

From: Natasha Seaforth [<mailto:natashas@senseinc.com>]

Sent: Wednesday, January 29, 2014 12:45 PM

Subject: Ltr and Final Report to Dr. Elaine Buckberg re: Follow-up from January 22, 2014 Quarterly Meeting of the IHS/TSGAC

MEMBERS OF THE TSGAC, TECHNICAL WORKGROUPS:

Please see the attached letter and TSGAC Final Report “ Enabling Electronic Verification of Eligibility For Indian-specific Benefits and Protections Under Medicaid and the Patient Protection and Affordable Care Act, P.L. 111-48.” This report was developed and submitted to Dr. Elaine Buckberg, Deputy Assistant Secretary for Policy, DOT office, IHS Director and OTSG Director by the TSGAC. We hope that you will find useful information in this report. Thank you

Regards

*Natasha Seaforth, Executive Administrator/ Human Resource Coordinator
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January 29, 2014

Dr. Elaine Buckberg
Deputy Assistant Secretary for Policy
Office of Economic Policy
Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Re: Follow up from January 22, 2014 Quarterly Meeting of the Indian Health Service Tribal Self-Governance Advisory Committee (TSGAC)

Dear Dr. Buckberg:

On behalf of the Indian Health Service Tribal Self-Governance Advisory Committee (TSGAC), we thank you and your colleagues for your participation in our January 2014 quarterly meeting. Along with the other Self-Governance Tribal leaders and advisors in attendance, we very much appreciated your sincere engagement and exchange of ideas with us.

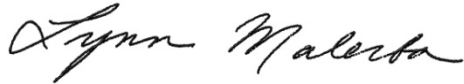
As we discussed, simplifying and making consistent the application process for the two Indian-specific exemptions from the Affordable Care Act's (ACA) tax penalty for not securing health insurance coverage would be of great benefit. Specifically, we urge the IRS to implement an exemption application for persons eligible for IHS services, if delegated by HHS, through the tax-filing process, as it currently is for those seeking an exemption as a member of a federally-recognized Tribe. The most expedient and cost effective means would be through self-attestation, but alternatively, the TSGAC recommends electronic verification with IHS records be implemented as soon as practicable. We believe that adoption of the Tribal recommendations will reduce the confusion felt, and the effort required by American Indian and Alaska Native families to apply for an exemption. Further, this will improve compliance with ACA requirements as well as reduce the costs to Tribes and the Federal government.

Per your request, attached is the TSGAC report entitled, ***Enabling Electronic Verification of Eligibility for Indian-specific Benefits and Protections Under Medicaid and the Patient Protection and Affordable Care Act, P.L. 111-48***. This report was prepared by the TSGAC and formally submitted to Indian Health Service (IHS) and the Centers for Medicare and Medicaid (CMS). The report was prepared in collaboration with IHS and received a favorable reception from the CMS leadership.

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We would like to reiterate our offer to make available TSGAC Tribal representatives and technical advisors for participation in any work groups you may establish to fashion an approach to implementing these exemptions. Thank you again for your contributions to the TSGAC meeting and your willingness to identify an approach that works for all parties. If you have any questions, you can reach me at (860) 862-6192; or via email: lmalerba@moheganmail.com.

Sincerely,



Chief Lynn Malerba, Mohegan Tribe
Chairwoman, TSGAC

Enclosure: ***Enabling Electronic Verification of Eligibility For Indian-specific Benefits and Protections Under Medicaid and the Patient Protection and Affordable Care Act, P.L. 111-48***

cc: Dr. Yvette Roubideaux, Director, IHS
P. Benjamin Smith, Director, Office of Tribal Self-Governance, IHS
TSGAC and Technical Workgroup Members



Health Care Reform in Indian Country

**ENABLING ELECTRONIC VERIFICATION OF ELIGIBILITY
FOR INDIAN-SPECIFIC BENEFITS AND PROTECTIONS
UNDER MEDICAID
AND THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT, P.L. 111-48**

**REPORT PREPARED BY:
TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE (TSGAC)**

MAY 22, 2013

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Acknowledgements:

Thank you to Indian Health Service for providing funding for this report.

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under Medicaid and the Patient Protection and Affordable Care Act, P.L. 111-48**

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A. Purpose of Report

As part of the health care reform analysis and implementation efforts being conducted by Self-Governance tribes, an issue under consideration is the extent to which eligibility can be verified for Indian-specific benefits and protections through an automated and real-time electronic process. The purpose of establishing a mechanism for real-time electronic verification is to facilitate timely determinations of eligibility and to do so in a manner that is accurate and is efficient (i.e., greatly reduces the level of effort required of applicants, tribes and eligibility staff), and that increases the number of eligible persons who actually receive the benefit or protection. Applicants would also continue to have the option of providing paper documentation, when needed, for verification purposes.

This TSGAC report (TSGAC Report) focuses on creating a mechanism for verifying eligibility for Indian-specific benefits and protections in instances in which eligibility is defined consistent with the definition of Indian in current CMS regulations for Medicaid at 42 CFR § 447.50.¹ As such, a mechanism for electronic verification of eligibility may be applied to the following:

- Indian-specific cost-sharing protections under Medicaid, in particular the protection from cost-sharing when an American Indian or Alaska Native is referred under Contract Health Services for services at a non-Indian health care provider; and
- Indian-specific exemptions from payment of a tax penalty for not maintaining minimum essential coverage (MEC) either a) as a “hardship exemption” or b) by considering Indian Health Service (IHS) coverage MEC for purpose of meeting the MEC requirement. (Tribal recommendations for creating these two exemptions from the tax penalty are pending with the Centers for Medicare and Medicaid Services (CMS).)²
- To the extent that eligibility for other Indian-specific benefits and protections under the Affordable Care Act are made consistent with the CMS regulations for Medicaid, this electronic verification mechanism could be applied to these provisions as well.

¹ 42 CFR 447.50 reads, in part: “(b) Definitions. For the purposes of this subpart: (1) Indian means any individual defined at 25 USC 1603(c), 1603(f), or 1679(b), or who has been determined eligible as an Indian, pursuant to § 136.12 of this part. This means the individual: (i) Is a member of a Federally-recognized Indian tribe; (ii) Resides in an urban center and meets one or more of the following four criteria: (A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; (B) Is an Eskimo or Aleut or other Alaska Native; (C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or (D) Is determined to be an Indian under regulations promulgated by the Secretary; (iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or (iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

² See TSGAC comments on CMS-9958-P; Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions, filed March 18, 2013.

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B. Use of Mechanism for Electronic Verification

As stated, the focus of this report is on verifying eligibility for the Indian-specific benefits and protections that apply a definition of Indian consistent with CMS regulations at 42 CFR § 447.50. This definition of Indian was established in regulation by CMS in order to implement section 5006 of the American Recovery and Reinvestment Act of 2009 which establishes protections for American Indians and Alaska Natives (AI/ANs) from premium and cost-sharing requirements that may be imposed under Medicaid. An electronic verification mechanism would be particularly useful in verifying eligibility for the Medicaid protections from cost-sharing when receiving a service through referral under Contract Health Services.³

Other Indian-specific benefits and protections under the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) include 1) cost-sharing protections under Exchange-facilitated coverage in the individual market, 2) monthly enrollment periods in Exchange-facilitated coverage in the individual market and through a SHOP Exchange, and 3) exemptions from tax penalties for not securing health insurance coverage. These provisions reference a definition of Indian under or similar to the definition at Internal Revenue Code 45A(c)(6). Efforts are being made to replace the definition at IRC 45A(c)(6) and related definitions with that found at 42 CFR § 447.50 in order to apply a consistent and more inclusive definition of Indian for health-related Indian provisions.⁴ One benefit of applying the definition under 42 CFR § 447.50 consistently across the Indian-specific provisions is to simplify administration of these provisions. Conversely, though, if the definitions are not applied consistently, the electronic verification process outlined here may be modified to accommodate different eligibility requirements for the different Indian-specific provisions.

As tribal representatives have previously indicated to CMS and IHS, an electronic verification mechanism on its own is insufficient to verify the status of *all* AI/ANs who are eligible for Indian-specific benefits and protections. Other avenues for verification must be allowed as well. Regulations promulgated by CMS at 45 CFR 155.350(c) confirm that an applicant may provide other (non-electronic) documentation.⁵ Nonetheless, the electronic data matching described below would provide an efficient mechanism for verifying the AI/AN status of a significant percentage of eligible persons.

³ Recently, CMS proposed in CMS-2334-P an approach to administer the cost-sharing protections when services are provided through referral under Contract Health Services. (*See* 78 Federal Register 4660, January 22, 2013.) The electronic verification mechanism proposed here could serve to verify eligibility for this purpose.

⁴ A consistent application of the definition of Indian could be achieved through the issuance of uniform operational guidance on the verification of Indian status for both Medicaid and Exchange purposes and/or through amendments to the relevant federal laws.

