations on how to reduce the data gaps for each program.

Figure 1. IHS and Tribal (I/T) providers: Map of states and counties included in the 12 IHS Areas Contract Health Service Delivery Areas (CHSDA). These areas are indicative of, but not exactly the same as, service areas of the IHS and Tribal facilities.



Source: US Government Accounting Office (GAO). Indian Health Service: Health Care Services Are Not Always Available to Native Americans. Washington DC: GAO-05-789. August 2005.

CMS TTAG Recommended Definitions of I/T/U Providers

The Strategic Plan of the CMS TTAG supplies three relevant definitions of providers to AIAN that are particularly important in CMS program performance and policy analysis: IHS, tribal and urban Indian (I/T/U) health care facilities (Table 5). In addition, AIAN populations using I/T/U facilities who have Medicaid or Medicare coverage, can use private or public facilities and professionals for health care services not provided in I/T/U facilities. Populations of Census AIAN or Tribal AIAN with Medicare, Medicaid or SCHIP health care coverage who do not live near I/T/U facilities, generally use the same providers as other US citizens.

IHS Direct Service Providers. Tribal AIAN who live in designated communities near IHS system facilities have access to health care facilities and their professional staff providers. The IHS is the principal source of federal health care for eligible AIAN with three types of facilities (I/T/U). IHS services are provided directly by IHS hospitals (currently 33 hospitals), health centers (54 centers) and health stations (38 stations). Staff providers of health care at the I/T/U facilities include physicians, nurses, pharmacists, dentists, and a variety of allied health professionals, such as nutritionists, physician assistants and medical assistants.

The CMS eligible services provided by IHS vary by facility but generally include inpatient, outpatient primary care, ancillary and specialty care services, and pharmacy services (Table 6).[24] Only a limited number of the hospitals have surgeons or anesthesiologists to provide surgical services.

IHS provider payment methods are specified for health care professional providers and facilities by Medicare, Medicaid and SCHIP (Table 7).[25] The Medicare and Medicaid All Inclusive Rate is negotiated with CMS and published annually in the Federal Register. Critical Access Hospital inpatient and outpatient Medicare rates are set based on cost reports sent directly to the Fiscal Intermediary for review. The basis of the All Inclusive Rate is derived from 46 hospital cost reports. IHS Inpatient and Outpatient RPMS Workload data is used to calculate the average All Inclusive Rate. The Fiscal Intermediaries or carriers process and pay claims. Trailblazers is the sole Medicare Fiscal Intermediary and Carrier for IHS. State programs determine handling of Medicaid and SCHIP claims.

Tribally-operated Health Program Providers. In recent decades tribes have become increasingly responsible for providing their own health care through Tribally-operated Health Programs (TOHP). Under the 1975 Indian Self-Determination Act (PL 93-638), federally-recognized Indian tribes were granted the opportunity to assume responsibility for the health of their own people under contracts and compacts with IHS, and many tribes have chosen to do so. Tribes either alone or in consortia with one another operate hospitals (15), health centers and stations (216), and Alaska village clinics (162).[26]

The CMS eligible services they provide also vary by facility. Services may include inpatient care and specialty care, but usually include comprehensive primary care, ancillary services, and limited pharmacy services (Table 6). Only a small number of tribal hospitals have surgical services.

Tribal provider payment methods are specified for tribal health care professionals and facilities by Medicare, Medicaid and SCHIP. The rate methods used with IHS providers are generally those used with

[24] Government Accounting Office Report. Indian Health Service: Health Care Services Are Not Always Available to Native Americans. Washington DC: GAO-05-789. August 2005

[25] Indian Health Service Revenue Operations Manual, July 2006. Available at: www.ihs.gov/NonMedicalPrograms/BusinessOffice/index.cfm?module=rom

[26] Indian Health Service Year 2006 Profile. Available at http://info.ihs.gov/Files/ ProfileSheet-June2006.pdf.

Tribal providers and facilities (Table 7). Payment methods may need to be adjusted, however, depending on payer guidelines. Unlike IHS, Tribes have the option of using Trailblazers or other Fiscal Intermediaries or Carriers for Medicare claims. State programs determine handling of Medicaid and SCHIP claims.

Urban Indian Health Organization Providers. As many as 70% of Census AIAN live in urban areas.[27] There are 34 urban Indian health organizations within the Urban Indian Health Organizations network that operate 41 sites in 19 states to provide medical services to this population. A number of the Urban Indian Health Organizations provide only behavioral health treatment or referral services, others offer both medical and behavioral health services, and still others provide only the medical services. None operate hospitals.

Figure 2. Map locating 34 Urban Indian Health Organization providers (and the AIAN Tribal and Urban Epidemiology Centers referred to in the Summary and Appendix D of the Report).

Source: Urban Indian Health Institute, home page: www.uihi.org

The CMS eligible services they provide vary by facility but are strictly outpatient services that generally include primary and some ancillary services (Table 6). Twenty of the 34 Urban Indian Health Organizations receive Medicaid reimbursement.[28] Depending on the scope of the program, Medicaid represents from as much as 38% to as little as 1% of operating revenues for urban Indian health agencies. Nineteen (19) Urban Indian Health Organizations are recognized as Federally Qualified Health Centers (FQHC) and are thus eligible for Prospective Payment System reimbursement.

Private and Public Providers. AIAN enrolled with Medicaid or Medicare can obtain care from private or public sector providers. Contract Health Service programs of I/T service units that contract with private and public providers for care of their AIAN users, help their users enroll. Services that Medicaid or Medicare enrollees use that are covered by the CMS programs are not eligible for IHS Contract Health Services funds.

[27] National Council of Urban Indian Health. Urban Indian Health Program Profiles 2006. Available at www.ncuih.org/Profile%20page.html

[28] Urban Indian Health Institute. Medicaid: Issues for Urban American Indians and Alaska Natives, 2006. www.uihi.org/factsheets/Medicaid%20FactSheet.pdf

Table 5. I/T/U and Other Providers Used by AIAN who use I/T/U Providers.

Definition	Who is Included	Examples of Services	Facilities 2006[29]
Tribal	Tribally Operated Health Programs (TOHP)—Both Contract "Public Law 638", and Compact	Primary Care (Medical, Dental), Ancillary (Limited laboratory, pathology, emergency transportation), Behavioral Health, Tribal Hospital may have some Specialty services	15 Hospitals, 216 Health Centers, 162 Alaska Village Clinics, 97 Health Stations, 9 School Health Centers
Indian Health Service	IHS Direct Services	Primary Care (Medical, Dental, Vision), Ancillary (laboratory, pathology, imaging, emergency transportation), Behavioral Health, Limited Hospital and some Specialty services	33 Hospitals 52 Health Centers 38 Health Stations 2 School Health Centers
Urban Indian	Urban Indian Health Organizations -Some in IHS system, some are not, some are FQHC some are not	Primary Care, Ancillary (Limited laboratory, pathology) Behavioral Health	34 Urban programs
Other Provider To I/T/U Users	Private – physicians, imaging centers, hospitals, pharmacies, etc. that accept Medicaid or Medicare	Primary Care, Ancillary, Specialty Care, Hospital services	Not IHS
	Public – FQHC, Rural Health Centers, safety net hospitals, etc	Primary Care, Ancillary, Specialty Care, Hospital services	Not IHS

Based on: US Government Accounting Office (GAO). Indian Health Service: Health Care Services Are Not Always Available to Native Americans. Washington DC: GAO-05-789. August 2005, with added Facilities Information from IHS Profile 2006.

Table 6. Examples of I/T/U Provider Services[30]

Primary Care Services	Ancillary Services	Specialty Services
Medical Care ❖ Evaluation and management of patient conditions performed by midlevel practitioners, or physicians with primary care specialties	Laboratory and pathology services ❖ Screenings for cancer, tuberculosis and elevated blood glucose ❖ Initial assessments for diabetes and pregnancy	Medical Care ❖ ObGyn, podiatry, nephrology, and other services provided by physician specialists
Dental Care ❖ Oral examinations, cleaning, sealants and amalgam restorations	Diagnostic imaging and testing ❖ X-ray, mammography, amniocentesis, computerized tomography, echocardiography	
Vision Care ❖ Eye examinations and prescriptions for vision correction	Pharmacy	Vision Care ❖ Diabetic Eye examinations and cataract surgery
	Durable medical equipment and adaptive devices ❖ Knee braces, canes, wheelchairs and eyeglasses	Behavioral health care
	Emergency medical transportation	Rehabilitation services ❖ Physical therapy

Source: US Government Accounting Office (GAO). Indian Health Service: Health Care Services Are Not Always Available to Native Americans. Washington DC: GAO-05-789. August 2005.

[29] IHS Year 2006 Profile. Available at http://info.ihs.gov/Files/ ProfileSheet-June2006.pdf

[30] US Government Accounting Office (GAO). Indian Health Service: Health Care Services Are Not Always Available to Native Americans. Washington DC: GAO-05-789. August 2005.

Table 7. IHS and Tribal (I/T) Provider Payment Methods for Professionals and Facilities for Medicare, Medicaid and SCHIP.

Payer	Fiscal Intermediary	Professionals		Hospital	Critical Access Hospital	Hospital Outpatient	Ambulatory Surgery	Pharmacy	Dental
		Inpatient	Outpatient						
Medicare	Trailblazers	Fee-for-service (FFS) Part B	Fee-for-service (FFS) Part B	Diagnosis Related Group Rate[4]	All Inclusive Rate (AIR)	All Inclusive Rate (AIR)	Ambulatory Surgery Center rate (ASC)	Fee-for-service (FFS) 2006	N/A (with certain exceptions)
Medicaid	State FI	FFS	AIR	AIR	AIR	AIR	ASC rate	AIR/FFS	AIR/FFS
SCHIP Private Insurance[1] Model	FI	FFS	FFS	FFS	FFS	FFS	FFS	FFS	FFS
SCHIP Medicaid[2] Model	FI	FFS	AIR	AIR	AIR	AIR	ASC rate & FFS	AIR & FFS	AIR & FFS
FQHC[3] Tribes only	FFS applies to Private Insurance	FFS for Professional Services	Encounter & FFS to Part B carrier & Private Ins	N/A	N/A	N/A	N/A	FFS/340B & Private Insurance	Encounter and FFS for Private Insurance

[1]Private Insurance rules apply; [2]Medicaid rules apply; [3]FQHC only pertains to Tribal outpatient clinics. IHS is not eligible for this provider status. Their rates are capped by Medicare regardless of costs and for Medicaid some states pay based on average Outpatient Prospective Payment System. The reimbursement is paid to tribes, not IHS. [4]Prospective Payment System: Payments under this system are made on a per discharge basis, Diagnosis-Related Groups (DRG) that take into account differences in resource use of patients with different diagnoses and the most recently available hospital discharge data. CMS is required to update the payments made under this system annually.

Data Source: *IHS Revenue Operations Manual* July 2006. Accessed at: www.ihs.gov/NonMedicalPrograms/BusinessOffice/ROM/Part4/ROM_P4_A.doc

Medicare Data Gaps Defining I/T/U Providers

I/T/U facilities are not identified as 'I/T/U' providers in Medicare provider or claims data bases, though all I/T/U facilities that bill Medicare are providers in the Medicare data bases. All I/T/U providers are likely to have National Provider Identifying Numbers (NPIN) soon, however these identifiers do not identify them as I/T/U facilities, nor do they link to data bases prior to the NPIN. Thus provider identifying numbers prior to NPIN are necessary for analyses of Medicare data bases prior to 2007. Medicare Providers are in the hospital, skilled nursing facility, physician or the Durable Medical Equipment provider data bases. The issue is whether I/T/U providers are in the OSCAR data base of hospitals and federal clinics.

OSCAR Data Base. The purpose of the Online Survey Certification and Reporting System (OSCAR) provider data base is to track the certification procedure which examines an institution's qualifications for furnishing safe and effective care to beneficiaries. It provides CMS and external researchers who want to measure an institution's capacity to provide acceptable care. It does not include physicians or durable medical equipment suppliers. The Provider of Service (POS) data base is created from OSCAR for researchers to use.

The OSCAR data base has 18 categories of providers. The main Medicare categories of provider facilities are hospitals and skilled nursing facilities because Part A coverage is primarily for inpatient care. Data on Location and Size of Hospital/Nursing Facility, Type of Control and Type of Hospital/Nursing Facility. It

needs to be confirmed whether IHS and Tribal hospitals are included in OSCAR and specified as IHS or Tribal under the Type of Control. OSCAR also includes Medicare categories of federal clinic program providers: Rural Health Clinics, FQHC. It needs to be confirmed whether I/T/U clinics are included in OSCAR. Home Health Agencies, portable X-ray suppliers, End Stage Renal Disease (dialysis) providers, organ procurement organizations, Clinical Laboratory Improvement Amendments (CLIA) laboratories and other providers for the ill aged and disabled are included as well. It therefore needs to be confirmed whether I/T/U providers in any of these categories are included in OSCAR.