⁵ 45 CFR 155.350(c) (77 Fed Reg 18461 – 62) reads: (c) *Verification related to Indian status.* To the extent that an applicant attests that he or she is an Indian, the Exchange must verify such attestation by— (1) Utilizing any relevant documentation verified in accordance with § 155.315(f); (2) Relying on any electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or (3) To the extent that approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an applicant's attestation, the Exchange must follow the procedures specified in § 155.315(f) and verify documentation provided by the applicant in accordance with the standards for acceptable documentation provided in section 1903(x)(3)(B)(v) of the Social Security Act.

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C. Proposal under Consideration

In this report, the following proposal is considered for implementation prior to the October 1, 2013 start date for the new health insurance enrollment options established pursuant to the Affordable Care Act.⁶ The proposal is to –

Design, populate and regularly update an “Indian Verification Data Mart” with a limited set of data extracted from IHS beneficiary files contained in the IHS National Data Warehouse. Owned and controlled by the IHS, the Indian Verification Data Mart would indicate who has been determined eligible for IHS services as an Indian, and the data set would be made accessible (possibly through the federal data services hub⁷) to the appropriate Federal government and state government agencies for use in the automated and real-time verification of Indian status for purposes of determining eligibility for the Indian-specific protections under Medicaid and, potentially, for an Indian-specific exemption from the tax penalties for not securing health insurance coverage.

D. Summary of Findings and Recommendations

The National Data Warehouse (NDW), which is maintained by the United States Department of Health and Human Services (HHS) Indian Health Service, is a functional and up-to-date repository of data generated from IHS and tribal sites from which a subset of data may be extracted to enable the real-time electronic verification of Indian status for purposes of confirming eligibility for the Indian-specific protections under Medicaid. It is important to note, though, that the electronic database described below would provide only one of the means available to AI/ANs to verify Indian status,⁸ and the NDW would not be able to verify eligibility for all potentially-eligible AI/ANs as the NDW database contains records for only a portion of all AI/AN-eligible persons.

From interviews with individuals most closely responsible for the maintenance of the NDW data set, there was a consensus that “the IHS database accurately identifies IHS patients who meet the eligibility criteria for IHS services as American Indians or Alaska Natives.” In addition, there was general agreement an Indian Verification Data Mart could be established, maintained, and made accessible with minimal additional effort on the part of the IHS, Indian Tribes, tribal organizations, or urban Indian organization (referred to collectively as Indian Health Care Providers or I/T/U.)⁹

⁶ To the extent this target implementation date is not feasible, implementation would be completed as soon as it is administratively feasible.

⁷ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/downloads/exchangemedicaiditguidance.pdf>

⁸ 77 Fed Reg 18461 – 62.

⁹ Indian Health Care Provider means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

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It is recommended that, for purposes of verifying eligibility for Indian-specific benefits and protections, a subset of the data in the National Data Warehouse (NDW) be regularly extracted from each beneficiary file to populate an “Indian Verification Data Mart.”

- The NDW data elements necessary to the verification of Indian status that are to populate the Indian Verification Data Mart need to be defined. A preliminary list of the data elements is shown in **Attachment A**.
- The frequency of the updates 1) from the IHS and tribal facilities into the NDW (possibly semi-annually with more frequent updates permitted) and 2) from the NDW to the Indian Verification Data Mart (possibly daily) need to be established.

Access to the Indian Verification Data Mart for electronic matching would be made available by IHS to the appropriate Federal and state agencies for use during Medicaid and Exchange eligibility determinations and redeterminations, but the Indian Verification Data Mart would be owned, controlled and maintained by the IHS.¹⁰

Outcomes of the matching would be either positive or indeterminate depending on the extent of the match between the elements in the application and the Indian Verification Data Mart. A positive match would verify eligibility for the applicable Indian-specific provisions. An indeterminate match would indicate the applicant’s eligibility was not able to be confirmed through this means. In the latter case, the applicant would need to provide evidence for verification through another means, as may be required.

Providing a means for electronic and real-time verification of Indian status for a significant percentage of AI/ANs would increase the likelihood that 1) AI/ANs (and only AI/ANs) are determined eligible for the Indian-specific benefits and protections that they are eligible to receive, 2) this is accomplished without the administrative costs to Medicaid, Exchange staff and contractors, and to IHS and other Indian Health Care Providers that is associated with preparing, submitting and processing paper documentation, and 3) without delays in completing eligibility determinations that may result from preparing, receiving and processing paper documentation.¹¹

E. Background

This report provides an analysis of an Indian Health Service (IHS) maintained data base that may have the capability to serve as a vehicle for enabling electronic verification of Indian status for purposes of confirming eligibility for various Indian-specific benefits and protections. As a Health Insurance Portability and Accountability Act (HIPAA) covered entity, IHS would be permitted to share these data

¹⁰ Depending upon the outcome of the tribal comments on CMS-9958-P (and related comments filed on IRS REG-148500-12), the timing and means of accessing the Indian Verification Data Mart for purposes of verifying eligibility for the exemptions from the tax penalties would be established.

¹¹ It is important to recognize that the Federal government, through the IHS, funds the development and maintenance of the National Data Warehouse. Not relying on the NDW for verification would result in a duplication of effort and expense on the part of the Federal government.

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to the extent necessary to carry out the health program purposes. This analysis includes a discussion of the breadth, timeliness and quality of the data in the IHS-maintained data set.

Percent of AI/AN-eligible Persons in IHS Data Base

The National Data Warehouse would serve as the consolidated source of data for this electronic verification mechanism. It is recognized, though, that the NDW does not contain information on all persons who are potentially eligible for the Indian-specific benefits and protections.

For example, in the IHS National Data Warehouse, a total of 2,557,707 “Indian Registrants” were included as of September 30, 2012.¹² Indian Registrants are unique patient identities in the NDW patient registration files that are considered Indian.¹³ These files date back to 2003.¹⁴

In contrast, through the U.S. Census, a count is generated of the number of Americans who identify themselves as AI/ANs. In 2010, the U.S. Census reported 5.2 million Americans identifying themselves as AI/ANs alone or in combination with one or more other races.¹⁵ The National Center for Health Statistics (NCHS) refined Census Bureau data (using 2000 Census data) to estimate the number of AI/ANs who reside in counties served by IHS or tribal providers.¹⁶ For 2012, the IHS Office of Public Health, Division of Program Statistics estimated that 2,051,718 such individuals live within the IHS service areas.¹⁷ Conversely, in 2009, IHS estimated that 43% of AI/ANs live outside of a contract health service delivery area.¹⁸

The number of self-identified AI/ANs in the Census represents the maximum pool of AI/ANs who are potentially-eligible for the Indian-specific benefits and protections. The actual number of potentially-eligible AI/ANs is a subset of these figures, though, as eligibility for the Indian-specific benefits and protections would be available only to those AI/ANs meeting the specific criteria of Indian status under 42 CFR 447.50, such as membership in or affiliation with a Tribe, documented Indian descendency, etc.

¹² Indian Health Service, “Comparison of Different American Indian and Alaska Native Populations”, provided by Kirk Greenway April 9, 2013.

¹³ According to IHS, a registrant is considered Indian if (1) the Tribe Code is designated “Indian”; or (2) the Tribal designation is “unspecified” and the beneficiary/classification and/or the Indian blood quantum code is “Indian”.

¹⁴ Approximately 1,561,075 of these Indian Registrants were served by I/T/U providers over the three-year period from October 1, 2009 through September 30, 2012. Sometimes referred to as “active users”, these individuals had at least one direct or contract inpatient stay, ambulatory care visit or dental visit during this period.

¹⁵ <http://www.commerce.gov/blog/2012/01/26/2010-census-shows-nearly-half-american-indians-and-alaska-natives-report-multiple-ra>

¹⁶ These health service areas encompass reservations, the counties containing them, and the counties adjoining them. Department of Health and Human Services, Indian Health Service. Geographic Composition of the Contract health Service Delivery Areas (CHSDA) and Service Delivery Areas (SDA) of the Indian Health Service. *Federal Register*;72 (119): 34262-34267.

¹⁷ Information reported by the Indian Health Service from NCHS data. Indian Health Service, “Comparison of Different American Indian and Alaska Native Populations”, provided by Kirk Greenway May 15, 2013.

¹⁸ Cara James, et al, Kaiser Family Foundation, “A Profile of American Indians and Alaska Natives and Their Health Coverage,” September 2009, page 6.

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For those AI/ANs who are represented in the NDW database, the Indian Verification Data Mart would serve as a functional mechanism to verify their status as an Indian.