Claims Data Bases. The alternative to identifying I/T/U facilities and professional providers from Medicare provider data bases is to have a comprehensive list of their NPIN and identifying numbers prior to 2007, and to have those numbers classified by their I/T/U and Medicare provider type status. By cross-referencing lists of I/T/U contact information with Medicare claims data bases, 'I/T/U' facilities could be identified with at least these three codes (I/T/U).

- ***Recommendations to Reduce Medicare Data Gaps Defining I/T/U Providers***

  - CMS should have IHS should provide a list of I/T/U providers so that CMS can screen their provider and claims data bases for these providers and add a data item that codes them with one of the three codes defined: I, T, or U.

  - CMS should add a data item in Medicare provider and claims data bases to allow IHS, Tribal and Urban providers to identify themselves with one of the three codes defined according to CMS TTAG definitions: I, T, or U.

  - IHS and CMS should work together to expand the CMS-IHS Data Exchange so that the 'IHS code' in the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base is expanded to indicate whether the IHS AIAN is currently designated as an A user of an IHS, Tribal or Urban provider.

Medicaid Data Gaps Defining I/T/U Providers

Medicaid at the national level does not have a provider data base, but they do have claims data in the MSIS electronic data files with providers identified by the states. IHS and Tribal, but not Urban, facilities are potentially identified by some states in the MSIS claims data base as a single Program (not provider) code: 'IHS Program.' Other types of Programs include FQHC and Rural Health Centers. The completeness of this 'IHS Program' code for all I/T/U in each state has not been verified. States that are interested in receiving the 100% FMAP for AIAN who use the IHS and Tribal facilities are likely to be better at identifying 'IHS Program' providers. Since the Urban clinics are not eligible for the 100% FMAP, it is not likely that states include them as 'IHS Program' providers.

In the State Summary Data Mart of MSIS data available online, the IHS Program data is aggregated at the state level. Since I/T/U providers and their service areas are organized by IHS Administrative Areas that contain part or all of states and counties in Contract Health Service Delivery Areas (CHSDA, Figure 1) it is important to analyze I/T/U provider information by Area, state and county (as attempted in Table 8). It is important not to combine data from different states, however, because each state affects the Area to a different extent depending on the numbers and kinds of IHS Program users in each state for each Area. Each state Medicaid program has a different combination of eligibility, services and payment policies. Only for California, Alaska and Tucson Areas are the IHS Program users mainly residents of a single state.

Table 8. All Races and AIAN of Medicaid Enrollees who use an IHS Program in each state with any CHSDA counties* for the IHS Administrative Areas (2004).

IHS Area and State	CHSDA Counties*	Medicaid Eligibles Enrolled who use IHS Program: All Races	AIAN	AIAN as Percent of All Races
	Number	Number	Number	
ABERDEEN	(115,812 Active Users*)			
Iowa	4	0	0	0.0%
Minnesota	1	10626	9581	90.2%
Nebraska	21	7812	7340	94.0%
North Dakota	20	2984	2762	92.6%
South Dakota	37	22431	21930	97.8%
Area Total	83	43,853	41613	94.9%
ALASKA	(125,759 Active Users)			
Alaska	26	29228	28893	98.9%
Area Total	26	29228	28893	98.9%
ALBQUERQUE	(86,624 Active Users)			
Colorado	3	889	737	82.9%
New Mexico	14	67274	66118	98.3%
Texas	2	18	3	16.7%
Utah	1	0	0	0.0%
Area Total	20	68181	66858	98.1%
BEMIDJI	(95,871 Active Users)			
Indiana	6	0	0	0.0%
Michigan	52	0	0	0.0%
Minnesota	28	10626	9581	90.2%
Wisconsin	33	1578	1411	89.4%
Area Total	119	12204	10992	90.1%
BILLINGS	(69,560 Active Users)			
Montana	23	16499	15926	96.5%
Wyoming	5	3597	3370	93.7%
Area Total	28	20096	19296	96.0%
CALIFORNIA	(71,696 Active Users)			
California	37	33389	9174	27.5%
Area Total	37	33389	9174	27.5%
NASHVILLE	(47,218 Active Users)			
Alabama	4	0	0	0.0%
Connecticut	1	0	0	0.0%
Florida	6	0	0	0.0%
Louisiana	4	0	0	0.0%
Maine	3	19	6	31.6%
Massachusetts	1	426	358	84.0%
Mississippi	10	2385	1949	81.7%
NAVAJO	(236,829 Active Users*)			
Arizona	3	68611	66261	96.6%
New Mexico	5	67274	66118	98.3%
Utah	2	0	0	0.0%
Area Total	10	135885	132379	97.4%
OKLAHOMA	(299,622 Active Users)			
Kansas	4	6	6	100.0%
Nebraska	1	1	2762	92.6%
Oklahoma	76	43612	32928	75.5%
Texas	1	18	3	16.7%
Area Total	82	46620	35699	76.6%
PHOENIX	(144,694 Active Users)			
Arizona	13	68611	66261	96.6%
California	4	33389	9174	27.5%
Colorado	1	889	737	82.9%
Idaho	1	2814	2421	86.0%
Nevada	17	2258	1533	67.9%
Oregon	1	1	3402	78.7%
Utah	15	0	0	0.0%
Area Total	52	112284	83528	74.4%
PORTLAND	(97,501 Active Users)			
Idaho	13	2814	2421	86.0%
Oregon	23	4323	3402	78.7%
Utah	1	1	0	0.0%
Washington	27	19022	12990	68.3%
Area Total	64	26159	18813	71.9%
TUCSON	(24,009 Active Users)			
Arizona	4	68611	66261	96.6%
Area Total	4	68611	66261	96.6%
(continue NASHVILLE)				
New York	14	2021	1543	76.3%
N. Carolina	11	0	0	0.0%
Pennsylvania	1	0	0	0.0%
Rhode Island	1	0	0	0.0%
S. Carolina	All 46	124	28	22.6%
Texas	1	18	3	16.7%
Area Total	103	4993	3887	77.8%

Data Sources: *Contract Health Service Delivery Area (CHSDA) Counties are from IHS data: See Figure 1, *Active Users from IHS Final 2004; Medicaid Eligibles Enrolled from MSIS State Summary Data Mart, FFY2004.

It is most important to IHS, tribes and urban providers to present I/T/U provider data by IHS Area. There are limitations to using state level data to present IHS Program information by Area as sown in Table 8. IHS Administrative Areas are mapped as Contract Health Service Delivery Areas (CHSDA) which include part or all of states and counties (Figure 1). The borders of states are not congruous with tribal lands and therefore IHS Areas. Some states have counties in two or more IHS Areas. California, Colorado, Idaho, Oregon, New Mexico and Texas are part of two IHS Areas. Arizona and Utah are part of three IHS Areas. When one state has many CHSDA counties in one Area, and only a few counties in another Area, using the full state level IHS Program data for both Areas misrepresents the IHS Programs of both Areas affected (Table 8). Arizona state level data from the Data Mart is the same for Phoenix, Navajo and Tucson Areas, California data for California and Arizona Areas, and Utah data in the Albuquerque, Navajo, Phoenix, and Portland Areas in Table 8.

The limitation of trying to use state level data from the State Summary Data Mart to present Medicaid provider data for IHS Areas is demonstrated by Arizona data in Table 8. The involvement of Arizona counties in three IHS Areas and the large numbers of Medicaid enrollees with IHS Program in Arizona, IHS Program data had to be allocated by a formula for these three Areas. There are a variety of allocation formulas that might be used with county-specific data for either Medicaid enrollees or IHS Active Users. But without county-specific information we instead had to use simply the number of counties. For Arizona only, we allocated 13/18 of the state level data to Navajo and 5/18 to Tucson. In other states included in more than one Area, the numbers of AIAN Medicaid enrollees with an IHS Program were small enough to include all counties in both Areas for the purpose of determining the ratio.

One strategy to overcome the limitation of state level data to report I/T/U provider results by IHS Area would be to use MSIS electronic file data that was used by CMS to create State Summary Data Mart data so that only the appropriate CHSDA counties of a state were included in each IHS Area presented. This would be a large improvement over state level data. There would however be certain limitations remaining: the borders of some counties are not congruous with tribal lands and therefore IHS Areas. Some counties are split between two Areas as is shown by the counties with two shaded colors in Figure 1: the eastern part of three counties in California Area are in the Phoenix Area; parts of two counties in Tucson Area are also part of Phoenix Area; part of three counties in Phoenix Area are part of Navajo Area; and part of two counties in Navajo Area are part of the Albuquerque Area. However, using the county level data for both areas would not be so severe a data limitation as using the state level data in both areas as is done in Table 8.

In spite of the serious data limitations in having only state level data for I/T providers from MSIS State Summary Data Mart data on IHS Programs (urban providers are not by 'IHS Program' definition included): some simple data consistency checks are possible (as in Tables 8 and 9):

1) States with at least one CHSDA county served by an I/T Provider that reported no IHS Program claims data in Federal Fiscal Year (FFY) 2004 include (Table 8): Alabama (4 counties, Nashville Area), Connecticut (1 county, Nashville Area), Florida (6 counties, Nashville Area), Iowa (4 counties, Aberdeen Area), Indiana (6 counties, Bemidji Area), Louisiana (4 counties, Nashville Area), Michigan (52 counties, Bemidji Area), North Carolina (11 counties, Nashville Area), Pennsylvania (1 county, Nashville Area), Rhode Island (1 county, Nashville Area), and Utah (3 counties, Phoenix, Navajo and Portland Areas). Either the providers or the states did not identify their claims as IHS Program claims.

2) States with unlikely low proportions of 'AIAN' in their IHS Program data include: California (37 counties, 27.5% AIAN), Texas (1 county, 16.7% AIAN) South Carolina (all counties, 22.7% AIAN), and Maine (5 counties, 31.6%) (Table 8). Generally over 90% of the Medicaid eligible enrollees served are classified racially as AIAN. Non AIAN served at I/T providers. It is not known to what extent Medicaid

data on non-AIAN served at I/T/U providers is misclassification of race at the state level, or properly classified non-AIAN. There are non-AIAN who are entitled to CMS financed care through I/T/U providers, including non-AIAN members of tribal AIAN families. These enrollees however are not entitle to the special considerations extended through the Federal Trust responsibility – such as 100% FMAP for their services. The non-AIAN Military, PHS Commissioned Officers and their dependents who are eligible for services at remote I/T facilities are not included in the MSIS non-AIAN figures for the IHS Program because their health care is paid by federal programs that are not eligible for Medicare or Medicaid.

3) Ratios of 'AIAN Medicaid enrollees with an IHS Program' in the states in an Area to 'Area IHS Active Users' can be calculated for each Area. Since some states are included in more than one Area, these ratios are *not* the same as the percent of Active Users who are Medicaid enrollees. These particular estimates are also affected by the lack of CHSDA county level data which led to the inclusion of complete state data even where only a few counties are included in the IHS Area. For illustration of the desirability of accurate information by IHS Area, State and County the area ratios calculated from data limited to Area and State in Table 8, and listed in order of increasing value, are:

Nashville	0.08
Bemidji	0.12
Oklahoma	0.12
California	0.13
Portland	0.19
Alaska	0.23
Billings	0.28
Aberdeen	0.36
Navajo	0.40*
Phoenix	0.58
Albuquerque	0.77
Tucson	0.77*

A number of factors contribute to this ratio including: 1) the relative poverty of the AIAN population; 2) how completely Medicaid eligibles are enrolled in Medicaid for the IHS Program; 3) how many categories and how inclusive each state's Medicaid eligibility criteria are; 4) how completely AIAN Medicaid eligibles enrolled are properly identified as AIAN by states in MSIS eligibility files; 5) how completely Medicaid eligibles enrolled by IHS Programs are identified as such by states in MSIS claims files; and 6) the extent to which Contract Health Service programs are used by AIAN.

As a further data consistency check of state reporting of IHS Program data, Table 9 shows state reporting of Medicaid Eligibles Enrolled in IHS Programs among states without IHS Programs. As expected nearly all states without IHS Programs report no enrolled eligibles with the IHS Program. Only one state that is not served by an I/T Provider had any IHS Program data. New Hampshire reported a small number (438) of Medicaid eligibles enrolled by the IHS Program in FFY 2004, none of whom were AIAN. Thus this is a likely data error, well within error limits.

Table 9. Data consistency check: State Reporting of Medicaid Eligibles Enrolled in IHS Programs among states without IHS Programs (2004).

States Outside IHS Area		Medicaid Eligibles Reported as Enrollees with IHS Program		
State	**Counties** Number	**All Races** Number	**AIAN** Number	**AIAN as Percent of All Races**
Arkansas	all	0	0	0.0%
Delaware	all	0	0	0.0%
District of Col	all	0	0	0.0%
Georgia	all	0	0	0.0%
Hawaii	all	0	0	0.0%
Illinois	all	0	0	0.0%
Kentucky	all	0	0	0.0%
Maryland	all	0	0	0.0%
Missouri	all	0	0	0.0%
New Hampshire	all	438	0	0.0%
New Jersey	all	0	0	0.0%
Ohio	all	0	0	0.0%
Tennessee	all	0	0	0.0%
Vermont	all	0	0	0.0%
Virginia	all	0	0	0.0%
West Virginia	all	0	0	0.0%

Data Sources: Same as Table 8.

- ***Recommendations to Reduce Medicaid Data Gaps Defining I/T/U Providers***

  - To the MSIS Claims Files in states with I/T/U providers, CMS should add a data item or Program Type Code that has states differentiate between IHS and Tribal Providers in IHS Program claims data, and IHS Service Area, States should also identify Urban Indian Health Organization as a provider or Program Type in MSIS claims data files.

  - For states with counties served by different IHS Areas, CMS should link the County Code from the MSIS Eligible File for the Medicaid enrollee served on an IHS Program claim in an MSIS Claims File through linkage by the Unique Personal Identifier in both MSIS Eligible and Claims files. In this way IHS Program data at the state level can be allocated to the proper IHS Area.

  - In IHS Program data in the MSIS State Summary Data Mart online**,** CMS should include any new MSIS information in which states distinguish IHS Program providers by I/T/U provider types, and the IHS Areas in their states.

IV. Medicare data useful for program performance and policy reports

Medicare data base statistics (measures) routinely used for program performance and policy reports consist generally of data on Enrollment, Services and Payments, and sometimes Health Status. The data come from enrollment of eligible people, registration of certified providers and claims paid to providers for services they provided. We did not have access to any electronic Medicare databases for this report and therefore we report here only statistics reported by CMS.[31] In this part of the report we apply the definitions for AIAN enrollees and I/T/U providers currently available in Medicare data bases.

Wherever possible, we provide two measures that contrast AIAN enrollment, service or payment data with that of all enrollees ('AIAN Differences'): the 'Difference in Percents' is useful in quickly identifying enrollment, service or payment categories in which there are proportionately more or proportionately fewer AIAN, and the 'Ratio of Percents' is useful in identifying the extent to which the relative proportion of AIAN to all enrollees in the category is larger or lower. The former measure is more appropriate when the number of AIAN affected is particularly important, and the latter when the category itself is particularly important (see Table 10 as an example).

We attempted to tabulate summative data for AIAN and I/T/U Enrollment, Services, Payments and Health Status, however for Medicare we had access only to tabulated data for AIAN Enrollment, but not Services or Payments, and not for I/T/U providers. For Services, Payments and Health Status data we instead provide an overview of Medicare data bases from which the data might be obtained after linking to Enrollment Data Base data items: Beneficiary Race Code and Beneficiary Race Source Code.

Medicare Enrollment Data

The CMS funded a study in 2001 to examine barriers to enrollment of AIAN in Medicare and to identify strategies that may be effective for increasing AIAN enrollment into these programs.[32] The original objective of the quantitative component of that project was to develop estimates of AIAN eligibility and enrollment in Medicare (as well as Medicaid, and SCHIP) and to estimate the ratio of enrollment to eligibility by state and sub-state areas. However, significant data limitations were identified during the project and, as a result, the analysis conducted was primarily methodological to illustrate the effects of data and other issues that affect the feasibility of estimating AIAN eligibility and enrollment in these programs. In our analysis we are not trying to determine Medicare eligible populations of AIAN, but instead Medicare eligibles enrolled and enrollees served, and therefore we can start with the use of currently available enrollment data for AIAN in Medicare as defined by the beneficiary race code for North American Native.

The comprehensive Medicare Beneficiary Database receives data from a variety of sources, both internal and external to CMS including the Enrollment Data Base (EDB), the Medicare Advantage Prescription Drug system (MARx) and the Medicaid state systems for dual eligibles. The Enrollment Data Base is the primary legacy beneficiary data repository and contains current and historical eligibility and coverage information, as well as the racial definition of AIAN, for eligibles enrolled. With access to the Enrollment Data Base, enrollment data can also be analyzed for IHS AIAN by using the Beneficiary Race-Source code

[31] *CMS Statistics 2005.* Available at: www.cms.hhs.gov/CapMarketUpdates/Downloads/2005CMSStats.pdf

[32] Langwell K, Cox D, Schur C, Bell T. 'AIAN Eligibility and Enrollment in Medicaid, SCHIP, and Medicare Estimating Eligibility and Enrollment: A Methodological and Data Exploration;' and: Langwell K, Laschober M, Cox D, Schur C, Bell T, Melman E, Greenberg L. 'AIAN Eligibility and Enrollment in Medicaid, SCHIP, and Medicare: Final Report.' BearingPoint Inc and Westat, CMS Contract No. 500-00-0037 (Task 5). December 2003.

= IHS. It is our understanding however that the Beneficiary Race-Source code data item is not present in any other Medicare data base.

The Medicare Denominator File contains Enrollment Data Base demographic and enrollment information about each Medicare eligible enrolled during a single calendar year. The file contains entitlement indicators for eligibility and coverage type for each month in the year. Monthly turnover involves approximately 200,000 new eligibles enrolled and 150,000 existing eligibles terminated. The Beneficiary Race-Source code, however, is not currently included in the Medicare Denominator File.

Table 10. Medicare Eligibility and Coverage of Eligibles Enrolled in 50 states, AIAN and All Races (2006).

	All Races		AIAN		AIAN Differences	
Medicare Eligibility and Coverage	Number	Percent of Total	Number	Percent of Total	Difference in Percents	Ratio of Percents
Eligibility						
Aged	36,141,694	83.4%	123,446	68.7%	-14.7%	0.8
Aged with ESRD	174,900	0.4%	1,677	0.9%	0.5%	2.3
Disabled	6,812,866	15.7%	51,545	28.7%	12.9%	1.8
Disabled with ESRD	169,248	0.4%	2,485	1.4%	1.0%	3.5
End-Stage Renal Disease (ESRD) only	39,863	0.1%	641	0.4%	0.3%	3.9
Coverage						
Hospital Inpatient	42,974,615	99.2%	176,232	98.0%	-1.1%	1.0
Supplemental (Part B) Outpatient	40,398,230	93.2%	162,696	90.5%	-2.7%	1.0
Total	43,338,571	100.0%	179,794	100.0%	0.0%	1.0

Data Source: *Medicare Enrollment Tables 2006*, Table 2: Data as of July 1, 2006, Job Name MC29TAB1, page 1-04; CMS Office of Research, Development and Information.

Eligibility and Coverage. The AIAN enrolled population is about 0.4% of all Medicare eligibles enrolled (Table 3 above). For Medicare, eligible enrollees are entitled to Medicare coverage because of their age (83.4% without End-Stage Renal Disease ESRD, 0.4% with ESRD) or disability (15.7% without, and 0.4% with ESRD respectively) (Table 10). Proportionately fewer AIAN are eligible because of their age (68.7% without ESRD, 0.9% with). Proportionately more AIAN are eligible because of disability (28.7% without ESRD, 1.4% with). More AIAN are eligible because of ESRD regardless of aged, disabled or ESRD only classification. While the total difference for AIAN in all three categories of ESRD eligibility is only 1.8% higher, that proportion is 2.3 times higher than for All Races in the Aged category, 3.5 times higher in the disabled category, and 3.9 times higher for ESRD only category.

Coverage of Medicare eligibles enrolled includes hospital inpatient, skilled nursing facility, hospice, and some home health services care for nearly all enrollees (Part A, 99.2%). Most enrollees also choose optional coverage obtained through an enrollee-paid premium for supplemental physician, clinic, hospital outpatient, home health care, and ancillary services that includes laboratory, imaging, and durable medical equipment coverage (Part B Supplementary Medical Insurance, 93.2%). The proportions of AIAN eligibles enrolled for hospital and supplemental care are lower but comparable (98.0% Part A and 90.5% Part B respectively).

Proportionately more AIAN eligibles are enrolled in traditional Medicare fee-for-service care (92.1%) rather than a prepaid health plan (Health Maintenance Organizations, HMO) compared to all Medicare eligibles (82.7%).

More than a third of AIAN Part B enrollees participate in a state Medicaid ('Buy-In') program paying Part B premiums (36.2%), while only an eighth of all eligibles enrolled do so (16.5%) (Tables 11). For Dual Eligibles enrolled in both Medicaid-Medicare, Medicaid pays Part B premiums (and in some instances Part A premiums), and Part A and Part B coinsurance and deductibles (as described in the next section, Table 12). State Medicaid programs have 'Buy-in' agreements with CMS to pay for Part B premiums. The Buy-in agreements can also be modified to include payment for Part A premiums.

Table 11. Characteristics of Medicare Eligibles Enrolled in 50 states, AIAN and All Races (2006).

	All Races		AIAN		AIAN Differences	
Eligible Enrollees Characteristics	Number	Percent of Total	Number	Percent of Total	Difference in Percents	Ratio of Percents
Beneficiary Type						
Fee For Service	35,847,218	82.7%	165,546	92.1%	9.4%	1.1
HMO	7,491,353	17.3%	14,248	7.9%	-9.4%	0.5
Part B Enrollee Type						
Non-Buy-In	36,206,092	83.5%	114,622	63.8%	-19.8%	0.8
Buy-In	7,132,479	16.5%	65,172	36.2%	19.8%	2.2
Residence Type						
Urban	34,354,120	79.3%	88,886	49.4%	-29.8%	0.6
Rural	8,984,451	20.7%	90,908	50.6%	29.8%	2.4
Total	43,338,571	100.0%	179,794	100.0%	0.0%	1.0

Data Source: *Medicare Enrollment Tables 2006*, Table 3: As of July 1, 2006, Job Name MC29TAB1, page 1-12; CMS Office of Research, Development and Information.

Not surprisingly, half (50.6%) of the AIAN identified as racial AIAN in the Medicare enrollment database are rural, and half urban, whereas only one-fifth (20.7%) of all Medicare eligibles enrolled are rural (Table 11).

We do not currently have any electronic Medicare data base and cannot give data on characteristics for AIAN eligibles enrolled beyond the data in Tables 10 and 11 without hand tabulation. Because of the possibility of dual eligibility for Medicare and Medicaid, and because the Medicaid (MSIS) data is available in State Summary Data Mart, we do have some information on enrollment program statistics for Dual Eligibles for Medicaid-Medicare. It is important to be able to analyze this data because these are low income Medicare eligible enrollees.

Medicaid-Medicare Dual Eligibles. One of the major Medicaid and Medicare program policy issues for IHS tribal AIAN is out-of-pocket cash payments associated with Medicaid and Medicare that are not characteristics of IHS coverage. At issue is why go to the trouble of Medicaid or Medicare coverage, only to be hit with monthly premiums, service-related deductibles and co-payments. For Medicaid-eligible people CMS has a number of policies that can reduce or remove out-of-pocket health care costs for Medicare benefits. Dual eligibles are individuals who are eligible for some form of Medicaid benefit and entitled to Medicare Part A or Part B as well. The following are categories of dual eligibility that reduce or remove out-of-pocket health care costs for Medicare benefits to low income enrollees.

***QMB with and without Medicaid Coverage*.** The Dual Eligible group with the most enrollees is that of Qualified Medicare Beneficiaries (QMB), which is also the lowest income group with full Medicaid (Table 12). QMB are about half (54.8%) of all Dual Eligibles enrolled, and two-thirds (67.0%) of AIAN

Dual Eligibles. QMB with Medicaid Coverage (QMB Plus) have incomes of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, are also entitled to Medicare Part A. Individuals in this group qualify for one or more Medicaid benefits.[33] Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance, and provides one or more Medicaid benefits.[34] Qualified Medicare Beneficiaries without other Medicaid (QMB Only) meet the same income and resource requirements, and are entitled to Medicare Part A, but their Medicaid benefits are restricted. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.

SLMB with and without Medicaid Coverage. Specified Low-Income Medicare Beneficiaries (SLMB) with Medicaid (SLMB Plus, 1.3% of AIAN Dual Eligibles) have slightly higher incomes of 100-120% FPL, resources that do not exceed twice the limit for SSI eligibility, and are entitled to Medicare Part A (Table 10). Individuals in this group qualify for one or more Medicaid benefits.[35] A more common group of low income Dual Eligibles among All Races and AIAN is that of Specified Low-Income Medicare Beneficiaries without other Medicaid (SLMB Only, 4.0% of AIAN eligibles enrolled). These Dual Eligibles have restricted Medicaid benefits but Medicaid pays their Medicare Part B premiums.

Table 12. Numbers of AIAN Dual Eligibles Enrolled by dual eligibility category (2004).