Indian-specific Premium and Cost-sharing Protections under Medicaid

Under section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA), no cost-sharing may be imposed on an AI/AN¹⁹ who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, tribal organization, or urban Indian organization (referred to as Indian health care providers or I/T/U)²⁰ for Medicaid-reimbursed services.²¹ In addition, no cost-sharing may be charged to an AI/AN for Medicaid reimbursed services received through referral from an I/T/U. Under ARRA § 5006, Indian health care providers and other providers through a Contract Health Services referral are to be paid in full under Medicaid, without a reduction for the cost-sharing amounts that would have been paid by the AI/AN patient absent this provision.²²

Indian-specific Benefits and Protections Established under the ACA

In addition to the Medicaid provisions, under the Affordable Care Act Indian-specific provisions were also included for AI/ANs who enroll in the individual market through an Exchange.²³ AI/ANs with income under 300 percent of the federal poverty level (FPL) who enroll in the individual market through an Exchange have no cost-sharing requirements, and AI/ANs of any income level are not required to pay cost-sharing when receiving services from Indian health care providers or through referral from an Indian health care provider for services elsewhere. Indian health care providers are to be paid by the plan (and the plan reimbursed by HHS) the amount of the cost-sharing otherwise owed by the patient.

The Affordable Care Act also established an Indian-specific exemption from tax penalties levied under the Internal Revenue Code for persons who do not secure “minimum essential coverage.”²⁴

At present, HHS and the Internal Revenue Service (IRS) are interpreting the statutory references to “Indian” in the ACA as including only enrolled members in federally-recognized tribes or shareholders in Alaska Native village or regional corporations. This interpretation of “Indian”, for one, does not include (non-enrolled)

¹⁹ A specific definition of “Indian” was not included or referenced in ARRA section 5006. The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) established through regulation a definition of Indian at § 447.50, which is generally consistent with determinations of eligibility for IHS services as an Indian. (The code reference to § 447.50 is proposed to be changed to § 447.51 under the currently pending CMS proposed rule on Medicaid eligibility, etc., in CMS-2334-P. 78 Fed Reg 4594)

²⁰ Indian health care provider means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

²¹ In addition, no enrollment fee, premium, or similar charge may be imposed against such an individual.

²² In addition to the ARRA Medicaid protections, the Balanced Budget Act of 1997 amended the Social Security Act at § 1932(a)(2)(C) to exempt AI/ANs from mandatory enrollment in a Medicaid managed care plan that is not a plan operated by an I/T/U. See 42 U.S.C. 1396u-2(a)(2)(C).

²³ The special monthly enrollment period also applies to AI/AN enrolled through a SHOP Exchange.

²⁴ The provision was contained in section 1501 of the ACA and is found at section 5000A(e)(3) of the Internal Revenue Code. For purposes of this provision, Indian is defined under section 45A(c)(6) of the Internal Revenue Code.

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decedents of enrolled members in contrast to the definition of Indian used to establish eligibility for the Indian-specific Medicaid premium and cost-sharing protections.

Coordination of Eligibility Determinations for Medicaid and Exchange-facilitated Coverage

Under section 1413 of the Affordable Care Act, a unified application for Medicaid and Exchange-facilitated coverage is to be developed.²⁵ To the extent possible, information requested on the application is to be populated and/or verified through automated electronic matching. The automated electronic matching is to serve to minimize the administrative burden on applicants and processors, minimize the need and cost to subsequently provide written materials, as well as to facilitate timely (and possibly immediate) eligibility determinations. In year one, the degree to which the *Medicaid* eligibility determination process is integrated with eligibility determinations for *Exchange-facilitated coverage* is subject to a state's decision. Nonetheless, whether conducted as a single eligibility determination process or two sequential processes, the ability for real-time electronic access to data on Indian status would serve to facilitate the eligibility determination process(es) for a significant percentage of AI/ANs who apply for Medicaid.

Figure 1 displays the questions regarding Indian status contained on the CMS-issued application for Medicaid and Exchange-facilitated coverage.²⁶ In **Attachment J**, additional information is provided on each of the three versions of the application that may be used by Exchange enrollees. In part, in Appendix B to the "Application for Health Coverage & Help Paying Costs" the document asks in Question 3, "Has this person ever gotten a service from [an I/T/U] or through referral from one of these programs?" and "If no, is this person eligible to get services from [an I/T/U] or through referral from one of these programs?"²⁷ An additional question – Question 2 – is asked to identify AI/AN persons who are members of a Federally-recognized Tribe. The application question on IHS eligibility – Question 3 – corresponds to identifying AI/ANs who are eligible for the pre-ACA premium and cost-sharing protections afforded AI/AN under Medicaid.

In a conference call convened by the Tribal Technical Advisory Group to CMS (TTAG) on May 8, 2013, a CMS representative indicated that the Federally-facilitated Exchange (FFE) would not require documentation for persons answering "yes" to either parts of Question 3 on Appendix B (i.e., have you received or are you eligible for IHS services?) The CMS representative stated, though, that the decision of the FFE to not require documentation on Question 3 did not determine whether a non-FFE Exchange would require documentation. In addition, the CMS representative indicated that the FFE's decision to not require documentation did not determine whether a state Medicaid program would require documentation prior to using an affirmative answer to Question 3 to indicate eligibility for the Indian-specific cost-sharing protections under Medicaid. In contrast to documentation requirements of an FFE pertaining to Question 3 (i.e., no requirement), CMS has indicated in rulemaking that documentation of Indian status would be required from an FFE and non-FFE under Question 2.

²⁵ Regulations on the unified application concerning Medicaid are at 42 CFR 435.907 and 457.330. Regulations on the unified application concerning Exchange-facilitated coverage are at 45 CFR 155.405a. On April 29, 2013, CMS issued a revised version of the application(s) for enrollment through an Exchange.

²⁶ <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-04-30-2013.pdf>

²⁷ The application also requests "Member of a federally recognized tribe?" and "If yes, give the name of the tribe".

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For AI/ANs who have previously interacted with the Indian health care system, and therefore they are identified in the IHS National Data Warehouse, the Indian Verification Data Mart could serve as a vehicle to provide real-time verification of an individual’s eligibility for I/T/U services as an Indian through an automated, electronic data match.

Figure 1: Indian-specific Questions on Appendix B to “Application for Health Coverage & Help Paying Costs”

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1		AI/AN PERSON 2	
1. Name (First name, Middle name, Last name)	First	Middle	First	Middle
	Last		Last	
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No		<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	

On-going Efforts at Electronic Data Matches for Verification of Indian Status

A select number of states have pursued electronic verification of Indian status for purposes of Medicaid claiming for the 100% federal contribution for health services provided to AI/ANs by I/T/Us. For example, the Alaska Medicaid program uses data matching with tribal health programs to verify AI/AN eligibility for the heightened federal match rate. In addition, a number of states are working to determine the preferred method for enabling electronic data matching for purposes of the Indian-specific Medicaid cost-sharing protections and potentially for verification of Indian status for Exchange purposes.

An example of one State-based Exchange that is considering utilizing I/T/U data for this purpose is in the State of Oregon. The Cover Oregon Exchange is considering allowing Tribal health programs to upload their RPMS or other health practice management data for the purposes of determining AI/AN eligibility for ACA benefits and protections. The data made available to the Cover Oregon Exchange would be a portion of the same data set that is uploaded on a routine basis to the IHS National Data Warehouse.

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In addition, IHS and the Center for Medicare at CMS have and continue to “data match” between their respective systems in order to identify AI/ANs who are Medicare beneficiaries.

F. Implementation of Indian-specific Benefits and Protections under Medicaid

In May of 2010, CMS issued proposed rules implementing ARRA section 5006.²⁸ Again, ARRA section 5006 amends section 1916 of the Social Security Act (42 U.S.C. 1396o) to prohibit states from charging cost-sharing under Medicaid to AI/ANs furnished items or services directly by an I/T/U or through a referral from an I/T/U. The regulations were added under 42 CFR §447.50.

Documentation of Indian Status under ARRA § 5006

In regard to documentation of eligibility for the ARRA § 5006 provisions, in the May 2010 proposed rule from CMS, the following was included in the preamble –

Documentation that an individual is an Indian could include Tribal enrollment and membership cards, a certificate of degree of Indian blood issued by the Bureau of Indian Affairs, a Tribal census document, or a document issued by a Tribe indicating an individual’s affiliation with the Tribe. The Indian health care programs and urban Indian health programs are responsible for determining who is eligible to receive an item or service furnished by their programs and so a medical record card or similar documentation that specifies an individual is an Indian as defined above could suffice as appropriate documentation. These documents are examples of documents that may be used, but do not constitute an all-inclusive list of such documents.²⁹

These documentation requirements outlined for the Medicaid protections established under ARRA section 5006 implementing regulations are consistent with the documentation requirements I/T/U programs have established for determining eligibility for IHS services as an Indian.

On January 22, 2013, CMS published a proposed rule that further refines regulations implementing the cost-sharing protections afforded AI/ANs under Medicaid.³⁰ In **Attachment B** to this report, a summary is provided of the CMS proposal for states to identify and use an AI/AN’s IHS user status to indicate eligibility for Medicaid cost-sharing protections for certain services received at non-I/T/U facilities. A mechanism such as that proposed in this report would seem to be particularly useful in identifying IHS user status. In contrast to proposal in the TSGAC Report to access the IHS National Data Warehouse, the CMS proposal recommends that a state access the state’s Medicaid claims database. An Indian Verification Data Mart, though, would capture all IHS users, not just those with prior Medicaid enrollment and IHS claims.

²⁸ 75 Fed Reg 30244, May 28, 2010.

²⁹ 75 Fed Reg 30247.

³⁰ See 78 Fed Reg 4704, Tuesday, January 22, 2013. CMS-2334-P, *Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Cost Sharing*. The regulatory changes are proposed to be made to § 447.56(a)(1)(vii) and (c).

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Documentation of Indian Status for IHS Eligibility and Exchange-related Provisions

From interviews with IHS and tribal health organization staff, the documentation identified for purposes of determining eligibility for the Indian-specific benefits and protections under section 5006 of ARRA mirrors the documentation accepted for purposes of determining eligibility for IHS services as called for under Part 2, Chapter 6.5 of the IHS Indian Health Manual.³¹ As such, a determination by an I/T/U of an individual's eligibility for IHS services as an AI/AN is effectively also a determination that satisfies the CMS standard for Indian status in 42 CFR §447.50 for premium and cost-sharing protections under Medicaid.

In **Attachment C**, a table is provided comparing the document types accepted for purposes of determining eligibility as an AI/AN for IHS services, for Medicaid cost-sharing protections, as well as for the cost-sharing protections for AI/AN enrolled in the individual market through an Exchange.

In **Attachment D**, excerpts from the IHS Indian Health Manual are taken from 2-6.4 Eligibility and 2-6.5 Operations Guidance, and excerpts from the Code of Federal Regulations (42 CFR § 136.12 and § 136.23) are also shown. The excerpts identify the data element fields included in the Patient Registration System and indicate which are mandatory fields for the service unit staff to populate.

In comparing the documentation requirements, it is relevant to note that for the purpose of verification of Indian status under the recently established regulations implementing the Exchange-related provisions of the Affordable Care Act (at 45 CFR 155.350), and specifically for the Indian-specific cost-sharing protections through an Exchange, the rule provides for "relying on any electronic data sources that are available to the Exchange which have been approved by HHS."³² Given that the Exchange will function as an entry point for eligibility determinations for Exchange-related coverage as well as for Medicaid and CHIP, and will use a single streamlined application in the process, verifying data elements (with paper documentation or via electronic means) for one program purpose are likely to subsequently serve to populate (and verify) the same data fields for the other health programs.

G. IHS, Tribal and Urban Indian Data Systems

IHS National Data Warehouse

Eligibility and encounter data for IHS beneficiaries are gathered and maintained through a combination of integrated and independent data bases. Some of the data are initially gathered through Tribes, tribal health organizations and urban Indian organizations (T/Us) and supplied to IHS, and other data are collected and maintained continuously by the Indian Health Service.

The **Resource and Patient Management System (RPMS)** is an IHS-wide, but decentralized data system. RPMS is designed to provide detailed and comprehensive clinical and administrative information to providers and managers at all levels of the Indian health system in order to allow them to better manage individual patients,

³¹ In particular see the documentation required under the Operations Guidelines, "Mandatory / Critical Fields" in section 2-6.5C of Part 2, Chapter 6 of the Patient Registration System in the Indian Health Manual.

http://www.ihs.gov/ihtm/index.cfm?module=dsp_ihm_pc_p2c6#2-6.5C.

³² 77 Fed Reg 18461-62.

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local facilities, and regional and national programs.³³ RPMS is comprised of over 50 integrated software applications with separate, individual databases at local sites. Some tribal facilities use RPMS, others have integrated commercial patient registration and management systems with RPMS, and others have adopted commercial, off-the-shelf systems entirely. Each of the systems, though, is able to extract and transmit data in a compatible format as required by IHS.

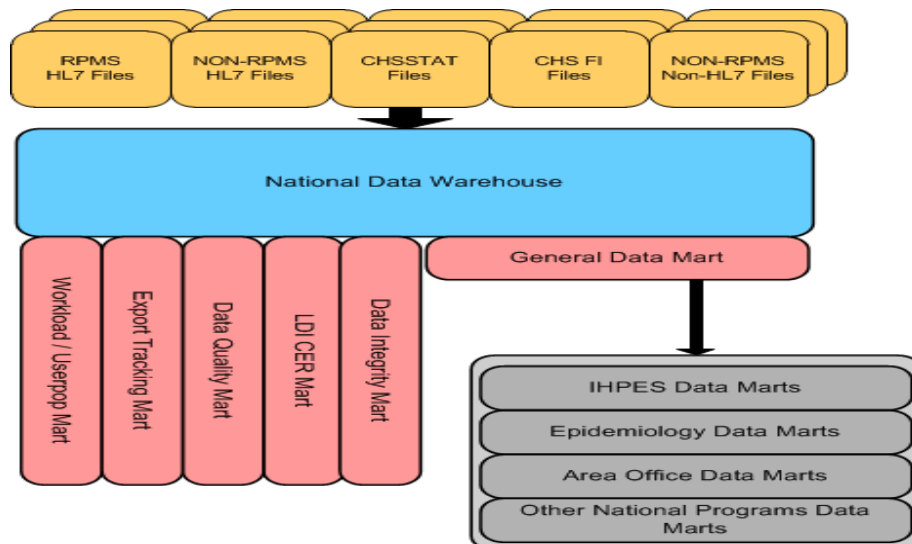
The **Patient Registration System (PRS)**, a component of RPMS, is the Indian Health Service’s official mechanism for collecting, identifying and recording patient demographic and eligibility information. In **Attachment E**, the first 36 of the 99 data entries in the PRS are shown.

From the comprehensive – but decentralized – RPMS data set, subsets of data are constructed and made available for both clinical and administrative purposes. For instance, a subset of the RPMS information is exported to the **National Data Warehouse (NDW)**.

NDW³⁴ is a centralized data warehouse designed to allow IHS to aggregate select RPMS data from all their local sites. Data elements exported to the NDW include certain patient demographics; encounter-based information such as the date, location of a visit (facility), provider, the “Purpose(s) of Encounter” using International Classification of Disease (ICD-9) codes, medications, and certain laboratory test data; and specific patient related clinical data such as health factors. NDW enables IHS to produce various reports that are required by statute and regulation and provide a broad range of clinical and administrative information to managers at all levels of the Indian health system.

Figure 2 depicts the organization and flow of data between feeder data bases and the centralized NDW.

Figure 2: National Data Warehouse Information Flow³⁵



³³ <http://www.ihs.gov/rpms/>

³⁴ <http://aspe.hhs.gov/hsp/06/catalog-ai-an-na/RPMS.htm>

³⁵ <http://www.ihs.gov/NDW/>

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The IHS instituted the NDW in 2006. The NDW is maintained by the Indian Health Service central administrative staff and is considered by IHS to be a state-of-the-art data repository.³⁶ According to IHS, “[the NDW] includes a national enterprise-level database that provides a relatively complete, historical repository of patient registration and encounter information dating back to October 2000.” The NDW pulls information from RPMS and non-RPMS sources to capture a complete data set for IHS sites and a narrower set of data from Tribes and tribal organizations, and urban Indian programs.³⁷ The data supplied to the NDW includes encounters involving referrals under Contract Health Services.

As constructed and maintained, the National Data Warehouse contains a defined set of data (for convenience referred to in this memorandum as the “NDW Data Set”) that originates at local Indian Health Care Provider facilities through entry into local (RPMS and non-RPMS) data bases and which is then extracted and sent to IHS for inclusion in the centralized NDW database.

Shown in **Figure 3** are the personal identification data elements required to be provided from T/U health facilities to the NDW.

Figure 3: Essential IHS NDW Identification Data Elements

UNIQUE REGISTRATION ID	Unique registration record ID generated by the source system. It is unique by registration record, not necessarily by patient, if a given patient has more than one registration record at the same facility or different facilities.
REGISTRATION CREATE DATE	Date on which the registration record was created on the local system.
DATE LAST MODIFIED	Date last modified by the local registration/encounter system.
REGISTERING FACILITY CODE (ASUFAC)	Area-Service Unit-Facility code to designate the facility where the chart is located.
CHART/HEALTH RECORD NUMBER	Patient's Chart/Health Record Number (HRN) at the Registering Facility
FIRST NAME	First name of the patient.
MIDDLE NAME	Middle name of the patient.
LAST NAME	Last name of the patient.
BIRTH DATE	Patient's date of birth.
GENDER CODE	Sex of patient as provided by the patient's registration information.
SOCIAL SECURITY NUMBER	Patient's Social Security Number.
BENEFICIARY CLASSIFICATION CODE	A category under which an individual can become eligible for IHS benefits.
TRIBE CODE	Patient's Tribe of Membership code
BLOOD QUANTUM CODE	Code to designate whether the patient is American Indian/Alaska Native and, if so, to what degree.
COMMUNITY OF RESIDENCE CODE	Code for the State/County/Community of Residence of the patient.