	All Races		AIAN		AIAN Differences	
Medicaid - Medicare Dual Eligibles	**Number**	**Percent of Total**	**Number**	**Percent of Total**	**Difference in Percents**	**Ratio of Percents**
QMB & Medicaid	4,578,665	54.8%	40,974	67.0%	12.3%	1.2
QMB Only	526,233	6.3%	3,162	5.2%	-1.1%	0.8
SLMB & Medicaid	237,014	2.8%	774	1.3%	-1.6%	0.4
SLMB Only	425,266	5.1%	2,425	4.0%	-1.1%	0.8
QI(1)	218,908	2.6%	1,079	1.8%	-0.9%	0.7
QI(2)	570	0.0%	4	0.0%	0.0%	1.0
QDWI	78	0.0%	0	0.0%	0.0%	-
Other Duals	2,132,267	25.5%	12,152	19.9%	-5.6%	0.8
Dual Category Unknown	203,604	2.4%	448	0.7%	-1.7%	0.3
Unknown	34,284	0.4%	92	0.2%	-0.3%	0.4
Total	8,356,889	100.0%	61,110	100.0%	0.0%	1.0

Data Source: Medicaid MSIS State Summary Data Mart, FFY2004. Accessed June 2007.

[33] Medicaid benefits through 2005 included prescription drug coverage. Effective 2006, these individuals qualify for one or more Medicaid benefits that do not include prescription drugs

[34] QMB individuals with prescription drug coverage are included in this group through December 2005. Beginning in January 2006, Part D provides drug coverage for these individuals, and Medicaid drug benefits are not required for an individual to be reported in this group.

[35] SLMB individuals with prescription drug coverage are included in this group through December 2005. Beginning in January 2006, Part D provides drug coverage for these individuals, and Medicaid drug benefits are not required for an individual to be reported in this group.

***Qualifying Individuals* (QIs).** Qualifying Individuals (QI) are a small portion of Dual Eligibles who have even higher incomes of 120 -135% FPL, though they still have resources that do not exceed twice the limit for SSI eligibility. They are entitled to Medicare Part A, but they are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only with 100% federal funding. There is an annual cap on the amount of money available, which may limit the number of individuals in the group (1.8% of AIAN Dual Eligibles).

***Qualified Disabled and Working Individuals* (QDWI).** There are apparently no AIAN who are QDWI (Table 12). These individuals have incomes up to 200% FPL, resources that do not exceed twice the limit for SSI eligibility, but they have lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

Other Dual Eligibles. Other Dual Eligibles with Medicaid Coverage are a quarter (25.5%) of all Dual Eligibles, and a fifth (19.9%) of AIAN Dual Eligibles (Table 10). These individuals are entitled to Medicare Part A or Part B, or both, and are eligible for one or more Medicaid benefits including prescription drug coverage. They are not eligible for Medicaid as a QMB, SLMB, QDWI or QI. Typically, these individuals need to spend down to qualify for Medicaid or fall into a Medicaid poverty group that exceeds the limits listed above. Through 2005, individuals in this group qualify for one or more Medicaid benefits including prescription drug coverage. Beginning in 2006, Part D provides drug coverage for these individuals, and Medicaid drug benefits are not required for an individual to be reported in this group. Medicaid pays for Medicaid services provided by Medicaid providers, but only to the extent that the Medicaid rate exceeds any Medicare payment for services covered by both Medicare and Medicaid. Payment by Medicaid of Part B premiums is a state option. There are also special dual eligible groups not included above, but approved under special circumstances (for example, 'Pharmacy + Waivers' in states that do not include prescription drugs in Medicaid benefits for some groups).

- ***Recommendations to Reduce Medicare Data Gaps Defining AIAN and I/T/U Enrollment***

  - Use the current Medicare Enrollment Data Base start with the Beneficiary Race Source Code identified through the IHS-CMS Exchange Files to track enrollment for IHS AIAN across IHS Administrative Areas to determine the impact of program and policy changes on IHS AIAN enrollment.

  - After IHS and CMS expand the 'IHS Code' for the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base to define AIAN beneficiaries according to each CMS TTAG definition (see above), analyze eligibility and coverage data across IHS Administrative Areas to determine the impact of program and policy changes on AIAN in Medicare.

  - Use MSIS eligibility and coverage data for Medicaid-Medicare dual eligibles for AIAN beneficiaries and IHS Program providers because of the disproportionate enrollment of AIAN in these low income categories, and the special impact of Medicare out-of-pocket costs for premiums co-pays and deductibles on the IHS AIAN. After using MSIS State Summary Data Mart data online for IHS Area and State level data; then analyze MSIS electronic Data Files to track for IHS Area, State and Contract Health Service Delivery Areas within states.

Medicare Service Data

The National Claims History (NCH) Data Repository houses all Common Working File claims that have been processed, both Part A and B. The National Medicare Utilization Database (NMUD) provides a data warehouse environment for quick and easy extraction or query of Medicare Claims Data. Information about the use of Medicare health care services is available from claims aggregated in the following groups:

1. Hospital Outpatient Services
2. Physician/Supplier Services
3. End Stage Renal Disease Program
4. Benefit Payment
5. Managed Care
6. Skilled Nursing Facility Services
7. Home Health Agency Services
8. Hospice Services

Measures of health care usage include, but are not limited to: persons served, units of service (such as numbers of discharges or claims.), and dimensions of the services rendered (including average length of stay). For hospital services the data include:

1. Number of Hospital stays (Discharges)
2. Days of Care
3. Location and Size of Hospital
4. Type of Control
5. Type of Hospital
6. Principal Diagnoses within Major Diagnostic Classifications
7. Principal Procedure within Major Procedure Classifications
8. Leading Diagnosis-Related Groups
9. Case-mix Index

Such service utilization measures can be aggregated by program coverage categories, provider characteristics, and demographic and geographic variables.

Research Data. Service data is available in Medicare research files categorized according to the level of beneficiary and provider identifying information they contain: Research Identifiable Files, Limited Data Set Files and Non-Identifiable files. In the first category are the claims files with beneficiary and provider identifying information such as the Medicare Provider Analysis and Review (MEDPAR) File, from which more restricted files can be prepared by eliminating, aggregating or encrypting identifying information. The Research Data Assistance Center (ResDAC) at the University of Minnesota is a CMS contractor that provides free assistance to academic, government and non-profit researchers using Medicare or Medicaid data.[36]

MEDPAR files summarize services provided to Medicare beneficiaries admitted to Medicare certified hospitals or skilled nursing facilities. A MEDPAR record has an accumulation of service claims from dates of admission to date of discharge to represent one stay. The file is used to update annual hospital and skilled nursing Prospective Payment System rates and allows researchers to track inpatient history and patterns of

[36] Research Data Assistance Center (ResDAC) is staffed by a consortium of epidemiologists, public health specialists, health services researchers, biostatisticians, and health informatics specialists from the University of Minnesota. www.resdac.umn.edu/Index.asp

care and outcomes over time. Health Status studies on disease prevalence and mortality have used the MEDPAR data files. The Beneficiary Race Codes as currently defined in the Enrollment data Base are included in the files .

Beneficiary Annual Summary Files are annual summary files for enrollees served include Diagnosis Related Group (DRG) codes, Aggregated Condition Categories (ACCs), and a few summary data items for utilization of inpatient and physician services, home health, hospice, outpatient and durable medical equipment.

Data Extracts. Medicare has the capability of providing data externally through the Data Extract System (DESY) which provides an access path to Service Utilization; Functional/Health Status; Services Expenditure and Financing; as well as demographic information such as age and gender. Two of the systems extracted include the Common Working File and National Claims History. Limited extracts of the former files are provided for a variety of projects including CMS-sponsored pilot projects. Part A and Part B claims data extracts of the National Claims History files are tailored to the requirements of the requesting organization.

Clinical Data. Clinical Data is collected from claims data and Quality Improvement Organizations, long-term care facilities, home health agencies, hospitals, dialysis facilities and Medicare Advantage Plans. The Quality Improvement Organizations maintain the most extensive repository of clinical data. The data used by Quality Improvement Organizations is pulled from sample claims and hardcopy medical records.

Chronic Care Data. The Chronic Condition Data Warehouse (CCW) provides researchers investigating health care and health status with chronic conditions with beneficiary, claims, and assessment data linked by beneficiary across the continuum of care for specified chronic conditions. In the past, researchers analyzing Medicare data files were required to perform extensive analysis related to beneficiary matching, duplication, and merging of the files in preparation for their study analysis. With the CCW data, this preliminary linkage work is already accomplished and delivered as part of the data files sent to researchers.

Prescription Drug Data. The Medicare Prescription Drug program (Part D) began in 2006 and data collection is in its infancy. Medicare receives a subset of drug claims called Prescription Drug Events from drug plans. Drug Event data includes: dates of service, national drug codes, charges and payments, as well as provider data. Beneficiary race is not among the data collected, but the Health Insurance Claim number is collected. The amount of data collected is limited and so are the uses of the collected data. Because the data is not for payment, the data can have a considerable lag time between date of service and date of submission to the data systems. Currently prescription drug data cannot be linked with other services provided to the enrollee served, including diagnosis information.

Managed Care Data. Encounter data is collected through the Risk Adjustment Payment System (RAPS). Managed Care Organizations submit hospital inpatient, outpatient, and physician encounters in a variety of formats categorized by diagnoses or illnesses. Medicare fee-for-service data is used to set capitated payment amount. Managed care data is used to reconcile past capitated payments and risk adjust future capitated payments.

The chief recommendations to Medicare are to see that service measures are analyzed at least by the currently available data for racial AIAN and the IHS AIAN (EDB Race Source Code = IHS), and by the three groups (I/T/U) of providers. This requires re-emphasizing the recommendations made above for AIAN and I/T/U:

- ***Recommendation to Reduce Medicare Data Gaps Defining AIAN and I/T/U Services***

  - Select current Medicare claims data bases that best track service utilization of AIAN beneficiaries and services provided by I/T/U providers and expand the definitions of AIAN and I/T/U providers represented in those data bases with the CMS TTAG definitions;

  - CMS should link the Medicare Enrollment Data Base that includes the current data item 'Beneficiary Race Source Code' with the selected claims data bases to track service utilization for 'IHS AIAN' beneficiaries across IHS Administrative Areas to determine the impact of program and policy changes on the care and health status of AIAN.

Medicare Payment Data

Included in claims data bases for services is information on Medicare program payments. Benefit payments comprise all withdrawals from the Hospital Insurance and Supplemental Medical Insurance trust funds to directly pay providers for services rendered for covered services to Medicare enrollees under the fee-for-service (FFS) payment system and monthly premiums to managed care organizations under capitated payment systems. Under FFS, payments recorded on bills (referred to as program payments) and payments made independently of the billing system (e.g., lump-sum adjustments to interim rates and end-of-year adjustments from cost settlements) are included.

Payments are analyzed by source of funds, types of service, per unit of-service, geographic area, and broad eligibility and coverage categories. Direct out-of-pocket payments by enrollees are also measured. Medicare Such out-of-pocket payments by enrollees are termed "cost-sharing liability" and include such things as coverage premiums, deductibles, and copayments.

Payment information is contained in the databases described for services: Research data, Data Extracts, Clinical Data, Chronic Care Data, Managed Care Data, and Prescription Drug Data.

The chief recommendations are to see that payment measures are analyzed at least by the currently available data for racial AIAN and the IHS AIAN (EDB Race Source Code = IHS), and by the three groups (I/T/U) of providers. This requires re-emphasizing the recommendations made above for AIAN and I/T/U:

- ***Recommendations to Reduce Medicare Data Gaps Defining AIAN and I/T/U Payments***

  - Using the claims data bases developed for AIAN and I/T/U service utilization, analyze the amount of payments made by Medicare for the care of AIAN beneficiaries and the services provided by I/T/U providers across IHS Administrative Areas, to determine the impact of program and policy changes on the health care of AIAN and the solvency of I/T/U providers

  - The extent of data gaps in payments, and the adjustments needed to compare payments across IHS Administrative Areas, will not begin to be known until the Medicare Enrollment Data Base that includes the current data item 'Beneficiary Race Source Code' that identifies 'IHS AIAN' beneficiaries is linked to the claims data bases.

V. Medicaid and SCHIP data useful for performance and policy reports

In this section we use electronic Medicaid MSIS State Summary Data Mart to apply the currently available definitions for AIAN and I/T/U providers, and evaluate summative data for Medicaid enrollment, services and payments in 50 states. The definition for AIAN in the Data Mart is the racial grouping of Table 4, Race-Ethnicity = 3. The definition for I/T providers in the Data Mart is 'IHS Program.' MSIS data systems now allow the monthly reporting of total eligibles enrolled for Medicaid, as well as for Medicaid expansion SCHIP (paid with Title XIX funds like Medicaid), but not state SCHIP which is paid with Title XXI funds. Not all eligibles enrolled actually use services. Data for enrollees served (also termed Medicaid recipients or beneficiaries) is presented in the Medicaid service use and payment section below.