IHS central office staff indicated that the NDW Data Sets are to be provided by T/U sites to the NDW at least annually, and some T/U sites submit the NDW Data Sets monthly or quarterly. In discussions with representatives of tribal health care facilities, the frequency by which the NDW Data Sets are sent to the NDW ranged from monthly, to quarterly, to annually.

³⁶ <http://www.ihs.gov/NDW/>

³⁷ Interviewees reported that a substantial number of urban Indian programs regularly report data to the NDW.

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Data Marts

The NDW also accommodates individual **Data Marts**.³⁸ Data Marts are highly focused databases where end users can quickly and efficiently access targeted information, often via a Web interface. Data Marts meet individual program search and reporting needs that the complete NDW Database is too large to efficiently support. Data Mart databases are created by importing from the NDW only the data required to fulfill the custom requirements of specific end users. Data Marts can be refreshed or purged and the data re-imported from the NDW whenever necessary.

To the extent that the Indian Health Service were to make available a select set of patient registry information for the purpose of enabling the electronic verification of Indian status for Medicaid program purposes, an **Indian Verification Data Mart** may serve this function, which would be constructed and maintained separately by IHS for this purpose. Access to the data in the Indian Verification Data Mart would be restricted to a single authorized entity or a limited number of authorized entities, and the broader set of data in the NDW would remain inaccessible to these authorized entities.

H. Creating an Indian Verification Data Mart Containing Beneficiary Eligibility Records

If an IHS-maintained database is to be used as an electronic source for verifying the eligibility of AI/ANs for Indian-specific protections under Medicaid, it is the IHS National Data Warehouse data set that will likely serve as that data source, with select data exported to a data mart – such as an Indian Verification Data Mart – designed specifically for this purpose.

Relevant data elements from NDW

The IHS NDW is guided by the IHS Standard Code Book.³⁹ In addition, an IHS Indian Health Manual contains standard operating procedures for IHS facilities,⁴⁰ including in Part 2, Chapter 6 which outlines Patient Registration requirements.⁴¹

Attachment F displays the twenty elements that comprise the IHS Standard Code Book Tables. Included within the tables of data is the “Classification (Beneficiary)” table, which contains data central to the function of verifying Indian status. The “Classification (Beneficiary)” table indicates the primary classification under which a patient qualifies for IHS services.⁴²

³⁸ <http://www.ihs.gov/NDW/>

³⁹ The IHS Standard Code Book is a uniform listing of descriptive terms and identifying codes for recording and reporting medical information collected during the provision of health care services. A standard set of codes provides the means for reliable communication between Indian Health Service providers, patients, and third parties (e.g., contract health service providers). <http://www.ihs.gov/scb/index.cfm?module=tablesSCB&reset=1>

⁴⁰ The Indian Health Manual (IHM) is the reference for IHS employees regarding IHS-specific policy and procedural instructions. <http://www.ihs.gov/i hm/index.cfm>

⁴¹ http://www.ihs.gov/i hm/index.cfm?module=dsp_i hm_pc_p2c6

⁴² See Indian Health Manual, Chapter 2-6.5, C.9. http://www.ihs.gov/i hm/index.cfm?module=dsp_i hm_pc_p2c6

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In the Classification (Beneficiary) table, there are 33 distinct categories listed. **Attachment G:** Classification (Beneficiary): Codes displays a screen shot of the thirty-three codes, as well as the classification label that describes each of the codes. Within the 33 categories in the “Classification (Beneficiary)” table, Classification (Beneficiary) Code 01: Indian or Alaska Native is the most relevant for indicating eligibility for the Indian-specific benefits and protections under Medicaid.⁴³ The remaining Classification (Beneficiary) codes identify non-Indian specific IHS user groups that gain, at least temporarily, eligibility for IHS services, such as Classification (Beneficiary) Code 06: Non-Indian Emergency, Classification (Beneficiary) Code 03: PHS Commissioned Officer, and Classification (Beneficiary) Code 12: Coast Guard.⁴⁴ *For purposes of verifying eligibility for the Indian-specific cost-sharing protections under Medicaid, IHS users without a designation of Code 01 (or possibly Code 32) would not be determined to be eligible for the Medicaid protections.*

Each IHS beneficiary record has one Classification (Beneficiary) Code number indicated (but only one code number indicated) for each IHS user. For example, an IHS user may be listed as code 01, Indian or Alaskan Native, but would not also be identified as code 17, National Guard even if the IHS beneficiary were an active National Guard member.

In addition to the Beneficiary Code, other data tables in the Standard Code Book include Service Unit, Facility, and Facility Type.⁴⁵ The Standard Code Book includes comprehensive lists of Tribe, Facility, Service Unit, Community, and Area.⁴⁶

If an electronic mechanism were put into place for the purpose of verifying eligibility for the Indian-specific protections under Medicaid, the IHS Standard Code Book-defined data elements determined necessary to verify Indian status could be extracted from the National Data Warehouse and used to populate, and periodically update, an Indian Verification Data Mart. For example, the relevant Classification (Beneficiary) Codes would be included as one of the elements in the Indian Verification Data Mart. **Attachment A** provides a preliminary list of NDW data elements that may populate an Indian Verification Data Mart.

I. Quality of Data and Reports from IHS National Data Warehouse

Current Strength of the NDW Data

In assessing the quality of the data generated from the NDW, two elements are important. The first element is the degree to which the reports generated from NDW represent the data contained in the NDW. The second is the validity of the data contained in the NDW that is being reported.

⁴³ In the Indian Health Manual, Part 2, Chapter 6, section 2-6.5 Operating Guidelines, C. Mandatory/Critical Fields, 9. Beneficiary Code, it states: “This is the primary classification under which this patient qualifies for IHS care. Until the present law is amended, patients are usually qualified because they possess Indian blood.”

⁴⁴ An additional code that may be relevant to identifying potential eligible persons is Classification (Beneficiary) Code 32: Dependent of Indian.

⁴⁵ <http://www.ihs.gov/scb/index.cfm>

⁴⁶ In addition to serving to verify Indian status, tables defined in the Standard Code Book (e.g., the comprehensive lists of Tribes and of Indian health care facilities) may be useful for other oversight purposes, such as assessing the adequacy of a health plan’s provider network.

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Quality of reports: On the first measure, for over two years IHS has rated the NDW as achieving a five (out of five) on performance, which indicates the degree to which the reports generated by the NDW represent the data contained in the NDW. The evaluation explanation indicates, “Sound management controls are in place to sustain strong overall performance and mitigate risk.”⁴⁷ In **Attachment H: IHS Assessment of NDW**, a screen shot is displayed of the evaluation of the NDW by the IHS Chief Information Officer. The strong ratings speak primarily to the capability of the NDW to produce regular and timely reports that accurately reflect the data stored in the NDW as well as accurately reflect the data contained in the feeder databases.

Validity of Data: There is not an equivalent set of performance measures that evaluate the validity of the data in the NDW. Nonetheless, through a review of the relevant IHS standard operating procedures (SOPs) and interviews with IHS and tribal health organization representatives on compliance with the SOPs, there was a general consensus from IHS and tribal representatives that “the IHS database accurately identifies IHS patients who meet the eligibility criteria for IHS services as American Indians or Alaska Natives.”⁴⁸ In **Attachment I: Sample of HHS/ASPE Reports on IHS Patient Registration System Data**, there is a description of the content of the PRS data set, the procedures for maintaining the data base, and the steps to take to access the data in the PRS.

With regard to the core data elements relevant to verifying eligibility for the Indian-specific benefits and protection under Medicaid, the Indian Health Manual describes a structured process for collecting, identifying, and recording patient demographic and eligibility information through the Patient Registration System (PRS).⁴⁹ For instance, a number of fields are identified as “mandatory/critical”, including name, date of birth, Tribe of membership, Indian blood quantum, beneficiary code, and eligibility status.⁵⁰ Documentation is required for several items, including for verification of Tribe of membership and Indian blood quantum. Names cannot be changed in the PRS records unless legal documentation is provided by the patient or patient representative.

In addition, each IHS service unit director and tribal health program director must designate a facility PRS manager who is responsible for, in part, assuring accuracy of data.⁵¹ According to the SOPs, the PRS manager is to “[e]nsure the accurate and timely updates to data in the PRS. The service unit PRS manager submits reports of corrections of PRS data to the Area office in a timely manner. These reports may include such items as reimbursements, registrations, duplicate registrations, and mismatches.”⁵²

IHS representatives indicated that the rigor by which the SOPs are followed may vary across IHS and tribal sites. It was also noted that SOPs are more likely to be followed strictly today as compared to a decade ago. It was emphasized that the potential lack of rigor previously in following SOPs does not mean that non-IHS

⁴⁷ <http://www.itdashboard.gov/investment?buscid=334>

⁴⁸ Opinion communicated in interviews with IHS representatives December 11, 2012 and subsequently with tribal representatives.

⁴⁹ http://www.ihs.gov/ihtm/index.cfm?module=dsp_ihm_pc_p2c6

⁵⁰ An analysis was not conducted to determine the degree to which “mandatory/critical” data elements are required for a particular beneficiary record and the extent to which the fields are populated.

⁵¹ See Indian Health Manual, Chapter 2-6.5, D.2, Assuring Data Accuracy.

⁵² See Indian Health Manual, Chapter 2-6.5, D.2, Assuring Data Accuracy.

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eligible persons have been registered as “eligible” under beneficiary codes 01 or 32. For example, in the past documentation may not have been required if a person is readily identified as an AI/AN member of the community. Today, the SOPs call for documenting the eligibility status of all patients by receiving the appropriate documentation from a patient on the initial visit or at least prior to the second visit.⁵³

Degree of I/T/U Participation: IHS staff reported that there is “virtually 100 percent” participation by IHS and tribal health programs in reporting requested data to the NDW. Except for a limited number of newly-recognized tribes, all programs were reported to have submitted data, with most submitting data quarterly. For urban Indian programs, there is less uniformity in submitting data, but a substantial number of the urban Indian programs provided data. In total, 26 sites reported data at least once.⁵⁴ For the 19 urban Indian sites that provided data in 2012, all but one provided the data monthly.

The frequency of the data submission does vary. For example, in the Bemidji Area of Minnesota 31 of 34 tribal health programs submit formatted data to the IHS NDW on at least an annual basis. The remaining three tribal health programs – representing 10 percent of the Bemidji Area tribal health programs – did not submit data sets every year, but they each provided data at least once in the past three years.⁵⁵ To the extent there are Indian Health Care Providers that are not submitting data in a timely manner, this could be improved – and the usefulness of the data broadened – over time.

It is also important to recognize that the National Data Warehouse only contains data on individuals served by Indian Health Care Providers and only for those individuals from whom an I/T/U submitted a record. But, as mentioned above, IHS estimates that the NDW contains nearly 100 percent of the I/T/U users.

IHS beneficiaries who are users of urban Indian programs may comprise a sizeable number of the IHS beneficiaries who are not represented in the NDW data. A recent analysis of the NDW found the following --

When the [AI/ANs] in IHS NDW data are grouped by the type of Service Unit (IHS, Tribal or Urban, I/T/U) to which the Active User was last assigned, three quarters of the IHS Active Users in the NDW data were assigned to IHS managed Service Units (IHS, I), one quarter Tribally managed Service Units (Tribal, T) and only 1% Urban Service Units (Urban, U; **Attachment B, Table B.1**). In the NDW data there were only 5,214 Active User records assigned to Urban Indian Health Programs nationwide which is only a fraction of actual total Active Users [of Urban Indian Health Programs] (California Area alone has 7,000 Active Users).⁵⁶

⁵³ Interview with IHS staff, December 11, 2012.

⁵⁴ At time of publication, a clarification was being sought to determine if each of the “urban sites” corresponds to one of the 34 urban Indian programs.

⁵⁵ Email exchange with Phil Norrgard, Director of Human Services, Fond du Lac Tribe, March 13, 2013.

⁵⁶ California Rural Indian Health Board, “*Integrating Medicaid and Indian Health Service Data*,” 2011, page 8.

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The lack of records in the NDW for some Active Users is, in part, a result of some urban Indian organizations and some tribal health organizations not submitting the requested user-specific data sets to the IHS at least annually.

Timeliness of Data: It was reported that Indian Health Care Providers submit data to the NDW on varying schedules, with some submitting monthly and others quarterly or annually. More regular, and frequent, submissions of data by I/T/U to the NDW would increase the usefulness of the Indian Verification Data Mart. But rather than mandate submission of the IHS User Data Sets as frequently as monthly (which would increase the timeliness of the IHS User Data Set but may be a burden on small T/U facilities), it may be more advantageous to establish a less taxing requirement (such as quarterly submission of data) and explain to I/T/U staff the benefits to their patients of regular and more frequent submissions of the data, if possible.

Strengthening the Confidence in the Data in the IHS National Data Warehouse

In discussing the potential use of the IHS National Data Warehouse for the purpose of verifying Indian status, there was concern raised by IHS and tribal representatives alike that the validity of the data in the IHS system was being called into question. Some I/T/U representatives indicated they heard parties outside of the I/T/U system – including senior staff in HHS – state that the NDW could not be relied upon for such a purpose because the determinations of eligibility for IHS services may not have been sufficiently documented or accurately made. These negative perceptions held by some senior IHS official and individuals outside the Indian health system are in conflict with the opinions of individuals operating within the Indian health system who were surveyed and who are responsible for and most familiar with various aspects of the IHS data systems. As noted above, IHS and tribal officials communicated the opinion that “the IHS database accurately identifies IHS patients who meet the eligibility criteria for IHS services as AI/ANs.”

A modest number of errors is to be expected, and acceptable error rates are established with the maintenance of any sizable data set.⁵⁷ Without evidence to the contrary, the eligibility determinations made by I/T/Us should be considered to be valid. To the extent that errors in eligibility determinations are identified, the specific errors identified should be corrected. The entire data set should not be discarded or put in question.

With that said, measures could be taken to strengthen the validity of the data and/or the confidence in the validity of the data through strengthening the integrity of the eligibility determination process.

Steps to consider that may strengthen the validity of the data and the confidence in the data include –

- Review and update SOPs to eliminate any weaknesses in the procedures, such as –
 - Add a standard for IHS and tribal health care providers to periodically review a sample of their IHS beneficiary files to confirm current compliance with SOPs, such as the maintenance of written documentation, where applicable; and

⁵⁷ See *Payment Error Rate Measurement (PERM,) Verifying Eligibility for Medicaid and SCHIP Benefits*, viewed February 13, 2013 at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/downloads/PERM_Eligibility_Review_Guidance.pdf. For example, the 2011 Medicaid national improper payment rate reflects a three-year weighted average of the 2009, 2010, and 2011 rates which were 8.7 percent, 9.0 percent and 6.7 percent respectively for the States reviewed in those years.

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- Require submission of data at least annually by all Indian Health Care Providers to the NDW (to improve comprehensiveness) and/or require submission of data at least quarterly from Indian Health Care Providers to the NDW (to improve timeliness);
- Conduct a one-time review of a sample of existing IHS beneficiary records to confirm compliance with SOPs and to confirm the accuracy of eligibility determinations;
- Confirm the appointment and training of a PRS manager for each site, as is called for in the IHS Indian Health Manual; and
- Retrain Indian health care provider administrative staff on the SOPs.

J. Conclusion

The National Data Warehouse, which is maintained by the United States Department of Health and Human Services Indian Health Service, appears to be a functional and reliable source of data from which a subset of data may be extracted, made available electronically, and updated regularly – with minimal additional effort – to enable real-time electronic verification of Indian status for purposes of determining eligibility for the Indian-specific protections under Medicaid.

In establishing an Indian Verification Data Mart that is owned, controlled, maintained and made accessible by the IHS, a mechanism would be made available to states that is accurate and offers less administrative complexity for state agencies than paper verification.⁵⁸ In addition, the Indian Verification Data Mart and the associated processes would reduce the administrative costs and burdens on individuals, while maintaining accuracy and minimizing delay in the determinations of eligibility.⁵⁹

K. Acknowledgements

The Tribal Self-Governance Advisory Committee leadership, in particular Chairwoman Lynn Malerba, provided critical direction and guidance on this report. Members of the TSGAC provided useful and much appreciated comments on earlier drafts. In addition, the staff and technical advisors of the Tribal Self-Governance Advisory Committee provided insights and edits on the content. Any errors in the report, though, are those of the primary researcher and not of the TSGAC members.

The Indian Health Service, and the Office of Self-Governance in particular, provided significant assistance in conducting the research for this project. P. Benjamin Smith and Andrea Patton of the Office of Self-Governance facilitated meetings and coordinated contacts with appropriate IHS staff. Special thanks as well to Dr. Richard Church and Francis Frazier (IHS/OPHS), Carl Harper and Felicia Roach (IHS/ORAP), Dr. Howard Hayes, James Garvie, Mark Rives and Kirk Greenway (IHS/OIT), Phyllis Wolfe and Sherriann Moore (IHS/UIHP), and Geoff Roth (Office of the Director).

⁵⁸ See 45 CFR 155.350(c)(2).

⁵⁹ See 45 CFR 155.315(h).