Medicaid Enrollment Data

Medicaid eligibility enrollees are categorized as a combination of two characteristics, their: 1) Maintenance Assistance Status, and 2) Basis of Eligibility. Maintenance Assistance Status refers to an eligible enrollee's income and resources (tangible assets). Basis of Eligibility refers to Age, Disability and Family status of an eligible enrollee. There are more than 90 combinations of Maintenance Assistance Status and Basis of Eligibility categories, and therefore it is difficult in this report to define and present all data categories. We present here descriptive definitions for the categories and then statistics for the AIAN enrollees in Medicaid across all 50 states. For more complete technical definitions we refer the reader to the MSIS Data Dictionary.[37]

Maintenance Assistance Status Categories

Receiving Cash. The most common Maintenance Assistance Status category among AIAN eligibles enrolled in Medicaid is that of individuals Receiving Cash assistance**.** Medicaid is the health care coverage program for recipients of cash assistance in such programs as TANF and SSI. These are generally the individuals with lowest income and resources with Medicaid coverage, but they are not necessarily ill or in need of medical care at all times they are enrolled. The proportion of all AIAN eligibles enrolled who are Receiving Cash is 43.3%, which is 7.6% higher than the proportion for all eligibles enrolled (Table 13)**.** This proportion is 1.21 times higher than the proportion for all eligibles enrolled.

Poverty Related. The second most common Maintenance Assistance Status category among AIAN eligibles enrolled in Medicaid is that of individuals in categories that are Poverty Related. The Poverty Related category includes, but is not limited to: 1) Children made eligible with more liberal income and resource limits than those for cash assistance programs; 2) Children made eligible by SCHIP Medicaid Expansion (Title XXI); 3) Medicare eligibles with low incomes and assets and therefore eligible for QMB, SLMB, QI, QDWI and other Dual Eligible programs described above under Medicare; 4) Pregnant and post-partum women made eligible with more liberal income and resource limits than those for cash assistance programs; 5) Women under age 65 with breast or cervical cancer, or pre-cancerous conditions. The proportion of AIAN eligibles enrolled in the Poverty Related category is 31.3%, which is only 0.8% higher than the proportion for all eligibles enrolled (Table 13)**.**

Waiver. Nearly one-tenth (9.4%) of AIAN eligibles are enrolled in Medicaid through the authority of a 'Section 1115 Waiver' Demonstration program that enrolls the eligibles in state designated managed care plans. The category includes but is not limited to Aged, Blind/Disabled, Children and Adults. Though the proportion

[37] All combinations are presented and defined in Attachment 3 to *Medicaid Statistical Information System (MSIS) Tape Specs & Data Dictionary*, December 2004; 159 Release 2, Version 5.

of AIAN eligibles enrolled in the Waiver category is only 1.6% lower than the proportion for all eligibles enrolled (11.0%)**,** the AIAN proportion is 0.86 times the proportion for all eligibles enrolled (Table 13).

Table 13. Differences in Maintenance Assistance Status for AIAN Eligibles Enrolled in 50 states in the State Summary Data Mart (AIAN non-Hispanic, 2004).

Maintenance Assistance	All Eligibles Enrolled		AIAN Eligibles Enrolled		AIAN Differences from All Eligibles	
	Number	Percent	Number	Percent	Difference in Percents	Ratio of Percents
Receiving Cash	20,710,337	35.7%	361,333	43.3%	7.6%	1.21
Poverty Related	17,667,302	30.5%	261,149	31.3%	0.8%	1.03
Waiver	6,378,970	11.0%	78,844	9.4%	-1.6%	0.86
Medically Needy	3,353,219	5.8%	28,678	3.4%	-2.3%	0.59
Other	9,890,065	17.1%	104,482	12.5%	-4.5%	0.73
Unknown	1,028	0.0%	17	0.0%	0.0%	1.15
Total	58,000,921	100.0%	834,503	100.0%	0.0%	1.00

Data Source: Medicaid State Summary Data Mart, FFY2004. Accessed June 2007.

Medically Needy. Only 3.4% of AIAN eligibles are enrolled as Medically Needy. The Medically Needy are eligibles enrolled who have income and assets that preclude Medicaid eligibility unless their medical bills are considered. The Medically Needy include Aged, Blind/Disabled, Children and Adult individuals, including individuals who would be ineligible if not for the costs of enrolling in a managed care plan (Health Maintenance Organization). People become Medically Needy as their income and resources are claimed by medical bill payments. The proportion of AIAN eligibles enrolled in the Medically Needy category is 2.3% lower than the proportion for all eligibles enrolled (5.8%, Table 13)**.** The AIAN proportion is only about half (0.59 times) the proportion for all eligibles enrolled.

Other. There are more than 60 other groups of eligibles enrolled in this Maintenance Assistance Status category (see reference in footnote). The percent of AIAN Eligibles Enrolled in this group (12.5%) is lower than the percent of All Eligibles Enrolled (17.1%) (Table 13).

Basis of Eligibility Categories

Proportionately more AIAN are in Medicaid eligibility categories of low income Children or Adults, and fewer are in categories of Aged or Disabled. The basis of eligibility for more than half of AIAN eligibles (53.8%) who are enrolled in Medicaid stems from their status as Children: in Low Income Families or other eligible situations, in any one of a dozen or more categories, with or without cash assistance.[38] Only 47.8% of all Medicaid eligibles enrolled are in these Children-based eligibility categories. Proportionately more AIAN (29.1%) than all eligibles (25.9%) are eligible for Medicaid based on their status as a low income Adult that meets income, resource and family composition requirements in any of several categories, with or without cash assistance. About a tenth (10.4%) of AIAN eligibles enrolled in Medicaid are eligible because they are Blind or Disabled and 4.0% because they are Aged. Among all eligibles enrolled, 15.1% are Blind or Disabled and 9.0% are Aged.

[38] MSIS Data Dictionary. *Medicaid Statistical Information System (MSIS) Tape Specs & Data Dictionary*. December 2004; 159 Release 2, Version 5. Attachment 3 - Comprehensive Eligibility Crosswalk**.**

Table 14. Differences in Basis of Medicaid Eligibility for AIAN Eligibles Enrolled in 50 states in the State Summary Data Mart (2004).

	All Eligibles Enrolled		AIAN Eligibles Enrolled		AIAN Differences from All Races	
Basis of Eligibility	Number	Percent of Total	Number	Percent of Total	Difference in Percents	Ratio of Percents
Aged	5,228,154	9.0%	33,618	4.0%	-5.0%	0.45
Blind & Disabled	8,806,436	15.1%	86,617	10.4%	-4.8%	0.69
Children	27,778,376	47.8%	449,053	53.8%	6.0%	1.13
Adults	15,055,110	25.9%	243,198	29.1%	3.3%	1.13
Children of Unemployed Parents	152,132	0.3%	2,015	0.2%	0.1%	0.92
Unemployed Adults	183,566	0.3%	2,278	0.3%	0.0%	0.86
Foster Care	935,225	1.6%	17,602	2.1%	0.5%	1.31
Unknown	1,119	0.0%	17	0.0%	0.0%	1.06
Breast Cancer Women	21,107	0.0%	152	0.0%	0.0%	0.50
Total	58,161,225	100.0%	834,550	100.0%	0.0%	1.00

Data Source: Medicaid State Summary Data Mart, FFY2004. Accessed June 2007.

SCHIP Enrollment Data

States report SCHIP Medicaid Expansion data to MSIS, but do not have to report data to non-Medicaid (state-only or 'Separate') SCHIP program data funded by Title XXI funds. Only 14 states have SCHIP programs that are restricted to just a Medicaid expansion and therefore must report all SCHIP data to the State Summary Data Mart. Seventeen (17) states had only Separate SCHIP programs in 2006.[39] Nineteen (19) states have a combination of a Medicaid expansion and a Separate SCHIP program. They must report the Medicaid expansion data, but may or may not report the Separate SCHIP program data. For this reason the data in MSIS on SCHIP is limited largely to Medicaid expansion data only (Table 15). Some states did not report their data in either the State only or Medicaid Expansion categories, this data is classified in MSIS State Summary data as 'Unknown.'

Enrollment data for both Medicaid and non-Medicaid types of SCHIP programs is available in the web-based Statistical Enrollment Data System (SEDS). However, SEDS does not require that states provide race or provider information, and therefore there is no information for AIAN or I/T/U providers. SCHIP surveys of states are done periodically to obtain more detailed information about SCHIP enrollees and these could be investigated for the possibility of information for AIAN or I/T/U providers.

Table 15. Number of SCHIP Eligibles Enrolled by Medicaid Expansion and state-only, 'Separate' SCHIP programs as reported to Medicaid (2004).

	All Eligibles Enrolled		AIAN		Difference in Percents
	Number	Percent	Number	Percent	
Medicaid	1,521,215	73%	23,477	97%	23.7%
Separate	413	0%	0	0%	0.0%
Unknown	563,891	27%	818	3%	-23.7%
Total	2,085,519	100%	24,295	100%	0.0%

Data Source: Medicaid State Summary Data Mart, FFY2004. Accessed June 2007.

[39] Kaiser Family Foundation, State Health Facts, SCHIP Program Types. Available at: www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=SCHIP&topic=SCHIP+Program+Type

- ***Recommendations to Reduce Medicaid Data Gaps Defining AIAN Enrollment***

  - Use available MSIS State Summary Data Mart data to analyze Medicaid Medical Assistance Status and Basis of Eligibility data for AIAN and the IHS Program both over time and across IHS Administrative Areas, States,

  - Use MSIS electronic data files to analyze Medicaid Medical Assistance Status and Basis of Eligibility data for AIAN and the IHS Program both over time and across IHS Administrative Areas, States, and CHSDA Counties to determine the impact of program and policy changes on AIAN and I/T/U participation in Medicaid programs.

- ***Recommendations to Reduce Medicaid Expansion SCHIP Data Gaps Defining AIAN Enrollment***

  - Use available MSIS State Summary Data Mart data to analyze Medicaid Expansion SCHIP enrollment data for AIAN and the IHS Program both over time and across IHS Administrative Areas, States,

  - Use MSIS electronic data files to analyze Medicaid Expansion SCHIP enrollment data for AIAN and the IHS Program both over time and across IHS Administrative Areas, States, and CHSDA Counties to determine the impact of program and policy changes on AIAN and I/T/U participation in Medicaid programs.

- ***Recommendation to Reduce State-Only ('Separate') SCHIP Data Gaps Defining AIAN Enrollment***

  - Investigate the possibilities of obtaining data on AIAN and I/T/U enrollment data from SCHIP surveys, Statistical Enrollment Data Systems, and other sources.

Medicaid Service Data

We present in this section service utilization data of the Medicaid State Summary Data Mart as aggregated in 18 service categories from the 35 service types monitored in MSIS claims files. There are four MSIS claims files that report the type of services provided to enrollees served, and some more detailed information required for each service type in the Data Mart. The regulations, standards and requirements of the providers and facilities to provide these services are specified in the MSIS Data Dictionary.[40] In this section using State Summary Data Mart online data, we contrast service utilization first of AIAN enrollees served by any provider to that of all enrollees served regardless of racial category (Table 16). We then contrast service utilization of AIAN enrollees served by IHS Program providers (I/T providers) to that of all enrollees served by any provider (Table 16).

Outpatient Services. Outpatient services include preventive, diagnostic, therapeutic, rehabilitative, and palliative services are furnished by a facility that is licensed or formally approved as a hospital to people not admitted to stay in the facility.[41] The most common services used by AIAN enrollees served through Medicaid are outpatient services. Half of the AIAN (50.5%) use outpatient services while only about a quarter of all enrollees served (28.7%) use outpatient services (Table 16). More than half of AIAN enrollees who used IHS Program providers used outpatient services (58.4% compared to 50.5%, Table 16).

[40] *Medicaid Statistical Information System (MSIS) Tape Specs & Data Dictionary*. December 2004; 159 Release 2, Version 5.
[41] By an officially designated authority for Medicaid State standard setting; the facility must also meet the requirements for participation in Medicare as a hospital.

Clinic Services. Clinic services include preventive, diagnostic, therapeutic, rehabilitative, and palliative items or services that are provided to outpatients by a facility that is not part of a hospital but is organized and operated to provide medical care to people who do not stay in any clinical facility. Proportionately more clinic services are provided to AIAN enrollees served than are provided to all enrollees served. Almost a third of AIAN enrollees served (30.0%) receive clinic services while only a fifth of all enrollees served receive them (20.0%, Table 16). Only a fifth of AIAN enrollees served by IHS Program providers (19.7%) used their clinic services.

Physicians' Services. Physician services are those services provided within the scope of practice of medicine or osteopathy as defined by state law by a licensed individual whether furnished in a physician's office, a recipient's home, a hospital, a nursing facility, or elsewhere. Services provided by dentists within the scope of their practice are included if allowed by state law. Services provided under the personal supervision of such an individual are also included. Physician services are used by more than a third of AIAN enrollees served (39.6%) similar to all enrollees served (43.2%, Table 16). But only 2.2% of AIAN served by IHS Program providers have physician services included in their IHS Program claims.