**Enabling Electronic Verification of Eligibility for Indian-specific Benefits and Protections
under Medicaid and the Patient Protection and Affordable Care Act, P.L. 111-48**

May 22, 2013

Page 21

**Attachment A:
Preliminary List of NDW Data Elements to Populate Indian Verification Data Mart**

The following is a preliminary list of data elements contained in the National Data Warehouse that may be exported to an Indian Verification Data Mart for purposes of verifying Indian status for purposes of eligibility for Medicaid Indian-specific cost-sharing protections.

FIRST NAME	First name of the patient.
MIDDLE NAME	Middle name of the patient.
LAST NAME	Last name of the patient.
BIRTH DATE	Patient's date of birth.
GENDER CODE	Sex of patient as provided by the patient's registration information.
SOCIAL SECURITY NUMBER	Patient's Social Security Number.
BENEFICIARY CLASSIFICATION CODE	A category under which an individual can become eligible for IHS benefits.
COMMUNITY OF RESIDENCE CODE	Code for the State/County/Community of Residence of the patient.

While name, birth date, gender, and Social Security Number are common matching data items with known strengths and limitations (pertaining to typographical errors, duplicates, etc.), others items (such as Beneficiary Classification Code) are unique to the NDW.

The intention of establishing an Indian Verification Data Mart is to make available only those data elements that are necessary to verify eligibility for the Indian-specific benefits and protections. The broader set of data in the NDW would remain inaccessible to these authorized entities.

Attachment B:
Documenting IHS User Status to Indicate Eligibility for Cost-sharing Protections under Medicaid for Services at Non-I/T/U facilities

On January 22, 2013, CMS published CMS-2334-P, *Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Cost Sharing*, a proposed rule that includes a proposal to modify the regulations pertaining to the cost-sharing protections afforded AI/ANs under Medicaid.⁶⁰

In regards to Indian-specific cost-sharing protections under Medicaid, CMS is proposing a modification to existing regulations in order to provide a more functional mechanism to identify persons eligible for the Indian-specific cost-sharing protections under Medicaid in instances when an AI/AN is provided a referral by an I/T/U for services at a non-I/T/U provider.

CMS is proposing that “those Indians who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services are exempt from all cost sharing.”⁶¹ Under this proposed rule, the cost-sharing protections for AI/ANs under Medicaid would be applicable at non-I/T/U providers without regard to whether an AI/AN patient received a referral to the non-I/T/U provider.

CMS is proposing this modification to the current rules “[b]ecause no formal paper trail may occur for the Medicaid agency to establish that a service has been delivered based on a referral under contract health services.” The proposed rule continues with a discussion of how a state may implement the proposed modification. It reads, in part –

States could implement this exemption by using claims payment data to identify Indians who have accessed services from an I/T/U, or as many states have done, by requesting that eligible Indians submit a letter, available through the Indian Health Service, designating them as Indians who have utilized such services and are, therefore, exempt from Medicaid cost sharing. We note that this provision would not impact contract health services eligibility or payment regulations.⁶²

As indicated, CMS is proposing that a state Medicaid agency could verify eligibility for this cost-sharing protection by accessing (electronic) claims data or through paper documentation issued by an I/T/U.

CMS also requests comment on whether to apply – and if so, how long – a periodic renewal process for exempting Indians from cost-sharing, such that the exemption would not be indefinite, but would instead be limited to a certain period of time following utilization of services at an I/T/U or under a contract health services referral.

A mechanism that enables electronic verification of both one’s Indian status and one’s status as an I/T/U user, such as that under consideration in this report, could serve as an additional method – and possibly preferred method – to identify individuals who are eligible for the Indian-specific cost-sharing protections at non-I/T/U facilities.

⁶⁰ The regulatory changes are proposed to be made to § 447.56(a)(1)(vii) and (c). *See* 78 Fed Reg 4704, Tuesday, January 22, 2013.

⁶¹ 78 Fed Reg 4660-4661, Tuesday, January 22, 2013.

⁶² 78 Fed Reg 4704, Tuesday, January 22, 2013.

Attachment C:

Comparison of Documentation Requirements under I/T/U Eligibility, Medicaid Indian-specific Cost-sharing Protections, and Indian-specific Cost-sharing Protections under Exchange Plans (DRAFT)

	IHS	Medicaid	Exchange	Document type applicable to eligibility for Indian-specific provisions	Notes
	I/T/U Eligibility (42 CFR § 136)	Premium and Cost-sharing Protections for Indians (ARRA § 5006)	Indian-specific Cost-sharing Protections in the Individual Market through an Exchange (ACA § 1402(d))		
1			45 CFR § 155.350 [77 Fed Reg 18461, March 27, 2012] § 155.350 Special Eligibility standards and process for Indians.*** (c) Verification –	(1) Utilizing any relevant document verified in accordance with § 155.315(f) “Inconsistencies” [77 Fed Reg 18462]	- § 155.315(f) can be found at 77 Fed Reg 18455. Under (f), a process is indicated, but no specific documentation is listed.
2			§ 155.350 Special Eligibility standards and process for Indians.*** (c) Verification – [77 Fed Reg 18462]	(2) Relying on any electronic data sources that are available and have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification. [77 Fed Reg 18462]	
3			§ 155.350 Special Eligibility standards and process for Indians.*** (c) Verification – [77 Fed Reg 18462]	(3) *** verify documentation provided by the applicant in accordance with the standards for acceptable documentation provided in section 1903(x)(3)(B)(v) of the Social Security Act (SSA)	The docs in SSA 1903(x)(3)(B)(v) are for purposes of documenting citizenship or nationality for Medicaid and CHIP purposes. SSA § 1903(x)(3)(B)(v) is codified at 42 U.S.C. 1396b(x)(3)(B)(v)
4			§ 1903(x)(3)(B)(v) of the SSA (v)(1)*** a document issued by a federally recognized Indian	- A tribal enrollment / membership card - A certificate of degree of Indian blood issued by the Bureau of Indian Affairs (BIA) - A tribal census document	The implementing guidance was issued by CMS in December 28, 2009 “Dear State Health Official” letter.

	IHS	Medicaid	Exchange		
	I/T/U Eligibility (42 CFR § 136)	Premium and Cost-sharing Protections for Indians (ARRA § 5006)	Indian-specific Cost-sharing Protections in the Individual Market through an Exchange (ACA § 1402(d))	Document type applicable to eligibility for Indian-specific provisions	Notes
			tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).	<ul style="list-style-type: none"> - A document issued by a Tribe indicating an individual's affiliation with the Tribe - "These documents are examples of documents that may be used, but do not constitute an all-inclusive list of such documents." - "The document must identify the Federally recognized Indian Tribe which issued it, identify the individual by name, and confirm the individual's membership, enrollment in, or affiliation with that Tribe." 	The letter indicated, "Tribal documents are now considered to be as reliable as a passport and are treated as "Tier 1" documents under Federal regulations at 43 CFR 435.407."
5	42 CFR 136, subpart B, §136.12			"... is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction."	See Attachment D. http://www.ihs.gov/ohm/index.cfm?module=dsp_ohm_pc_p2c6#2-6.4
6	IHS Indian Health Manual, Part 2, Chapter 6.5			<ul style="list-style-type: none"> - Documentation from the BIA concerning an individual's blood quantum fraction - Tribal membership - Proof of Indian descent <p>[A more comprehensive list to be entered.]</p>	The IHS Indian Health Manual indicates "It is important to obtain verification of tribal membership, proof of Indian descent, and to maintain a photocopy of the certificate in the patient's record or maintain a verified notation regarding the page of the tribal documents that indicates the individual's membership." See Attachment D . http://www.ihs.gov/ohm/index.cfm?module=dsp_ohm_pc_p2c6#2-6.4
7		42 CFR §		- A tribal enrollment / membership card	See 75 Fed Reg 30247, May 28, 2010

	IHS	Medicaid	Exchange		
	I/T/U Eligibility (42 CFR § 136)	Premium and Cost-sharing Protections for Indians (ARRA § 5006)	Indian-specific Cost-sharing Protections in the Individual Market through an Exchange (ACA § 1402(d))	Document type applicable to eligibility for Indian-specific provisions	Notes
		447.50 [75 Fed Reg 30244, May 28 2010]		<ul style="list-style-type: none"> - A certificate of degree of Indian blood issued by the Bureau of Indian Affairs (BIA) - A tribal census document - A document issued by a Tribe indicating an individual's affiliation with the Tribe - A medical record card - "The Indian health care programs and urban Indian health programs are responsible for determining who is eligible to receive an item or service furnished by their programs and so a medical record card or similar documentation that specifies an individual is an Indian as defined above could suffice as appropriate documentation." - "These documents are examples of documents that may be used, but do not constitute an all-inclusive list of such documents." 	

Attachment D:

IHS Indian Health Manual and Federal Regulations (excerpts)

(Highlights in underline added.)