Table 16. Differences in service utilization of all enrollees served and AIAN enrollees who were served by IHS Program providers compared to all Medicaid enrollees served (2004).

	All Enrollees Served		AIAN Enrollees Served		AIAN Differences with All	AIAN Enrollees Served by IHS Program		IHS Program Differences with All
Service Types	Number	Percent	Number	Percent	Difference in Percents	Number	Percent	Difference in Percents
Outpatient	15,919,109	28.7%	373,327	50.5%	21.8%	169,071	58.4%	29.7%
Clinic	11,083,587	20.0%	221,505	30.0%	10.0%	56,975	19.7%	-0.3%
Physician	23,925,784	43.2%	292,558	39.6%	-3.6%	6,510	2.2%	-40.9%
Filled Prescriptions	27,934,086	50.4%	352,612	47.7%	-2.7%	34,723	12.0%	-38.4%
Inpatient	5,405,591	9.8%	97,788	13.2%	3.5%	23,835	8.2%	-1.5%
Laboratory & Imaging	16,012,292	28.9%	174,668	23.6%	-5.3%	2,588	0.9%	-28.0%
Dental	9,012,796	16.3%	109,189	14.8%	-1.5%	12,492	4.3%	-12.0%
Home Health	1,145,448	2.1%	8,655	1.2%	-0.9%	225	0.1%	-2.0%
Intermediate Care Facility*	113,498	0.2%	502	0.1%	-0.1%	0	0.0%	n.a.
Nursing Facility	1,712,391	3.1%	8,386	1.1%	-2.0%	129	0.04%	-3.0%
Mental Health Facility	116,256	0.2%	2,896	0.4%	0.2%	62	0.02%	-0.2%
Other Care	12,420,020	22.4%	191,697	26.0%	3.5%	17,225	6.0%	-16.5%
Other Practitioner	5,913,591	10.7%	87,741	11.9%	1.2%	1,402	0.5%	-10.2%
Capitated Care	30,000,601	54.2%	422,632	57.2%	3.0%	17,643	6.1%	-48.1%
Primary Care Case Management	8,547,877	15.4%	90,481	12.2%	-3.2%	5,442	1.9%	-13.6%
Personal Support	6,277,248	11.3%	75,080	10.2%	-1.2%	3,879	1.3%	-10.0%
Sterilizations	174,228	0.3%	1,775	0.2%	-0.1%	12	0.0%	-0.3%
Unknown	82,158	0.1%	3728	0.5%	0.4%	8	0.0%	-0.1%
Total Enrollees Served	55,395,763	100%	738,694	100%	0.0%	289,434	100.0%	0.0%

*For Mentally Retarded individuals.

Data Source: Medicaid State Summary Data Mart, FFY2004. Accessed June 2007.

Prescribed Drugs. Prescribed drugs include filled prescriptions for medications for the cure, mitigation, or prevention of disease or for health maintenance that are prescribed by a physician or other licensed practitioner within the scope of professional practice as defined and limited by federal and state law on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records; and dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act. Nearly half of AIAN enrollees served (47.7%) and all enrollees served (50.4%) have prescribed drugs (Table 16). But only 12.0% of AIAN enrollees served have prescribed drugs claims through the IHS Program. The main reasons for the low proportion of paid claims for prescriptions recorded by or attributed to IHS program providers need further investigation. I/T providers can establish Medicaid pharmacies that have All-Inclusive Rates or fee-for-service rates (Table 7).

Inpatient Hospital Services. Inpatient hospital services are ordinarily furnished in a hospital for the care and treatment of people who are admitted to stay for treatment for disorders other than mental diseases under the direction of a physician or dentist. The facility is licensed or formally approved (as for Outpatient Services above) and has in effect a utilization review plan applicable to all Medicaid patients unless a waiver has been granted by the Secretary of Health and Human Services. More than a tenth of AIAN enrollees with claims are hospitalized (13.2%), but only 9.8% of all enrollees served and 8.2% of AIAN enrollees served by an IHS Program are hospitalized (Table 16).

Laboratory and Imaging Services. Laboratory and imaging services in this category are professional or technical laboratory or imaging services (X-rays, CAT scans, MRI, etc) that are provided by a facility *other than a hospital inpatient or outpatient department or clinic*. Laboratory and imaging services provided within I/T hospitals, outpatient departments and clinics thus are not included, only those services ordered from outside laboratories. These are costs to I/T hospitals and clinics and can be included in the Medicaid All-Inclusive Rate (Table 7). X-ray services provided by dentists are reported under dental services. Claims for laboratory and imaging services other than a hospital or clinic are filed for nearly a quarter (23.6%) of AIAN enrollees with claims and a little more than a quarter (28.5%) of all enrollees with claims (Tables 16). But only 0.9% of AIAN with IHS Program claims have separate Medicaid claims for these services.

Dental Services. Dental services include diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of the teeth and associated structures of the oral cavity; and disease, injury, or an impairment that may affect the oral or general health of the recipient. A dentist is an individual licensed to practice dentistry or dental surgery. Dental services include dental screening and dental clinic services and services related to providing and fitting dentures as dental services. Dental services included in this Medicaid category do not include services provided as part of inpatient hospital, outpatient hospital, non-dental clinic, or laboratory services and billed by the hospital, non-dental clinic, or laboratory or services. Nearly a sixth of AIAN enrollees served (14.8%) and all enrollees served (16.3%) have Medicaid dental claims (Table 16), but only 4.3% of AIAN enrollees served have IHS Program claims for these services.

Home Health Services. These are services provided at the patient's place of residence, in compliance with a physician's written plan of care. Mandatory services include nursing services provided on a part-time or intermittent basis by a home health agency (a public or private agency or organization, or part of any agency or organization that meets the requirements for participation in Medicaid). If there is no agency in the area, it is mandatory that the services be provided by a registered nurse who is licensed to practice in the State, receives written orders from the patient's physician, documents the care and services provided; and has had orientation to acceptable clinical and administrative record keeping from a health department nurse. Services must also include home health aide services provided by a home health agency; and medical supplies, equipment, and appliances suitable for use in the home. Other services are optional: physical

therapy, occupational therapy, or speech pathology and audiology services. Only 2.1% of all enrollees served have claims for Home Health Services, and only 1.2% of AIAN enrollees served (Table 16). An even lower percent of AIAN enrollees with IHS Program claims have these services (0.1%). It is likely that more home health services are provided to Medicaid eligible AIAN through IHS Programs, but the services do not meet Medicaid requirements and are not billed to Medicaid.

Intermediate Care Facilities Services. These are services provided in an institution for mentally retarded persons or persons with related conditions if the primary purpose of the institution is to provide health or rehabilitative services to such individuals. Only 0.2% of all enrollees served and 0.1% of AIAN enrollees served are in this category (Table 16). None of the AIAN enrollees with IHS Program claims have IHS Program claims for these services.

Nursing Facilities Services. These are services provided in an institution (or a distinct part of an institution) which is primarily engaged in providing to residents: 1) Skilled nursing care and related services for residents who require medical or nursing care; 2) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or 3) health-related care and services to individuals who, because of their mental or physical condition, require care and services on a regular basis above the level of room and board) which can be made available to them only through institutional facilities. . Only 3.1% of all enrollees served, only 1.1% of AIAN and 0.04% of the AIAN among IHS Program enrollees served have these services through the program (Table 16).

Mental Health Facility Services. An institution for mental diseases is a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care of individuals with mental diseases, including medical care, nursing care, and related services. Only 0.2% of all enrollees served, only 0.4% of AIAN and 0.02% of the AIAN IHS Program enrollees served are in this category (Table 16).

Other Care. These transportation, abortions and other services do not meet the definitions of any of the previously described service categories. They may include, but are not limited to Prosthetic devices, Eyeglasses, Home and Community-Based Waiver services (for example, community homes for the disabled and adult day care).

Other Licensed Practitioners' Services. These are medical or remedial care or services, other than physician services or services of a dentist, provided by licensed practitioners within the scope of practice as defined under State law who can file claims for their services with the state Medicaid program. The category “Other Licensed Practitioners' Services” is different than the “Other Care” category. Examples of other practitioners (if covered under State law) include: Chiropractors; Podiatrists; Psychologists; and Optometrists. Speech therapists, audiologists, opticians, physical therapists, and occupational therapists are not included within Other Licensed Practitioners' Services. Other Licensed Practitioners' Services do not include prosthetic devices billed by physicians, laboratory or X-ray services provided by other practitioners, or services of other practitioners that are included in inpatient or outpatient hospital bills. These services are counted under the related type of service as appropriate. Devices billed by providers not included under the listed types of service are counted under Other Care.

Capitated Care. Capitated care enrollees and capitated payments for the plan types defined in Health Maintenance Organization (HMO) and Prepaid Health Plans contracted to provide capitated comprehensive and less than comprehensive services. A Prepaid Health Plan is an entity that provides a non-comprehensive set of services on either capitated risk or non-risk basis or the entity provides comprehensive services on a non-risk basis. This service category includes dental, mental health, and other plans covering limited services under Prepaid Health Plans. More than half of AIAN (57.2%) and all enrollees served (54.2%) have

at least one capitated care claim (Table 16), but only 6.1% of AIAN enrollees served by IHS Program have claims for capitated care. These IHS Program claims for capitated care are all from one state: New Mexico.

Primary Care Case Management. The State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most such programs pay the primary care physician a monthly case management fee. Where the fee includes services beyond case management, the enrollees and fees are reported under prepaid health plans. Nearly an eighth of AIAN (12.2%) and a sixth of all enrollees served (15.4%) have Medicaid Primary Care Case Management (Table 16), but only 1.9% of AIAN who are IHS Program enrollees served have such services through the program.

Personal Support Services. This service category includes services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are authorized for an individual usually in accordance with an approved service plan. The services include Personal Care Services, Targeted Case Management Services, and Rehabilitative Services, Physical Therapy, Occupational Therapy, and Services for Individuals with Speech, Hearing, and Language Disorders, Hospice Services, Nurse Midwife, Nurse Practitioner, Private Duty Nursing, Religious Non-Medical Health Care Institutions. A tenth of AIAN (10.2%) and all enrollees served (11.3%) have personal support services (Table 16), but only 1.3% of AIAN who are IHS Program enrollees served have such services through the program.

Sterilizations. Sterilizations are medical procedures, treatment or operations for the purpose of rendering an individual permanently incapable of reproducing than all enrollees served. Proportionately fewer AIAN (0.2%) served by any provider (Table 16) had a sterilization. Less than 0.1% of AIAN with at least one IHS Program claim had a sterilization claim filed by an IHS Program provider (0.3%).

- ***Recommendations to Reduce Medicaid Data Gaps Defining AIAN and I/T/U Services***

  - Use available MSIS State Summary Data Mart data to analyze the 18 categories of services data for AIAN and the IHS Program both over time and across IHS Administrative Areas at the State level.

  - Obtain MSIS electronic data files, and analyze the 35 categories of services data relevant for AIAN and the IHS Program both over time and across IHS Administrative Areas, States, and CHSDA Counties to determine the impact of program and policy changes on AIAN and I/T/U service utilization in Medicaid programs.

- ***Recommendations to Reduce Medicaid Expansion SCHIP Data Gaps Defining AIAN and I/T/U Services***

  - Use available MSIS State Summary Data Mart data on Medicaid Expansion SCHIP to analyze the 18 categories of services data for AIAN and the IHS Program both over time and across IHS Administrative Areas at the State level.

  - Obtain MSIS electronic data files data on Medicaid Expansion SCHIP, and analyze the 35 categories of services data relevant for AIAN and the IHS Program both over time and across IHS Administrative Areas, States, and CHSDA Counties to determine the impact of program and policy changes on AIAN and I/T/U service utilization in Medicaid programs.

Medicaid Payment Data

We present in this section analysis of the data for the Medicaid amounts paid per enrollee served in the 18 categories of service types in the State Summary Data Mart described in the previous section (Table 16). These amounts are adjusted for overpayment and underpayment of claims (adjusted claims). In this section using MSIS State Summary Data Mart online data, we contrast payments per Medicaid enrollee served first of AIAN enrollees served by any provider to that per enrollee served regardless of racial category (Table 17). We then contrast payments per AIAN enrollee served by IHS Program provider (I/T providers) to that per enrollee served by any provider.

The relative payments for AIAN are lowest when differences per AIAN enrollee served have largest negative balances compared to payments per Medicaid enrollee served. The lowest relative payments for AIAN are for: Intermediate Care Facility (-$17,413), Home Health (-$1,413), Nursing Facility (-$758), Prescribed Drugs (-$517), Capitated Care (-$320), and Inpatient Services (-$361) (Table 17).

Table 17. Differences in payments per enrollee served for all AIAN enrollees served and AIAN enrollees served by IHS Programs compared to all Medicaid enrollees served (2004).

	All Enrollees Served		AIAN Enrollees Served		AIAN Differences with All	AIAN Enrollees Served by IHS Program		IHS Program Differences with All
Service Types	Total Payment Amount in Millions	Payment per Enrollee Served	Total Payment Amount in Millions	Payment per Enrollee Served	Difference in Payment per Enrollee	Total Payment Amount in Millions	Payment per Enrollee Served	Difference in Payment per Enrollee
Outpatient	$10,127.7	$636	$487.9	$1,307	$671	$60.2	$1,057	$421
Clinic	$8,254.1	$745	$200.2	$904	$159	$203.7	$1,205	$460
Physician	$10,135.8	$424	$149.0	$509	$86	$2.52	$386	-$37
Prescribed Drugs	$39,359.3	$1,409	$314.6	$892	-$517	$24.5	$706	-$703
Inpatient	$34,658.7	$6,412	$591.6	$6,050	-$361	$135.4	$5,679	-$733
Laboratory & Imaging	$2,687.0	$168	$26.3	$151	-$17	$1.01	$391	$224
Dental	$2,846.5	$316	$44.3	$405	$90	$4.5	$362	$46
Home Health	$4,564.8	$3,985	$22.3	$2,572	-$1,413	$0.45	$2,017	-$1,968
Intermediate Care Facility*	$11,140.5	$98,156	$40.5	$80,744	-$17,413	$0.0	$0	$0
Nursing Facility	$41,999.8	$24,527	$199.3	$23,769	-$758	$18.4	$14,300	-$10,227
Mental Health Facility	$2,262.0	$19,457	$75.2	$25,952	$6,495	$1.0	$15,448	-$4,009
Other Care	$24,798.2	$1,997	$316.3	$1,650	-$346	$27.7	$1,605	-$391
Other Practitioner	$943.2	$160	$15.8	$180	$21	$0.14	$96	-$63
Capitated Care	$42,600.9	$1,420	$464.9	$1,100	-$320	$8.11	$460	-$960
Primary Care Case Management	$499.8	$58	$3.0	$33	-$25	$0.11	$20	-$38
Personal Support	$18,387.8	$2,929	$235.0	$3,130	$201	$4.55	$1,173	-$1,756
Sterilizations	$206.5	$1,185	$2.0	$1,122	-$63	$0.0037	$309	-$876
Unknown	$1,345.2	$16,373	$2.8	$764	-$15,609	$0.0014	$177	-$16,196
Total	$256,817.8	$4,636	$3,191.2	$4,320	-$316	$475.6	$1,643	-$2,993

*For Mentally Retarded individuals.

Data Source: Medicaid State Summary Data Mart, FFY2004. Accessed June 2007.

The relative payments for AIAN are highest per when differences per AIAN enrollee served have largest positive balances compared to payments per Medicaid enrollee served. The highest relative payments for AIAN are for: Mental Health Facility services ($6,495), Outpatient Services ($671), Personal Support ($201), and Clinic Services ($159) (Table 17).

Lowest relative payments for AIAN enrollees served by IHS program providers relative to all enrollees served by any provider (largest negative IHS Program Differences, Table 17) are for: Nursing Facilities (-$10,227), Mental Health Facility services (-$4,009), Home Health (-$,1968), Personal Support ($1,756), Capitated Care (-$960), Sterilizations (-$876), Inpatient Services (-$733), and Prescribed Drugs (-$703).

Highest relative payments for AIAN enrollees served by IHS program providers relative to all enrollees served by any provider (largest positive IHS Program Differences, Table 17) are for: Clinic ($460), Outpatient ($421) and Laboratory and imaging ($224).

- ***Recommendations to Reduce Medicaid Data Gaps Defining AIAN and I/T/U Payments***

  - Use available MSIS State Summary Data Mart data to analyze what factors determine the differences in payments for 18 categories of services for AIAN and the IHS Program both over time and across IHS Administrative Areas at the State level.

  - Obtain MSIS electronic data files, and analyze what factors determine the differences in payments for 35 categories of services data relevant for AIAN and the IHS Program both over time and across IHS Administrative Areas, States, and CHSDA Counties to determine the impact of program and policy changes on AIAN and I/T/U service utilization in Medicaid programs.

- ***Recommendations to Reduce Medicaid Expansion SCHIP Data Gaps Defining AIAN and I/T/U Payments***

  - Use available MSIS State Summary Data Mart data on Medicaid Expansion SCHIP to analyze the 18 categories of services data for AIAN and the IHS Program both over time and across IHS Administrative Areas at the State level.

  - Obtain MSIS electronic data files data on Medicaid Expansion SCHIP, and analyze the 35 categories of services data relevant for AIAN and the IHS Program both over time and across IHS Administrative Areas, States, and CHSDA Counties to determine the impact of program and policy changes on AIAN and I/T/U service utilization in Medicaid programs.

VI. Summary of Recommended Strategies

The CMS TTAG guidance cited in the Introduction asks for specific recommendations on strategies for reducing gaps in CMS data bases and generating useful CMS program and policy reports on AIAN populations and I/T/U providers. To achieve this objective we first summarize the recommendations made in the report above by aggregating the recommendations made for each CMS program: Medicare, Medicaid and SCHIP, first for improving data on AIAN beneficiaries and ITU providers, and then for reporting enrollment, services, and payment data in ways useful for tracking and evaluating CMS program and policy impact on AIAN beneficiaries and ITU providers. We then summarize an implementation plan for those that starts with Medicaid because of the MSIS State Summary data currently available online.

Recommendations to CMS and IHS to Reduce Medicare Data Gaps

- ***Collect Data on Medicare Beneficiaries with CMS TTAG definition for 'Tribal AIAN'***

  - IHS and CMS should work together to expand the CMS-IHS Data Exchange so that the 'IHS code' in the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base is expanded to indicate 'Tribal AIAN' (Table 1). In the Medicare Return File of the data exchange, IHS should include a data item on whether or not each Medicare beneficiary is a Tribal AIAN or their descendant entitled to health care through federal trust, and government-to-government derived rights.

  - CMS should include the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base in all linkages of the Enrollment Data Base to other Medicare data bases so that any Medicare data base intended for analysis of beneficiary information could be analyzed for Tribal AIAN beneficiaries.

  - CMS should examine the feasibility, costs and relative effectiveness of having a question added to the following to obtain Tribal AIAN information conforming to IHS Tribe codes that indicate tribes entitled to health care through federal trust, and government-to-government derived rights:
    - At time of application for birth certificate, and arrange for information to be exchanged with the Social Security Administration during the Enumeration at Birth
    - At time of application for Social Security card (Form SS-5) [and specify evidence required to document the information]
    - At time of application to enroll in Medicare [and specify evidence required to document the information]
    - Add Question to Medicare Beneficiary
    - Perform a special Medicare Beneficiary survey of AIAN designated by Medicare Beneficiary Race Code

- ***Collect Data on Medicare Beneficiaries with CMS TTAG definition for 'IHS AIAN'***

  - CMS should make available the Beneficiary Race Source Code data item with the Medicare Enrollment Data Base for use of the current 'IHS code' in designating 'IHS AIAN' (Table 1) beneficiaries in Medicare.

  - CMS should include the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base in all linkages of the Enrollment Data Base to other Medicare data bases so that any Medicare

data base intended for analysis of beneficiary information could be analyzed for 'IHS AIAN' beneficiaries.

- IHS and CMS should work together to expand the 'IHS code' in the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base to indicate 'IHS AIAN' according to the CMS TTAG definition. In the Medicare Return File of the data exchange with the IHS registry system, CMS should include a data item on whether or not each Medicare beneficiary is in the IHS user population of active patients and all the I/T/U providers with whom the beneficiary is registered.

- ***Collect Data on Medicare Beneficiaries with CMS TTAG definition for 'Census AIAN'***

  - CMS should examine the feasibility, costs and relative effectiveness of having questions added to the following to obtain Race and Ethnicity conforming to 1997 OMB standards allowing beneficiaries to self-declare their identification with multiple races, and to additionally indicate their Hispanic/Latino ethnicity (Census AIAN, Table 1):
    - At time of application for birth certificate, and arrange for information to be exchanged with the Social Security Administration during the Enumeration at Birth
    - At time of application for Social Security card (Form SS-5) the Social Security Administration should collect information on race and ethnicity on Form SS-5 and through the Enumeration at Birth process.
    - At time of application to enroll in Medicare.
    - Add Question to Medicare Beneficiary Surveys
    - Perform a special Medicare Beneficiary survey of AIAN designated by Medicare Beneficiary Race Code to obtain this information
    - Medicare prepaid health plans (which enroll 12 percent of beneficiaries) should be required to collect and report to CMS the race and ethnicity of all enrolled Medicare members.

- ***Collect Data on Medicare Providers with CMS TTAG definition for I/T/U Providers***

  - CMS should have IHS provide a list of IHS, Tribal and Urban providers so that CMS can screen their provider and claims data bases for these providers and add a data item that codes them with one of the three codes defined: I, T, or U.

  - CMS should add a data item in Medicare provider and claims data bases to allow IHS, Tribal and Urban providers to identify themselves with one of the three codes defined according to CMS TTAG definitions: IHS, Tribal or Urban provider (Table 5).

  - IHS and CMS should work together to expand the CMS-IHS Data Exchange so that the 'IHS code' in the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base is expanded to indicate whether the IHS AIAN is currently designated as an of an IHS, Tribal or Urban provider.

- ***Report on AIAN and I/T/U Medicare Data***

  - CMS should Use current Medicare enrollment and claims data bases that best track enrollment, service utilization and payment data of AIAN beneficiaries and services provided by I/T/U provider groups using current CMS definitions;

- CMS should Link the Medicare Enrollment Data Base that includes the current data item 'Beneficiary Race Source Code' with the selected claims data bases to track enrollment, service utilization and payments for 'IHS AIAN' beneficiaries according to the CMS TTAG definition across IHS Administrative Areas.

- After IHS and CMS expand the 'IHS Code' for the Beneficiary Race Source Code data item in the Medicare Enrollment Data Base to define AIAN beneficiaries according to the CMS TTAG definitions for 'Tribal AIAN', 'IHS AIAN', CMS should analyze enrollment, service utilization and payments by I/T/U provider groups across IHS Administrative Areas.

- CMS should Use MSIS eligibility and coverage data for Medicaid-Medicare dual eligibles for AIAN beneficiaries and IHS Program providers according to CMS TTAG definitions, because of the disproportionate enrollment of AIAN in these low income categories, and the special impact of Medicare out-of-pocket costs for premiums co-pays and deductibles on the IHS AIAN. After using the current AIAN and IHS Program definitions for AIAN and ITU Providers in the MSIS State Summary Data Mart data online for IHS Area and State level data; then analyze MSIS electronic Data Files to track enrollment, service utilization and payments for IHS Area, State and Counties, to represent Contract Health Service Delivery Areas within and across states.

Recommendations to Reduce Medicaid and SCHIP Data Gaps

- ***Collect Data on Medicaid Beneficiaries with CMS TTAG definition for 'Tribal AIAN'***

  - CMS should examine the feasibility, costs and relative effectiveness of having a question added to MSIS to obtain Tribal AIAN information conforming to IHS Tribe codes to identify Tribal AIAN who are not in the Indian Health Service registry system but are entitled to health care through federal trust, and government-to-government derived rights, federal

- ***Collect Data on Medicaid Beneficiaries with CMS TTAG definition for 'IHS AIAN'***

  - While there is no Medicaid data at the national level on 'IHS User AIAN' CMS TTAG definition, Racial AIAN defined by the Race-Ethnicity codes of the MSIS Eligible File can be cross-tabulated with IHS Program (provider) information in MSIS Claims files to analyze information on racially coded 'AIAN only' who have paid claims with an IHS program provider. Many, if not most, of these AIAN are likely to also meet the IHS definition of federally recognized AIAN living on or near tribal lands, but they are not necessarily identical to the 'IHS AIAN' verified user active patients.

- ***Collect Data on Medicaid Beneficiaries with CMS TTAG definition for 'Census AIAN'***

  - There is Race-Ethnicity data in the MSIS electronic Eligible File that would allow construction of the Census AIAN groups recommended by the CMS TTAG (see Table 1), but not in the data that has been aggregated for the MSIS State Summary Data Mart that is available online. Therefore to perform analyses of AIAN according to Census AIAN definitions, it is important to use MSIS electronic files and not State Summary online data.

- ***Collect Data on Medicaid Providers with CMS TTAG definition for I/T/U Providers***

  - To the MSIS Claims Files in states with I/T/U providers, CMS should add a data item or Program Type Code that has states differentiate between IHS and Tribal Providers in IHS Program claims data, and IHS Service Area, States should also identify Urban Indian Health Organization as a provider or Program Type in MSIS claims data files.

  - For states with counties served by different IHS Areas, CMS should link the County Code from the MSIS Eligible File for the Medicaid enrollee served on an IHS Program claim in an MSIS Claims File through linkage by the Unique Personal Identifier in both MSIS Eligible and Claims files. In this way IHS Program data can be allocated to the proper IHS Contract Health Service Delivery Area.

  - In IHS Program data in the MSIS State Summary Data Mart online**,** CMS should include any new MSIS information in which states distinguish IHS Program providers by I/T/U provider types, and the IHS Contract Health Service Delivery Areas in their states.

- ***Report on AIAN Medicaid Enrollment, Service Utilization and Payment Data***

  - CMS should First use available MSIS State Summary Data Mart data to analyze Medicaid enrollment, service utilization and payment data for AIAN and the IHS Program according to current

definitions both over time and across states allocated to the proper IHS Contract Health Service Delivery Area.

- CMS should Then use MSIS electronic eligibility and claims data files to analyze enrollment, service utilization and payment data for AIAN and the IHS Program according to the CMS TTAG definitions both over time and across states *and counties* allocated to the proper IHS Contract Health Service Delivery Area. Analyze the service use and payment data for the 35 categories of services data for AIAN and the IHS Program to determine the most relevant services for AIAN and the IHS Program.

- ***Report on AIAN Medicaid Expansion SCHIP Enrollment, Service Utilization and Payment Data***

  - CMS should First use available MSIS State Summary Data Mart data to analyze Medicaid Expansion SCHIP enrollment, service utilization and payment data for AIAN and the IHS Program both over time and across states allocated to the proper IHS Contract Health Service Delivery Area.

  - CMS should then use MSIS electronic data files to analyze Medicaid Expansion SCHIP enrollment, service utilization and payment data for AIAN and the IHS Program both over time and across states *and counties* allocated to the proper IHS Contract Health Service Delivery Area to determine the impact of program and policy changes on AIAN and I/T/U participation in Medicaid programs.

- ***Report on AIAN State-Only ('Separate') SCHIP Enrollment***

  - CMS should investigate the possibilities of obtaining data on AIAN and I/T/U enrollment data from SCHIP surveys, Statistical Enrollment Data Systems, and other sources.

Implementation of Strategies

As directed by the CMS TTAG guidance (see Introduction) we provide an Implementation Plan with a Timeline and Budget for reducing many of the gaps in CMS data, and generating useful program and policy reports, as well as training interested data users in using the CMS data bases (Appendices A, B and C).

In the first 18 months of the implementation it is important for the CMS to begin to improve data definitions and data collection for AIAN and I/T/U providers according to the CMS TTAG definitions in all three CMS Programs: Medicare, Medicaid and SCHIP.

The Implementation Plan strategies for generating AIAN population and I/T/U provider program and policy reports start with Medicaid – not Medicare – because there is already MSIS State Summary data available online from which general information on Medicaid and some SCHIP enrollment, services and payments can be gathered for AIAN and the IHS Program by accepting current Medicaid definitions for AIAN and I/T (but not Urban) providers.

Also in the first 18 months it is important to obtain access to AIAN population and ITU provider information in the MSIS electronic Eligible and Claims data files and the Medicare Enrollment Database (with the Beneficiary Race Source Code) as now defined. The MSIS electronic data files with Eligible File data items of 1 to 5 Race Codes, an Ethnicity Code and a County Code would be valuable to begin analyses using CMS TTAG definitions for 'IHS AIAN' and 'Census AIAN,' presented by state and county of the appropriate IHS County Health Service Delivery Area, after the first 6 months of the Plan. These

definitions and assignments are not available in the MSIS State Summary data mart. The Medicare Enrollment Database electronic file with Beneficiary Race Source Code, and Beneficiary State and County Codes would be valuable to begin analyses using CMS TTAG definitions for 'IHS AIAN,' presented by state and county of the appropriate IHS County Health Service Delivery Area in the last 12 months of the Plan.

Finally the CMS TTAG guidance also asks for recommendations on training data users for AIAN populations and I/T/U providers on how to use the data and produce useful reports. We recommend:

- CMS should sponsor an IHS-Tribal-Urban-CMS Joint AIAN Data Users Group of key IHS, Tribal Epidemiology Centers, Urban AIAN Epidemiology Centers, and Medicaid designated people to develop supporting documentation, and to provide training that expands the understanding and use of CMS AIAN and I/T/U data.

We propose in the first year of the Implementation Plan to start by offering workshops at annual IHS Research Conferences on access and analysis of Medicaid program information for AIAN and IHS Programs in the MSIS State Summary Data Mart. These conferences are attended by investigators from the IHS Native American Research Centers in Health, members of Tribal Epidemiology Centers and Urban AIAN Epidemiology Centers.

Appendix A. Implementation Plan: Strategies to Improve CMS AIAN and I/T/U/ Data

Medicaid Implementation Plan: Strategies to Improve AIAN and I/T/U Data

	Strategies	Data Base	AIAN Groups	Provider Groups	Measures	Dimensions of the Measures	Products
1	Develop routine data processing of the Medicaid data base for on-going reporting using available AIAN and ITU data; store and maintain reusable master databases of the processed data	MSIS State Summary Data Mart (available now online)	AIAN only, non-Hispanic; *Contrast*: Non-AIAN (all other races)	IHS Program (I/T combined); *Contrast*: All Providers; Rural Health Clinics; FQHC.	Eligibles Enrolled; Enrollees Served; Service measures; Payment measures	Year, IHS Area (State), Demographics (age, gender)	Data Bases
2	Analyze AIAN and ITU Provider Program and Policy Statistics	Same as above	Same as above		Same as above	Same as above	Data Tables
3	Develop Table Templates for routine on-going reporting for AIAN and ITU data	Same as above	Same as above	Same as above	Same as above	Same as above	Data Tables
4	Produce routine on-going expandable Medicaid Statistics Reports for AIAN and ITU data^	Same as above	Same as above	Same as above	Same as above	Same as above	Quarterly Data Report*
5	Produce special topic annual CMS Statistics Report for AIAN and ITU	Same as above	At the request of the CMS TTAG	At the request of the CMS TTAG	At the request of the CMS TTAG	At the request of the CMS TTAG	Special Report*
6	Report on the strengths and limitations of using the data base for AIAN Health Status Reports	Same as above	AIAN only, non-Hispanic; *Contrast*:Non-AIAN (all other races)	IHS Program (I/T combined); *Contrast*: All Providers; Rural Health Clinics; FQHC.	Health Status Measures to be determined	Year, IHS Area (State), age, gender	Issue Brief*
7	Report on how evidence of ITU Provider Performance and Compliance with Medicaid standards could be documented	To be determined	Not Predefined	To be determined	Provider Performance and Compliance measures to be determined	To be determined	Issue Brief*
8	Provide training workshops on use of the AIAN and ITU Medicaid data with AIAN EpiCenters and others	MSIS State Summary Data Mart	AIAN and Contrast groups	IHS Program (I/T combined)	Eligibles Enrolled; Enrollees Served; Service measures; Payment measures	Year, IHS Area (State), age, gender	At least 2 Workshops per year
9	Obtain approval to receive and process MSIS electronic data files (not online) in approved form; and start Tasks 1 to 8 for these data files	MSIS Eligibility and claims Data Files	AIAN including multiple race data items, AIAN Hispanics; Contrast groups as above	Check 'IHS Program' definition for consistency with other data items on claims	Expanded Enrollment, Service and Payment measures	Expanded Dimensions	Approved Release of Data Base for TTAG Reporting

Appendix A. Implementation Plan: Strategies to Improve CMS AIAN and I/T/U/ Data

SCHIP Implementation Plan: Strategies to Improve AIAN Data

	Strategies	Data Base	AIAN Groups	Provider Groups	Measures	Dimensions	Products
1	Separate data for SCHIP Medicaid Expansion eligibles enrolled and enrollees served from other Medicaid data when performing Medicaid Tasks 1 to 4 above.^	MSIS State Summary Data Mart (available now online)	AIAN only, non-Hispanic; *Contrast*:Non-AIAN (all other races)	IHS Program (I/T combined); Contrast: All Providers	Eligibles Enrolled; Enrollees Served; Service measures; Payment measures	Year, IHS Area (State), Demographics (age, gender)	Data Bases, Tables, Quarterly Reports
2	Obtain approval to use SCHIP SEDS electronic data base (online)	Statistical Enrollment Data System (SEDS).	No Racial Groups Reported	All Providers combined	Enrollment measures only	Year, IHS Area (State)	Approved Access to Data Base
3	Produce special topic, one-time only, SCHIP Data Gaps and Strategies for AIAN and ITU Issue Brief	Various	AIAN only, non-Hispanic; *Contrast*:Non-AIAN (all other races)	IHS Program (I/T combined); Contrast: All Providers	Eligibles Enrolled; Enrollees Served; Service measures; Payment measures	Year, IHS Area (State), Demographics (age, gender)	Issue Brief*

^This task is an annual renewable ongoing quarterly task; *An Issue Brief is up to 4 pages; while a Report is up to 30 pages.

Appendix A. Implementation Plan: Strategies to Improve CMS AIAN and I/T/U/ Data

Medicare Implementation Plan: Strategies to Improve AIAN and I/T/U Data

	Strategies	Data Base	AIAN Groups	Provider Groups	Measures	Dimensions	Products
1	Obtain approval to receive and process Medicare EDB electronic data files (not online) in approved form: explore adding ITU Provider Type data item to each AIAN in the IHS Data Exchange with CMS	Enrollment Data Base (EDB)	CMS AIAN (Beneficiary Race Code = "North American" AIAN) & IHS AIAN (Beneficiary Race Resource Code = IHS)	To be determined (Possible to identify I/T/U providers in the IHS Data Exchange with CMS)	Expand AIAN Enrollment Measures to include an IHS AIAN Group	Expanded AIAN and ITU Groups	Approved Release of Data Base
2	Develop routine data processing of the Medicare data base for on-going reporting using available enrollment data; store and maintain reusable master databases of the processed data	Same as above		To be determined	Eligibles Enrolled; Enrollees Served; and other EDB enrollment measures	Year, IHS Area (State), age, gender and others	Data Bases
3	Analyze CMS AIAN and IHS AIAN Enrollment Data	Same as above	Same as above	Same as above	Same as above	Same as above	Data Tables
4	Develop Table Templates for routine on-going reporting of CMS AIAN and IHS AIAN Enrollment Data	Same as above	Same as above	Same as above	Same as above	Same as above	Data Tables
5	Produce routine on-going expandable Medicare Enrollment Reports for CMS AIAN and IHS AIAN data^	Same as above	Same as above	Same as above	Same as above	Same as above	Quarterly Data Report*
6	Produce special topic, one-time only, Medicare Enrollment Report	Same as above	At the request of the CMS TTAG	At the request of the CMS TTAG	At the request of the CMS TTAG	At the request of the CMS TTAG	Special Report*
7	Obtain approval to receive a Medicare claims research data base linked to EDB with the IHS AIAN data item in an approved form; and start Tasks 1 to 6 for the claims data files	MedPAR data base	Linked to EDB so that the IHS AIAN data item is included with the claims information	Check 'IHS AIAN' group definition for consistency with other data items on claims	Service and Payment measures	Expanded Dimensions	Approved Release of Data Base

^This task is an annual renewable ongoing quarterly task; *An Issue Brief is up to 4 pages; while a Report is up to 30 pages.

Appendix B. Implementation Plan: Timeline

[Dated material: Removed]

Appendix C. Implementation Plan: Budget

[Dated material: Removed]

Appendix D.
CMS TTAG Data Subcommittee Members

As of 08/14/07

Co-Chairs
James A. Crouch (California Rural Indian Health Board)
Michael D. Lyman (CMS/Office of External Affairs/Tribal Affairs Group)

Tribal Members
Ex officio: Stacy A.Bohlen (National Indian Health Board)
Brent C. Bizik (Arizona Health Care Cost Containment System)
Candi Carmi (Native American Management Services)
Carolyn Finster (IHS/ALBPHC)
Ed Fox (Dept. of HHS, Squaxin Island Tribe Health Clinic)
Linda Martin (Arizona Health Care Cost Containment System)
JT Petherick (Cherokee Nation)
Jim Roberts (Northwest Portland Area Indian Health Board)

Department of Health and Human Services (CMS/IHS/ASPE)
Ex officio: Dorothy A. Dupree (CMS/Office of External Affairs/Tribal Affairs group)
David K. Baugh (CMS/Office of Research and Data Integration)
Elmer Brewster (IHS/Headquarters, East)
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Frank D Cipolloni (CMS/Office of Information Services)
Sue Clain (HHS/Office of the Assistant Secretary for Planning and Evaluation)
Theresa Cullen (IHS/Headquarters, East)
Robin M. Dalton (CMS/Office of Information Services)
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