IHS Indian Health Manual⁶³

2-6.4 ELIGIBILITY. The patient registration staff must be conscientious in obtaining and recording comprehensive and accurate data during patient interviews. The information collected and recorded in the PRS is used to determine an individual's eligibility for IHS direct health care services and Contract Health Services (CHS) from the IHS.

2-6.5 OPERATIONS GUIDELINES.

- A. **Mandatory/Critical Fields.** The service unit patient registration staff must obtain and enter information in the following PRS fields. The fields considered mandatory are noted by an asterisk (*).⁶⁴
1. **Name *** The patient's full legal name must be entered in the PRS preceding each visit, otherwise duplicate records may be generated. Check for different name spellings to ensure that the patient does not already have a health record number. Names cannot be changed unless legal documentation is provided by the patient.
 2. **Health Record Number *** Each patient should have only one health record number at a facility or service unit. When entering this number in the system, check for an exact match within the files of the facility.
 3. **Date of Birth *** The date of birth is one of the field identifiers from the patient file that is used to search for potential duplicates. Verify the date of birth to ensure there are no different entries that would imply different patient files. If the 'official' Social Security date of birth is in error, assist the patient in notifying the Social Security Administration (SSA) to make a correction. Date of birth should not be changed unless the patient provides a birth certificate or other certified legal document. Otherwise, use of the wrong date of birth will generate an error report.
 4. **Sex *** This notation would be either 'F' for female or 'M' for male This is one of the field identifiers used to search for potential duplicate files.
 5. **Social Security Number (SSN).** For all persons ages two and above it is strongly encouraged that they have a SSN, according to IRS requirements. Therefore, all patients are strongly encouraged to obtain a SSN for their children at birth. Application forms for obtaining a SSN can be provided to patients.

Even though having a SSN is not mandated, it is extremely beneficial in identifying patient records. If possible, maintain a photocopy of the Social Security card in the patient's record at each facility where he is treated to verify the SSN. This number must be recorded accurately because it is a major identifier of the patient for third-party billing. Use of "pseudo numbers" will generate error reports.

⁶³ http://www.ihs.gov/ihtm/index.cfm?module=dsp_ihm_pc_p2c6

⁶⁴ The term "mandatory" refers to the requirement for patient registration staff to enter information into the data fields. It does not connote a requirement to be a member of a Tribe, etc.

6. **Tribe of Membership/Tribe Codes ***. The list of recognized tribes is already in the Patient Registration System to be accessed in order to match and update the tribe of membership information provided by the patient.

It is important to obtain verification of tribal membership, proof of Indian descent, and to maintain a photocopy of the certificate in the patient's record, or maintain a verified notation regarding the page of the tribal documents that indicates the individual's membership.

The complete listing of tribe codes is in the User Guide/Standard Code Book Tables (Vol. II.) May 24, 1991, provided by the data center in Albuquerque, New Mexico.

7. **Indian Blood Quantum ***. The actual blood quantum fraction of the patient must be entered into the PRS as verified with BIA documents. Since membership in a tribe is important to eligibility for CHS, a notation regarding verified blood quantum will be made in the Patient Registration System. (Making an entry in this PRS field is required to continue in the database as it is presently structured.)
8. **Present Community/Community of Residence ***. This refers to the community in which the patient currently resides, and may not be the same as the mailing address. Be sure to indicate when the patient moved to their present community because official residence affects CHS eligibility.
9. **Beneficiary Code ***. This is the primary classification under which this patient qualifies for IHS care. Until the present law is amended, patients are usually qualified because they possess Indian blood.
10. **Eligibility Status ***. The types of eligibility for the patient will be determined based on the accuracy of the various data entered in the Patient Registration System.
11. **Veteran Status ***. Verify, if possible, the veteran status of the patient. This is important to determine potential eligibility for other services. Veteran information may include items such as: branch of service; service entry date service separation date; and Veterans Administration medical care eligibility.

Federal Regulations: 42 CFR § 136.12 and § 136.23⁶⁵

§ 136.12 Persons to whom services will be provided.

(a) *In general.* Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program. Services will also be made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through postpartum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction. The Service will also provide medically indicated services to non-Indian members of an eligible Indian's household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard.

(2) Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.

(b) *Doubtful cases.* (1) In case of doubt as to whether an individual applying for care is within the scope of the program, the medical officer in charge shall obtain from the appropriate BIA officials in the jurisdiction

⁶⁵ <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=e43fb9d88598fce72402ddf55ac32e9f&rgn=div5&view=text&node=42:1.0.1.13.84&idno=42#42:1.0.1.13.84.3.47.3>

information that is pertinent to his/her determination of the individual's continuing relationship to the Indian population group served by the local program.

(2) If the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.

(c) *Priorities when funds, facilities, or personnel are insufficient to provide the indicated volume of services.* Priorities for care and treatment, as among individuals who are within the scope of the program, will be determined on the basis of relative medical need and access to other arrangements for obtaining the necessary care.

§ 136.23 Persons to whom contract health services will be provided.

(a) *In general.* To the extent that resources permit, and subject to the provisions of this subpart, contract health services will be made available as medically indicated, when necessary health services by an Indian Health Service facility are not reasonably accessible or available, to persons described in and in accordance with § 136.12 of this part if those persons:

(1) Reside within the United States and on a reservation located within a contract health service delivery area; or

(2) Do not reside on a reservation but reside within a contract health service delivery area and:

(i) Are members of the tribe or tribes located on that reservation or of the tribe or tribes for which the reservation was established; or

(ii) Maintain close economic and social ties with that tribe or tribes.

(b) *Students and transients.* Subject to the provisions of this subpart, contract health services will be made available to students and transients who would be eligible for contract health services at the place of their permanent residence within a contract health service delivery area, but are temporarily absent from their residence as follows:

(1) Student—during their full-time attendance at programs of vocational, technical, or academic education, including normal school breaks (such as vacations, semester or other scheduled breaks occurring during their attendance) and for a period not to exceed 180 days after the completion of the course of study.

(2) Transients (persons who are in travel or are temporarily employed, such as seasonal or migratory workers) during their absence.

(c) *Other persons outside the contract health service delivery area.* Persons who leave the contract health service delivery area in which they are eligible for contract health service and are neither students nor transients will be eligible for contract health service for a period not to exceed 180 days from such departure.

(d) *Foster children.* Indian children who are placed in foster care outside a contract health service delivery area by order of a court of competent jurisdiction and who were eligible for contract health services at the time of the court order shall continue to be eligible for contract health services while in foster care.

(e) *Priorities for contract health services.* When funds are insufficient to provide the volume of contract health services indicated as needed by the population residing in a contract health service delivery area, priorities for service shall be determined on the basis of relative medical need.

(f) *Alternate resources.* The term “alternate resources” is defined in § 136.61(c) of subpart G of this part.

Attachment E:

Data Elements in the Patient Registration System (36 of 99 entries)

Data Items in the IHS Patient Registration System (PRS)

	Label	Description
1	UNIQUE REGISTRATION ID	Unique registration record ID generated by the source system. It is unique by registration record, not necessarily by patient, if a given patient has more than one registration record at the same facility or different facilities.
2	REGISTRATION CREATE DATE	Date on which the registration record was created on the local system.
3	DATE LAST MODIFIED	Date last modified by the local registration/encounter system.
4	REGISTRATION STATUS CODE	Status of a patient registration record and all of its components; i.e., demographic states, charts, aliases, and insurance eligibilities. Examples of why registration might be Inactive: death of patient, registration consolidated with another for same patient. Examples of why registration might be deleted: entered in error, never a valid registration.
5	REGISTERING FACILITY CODE (ASUFAC)	Area-Service Unit-Facility code to designate the facility where the chart is located.
6	CHART/HEALTH RECORD NUMBER	Patient's Chart/Health Record Number (HRN) at the Registering Facility
7	NAME TITLE/PREFIX	Title of the patient; e.g., Mr., Mrs., Dr., etc.
8	FIRST NAME	First name of the patient.
9	MIDDLE NAME	Middle name of the patient.
10	LAST NAME	Last name of the patient.
11	NAME SUFFIX	Suffix of patient's name; e.g., Sr., Jr., III, etc.
12	BIRTH DATE	Patient's date of birth.
13	DEATH DATE	Patient's date of death.
14	ICD9 DIAGNOSIS CAUSE OF DEATH CODE	ICD-9 code for cause of death.
15	GENDER CODE	Sex of patient as provided by the patient's registration information.
16	SOCIAL SECURITY NUMBER	Patient's Social Security Number.
17	SSN PSEUDO CODE	Field used by the load process to determine if the SSN is actually a pseudo-ssn assigned by the facility. For those systems where an SSN is required but the real value is unknown, 'P' indicates that the SSN supplied is a place-holder only.
18	BENEFICIARY CLASSIFICATION CODE	A category under which an individual can become eligible for IHS benefits.
19	TRIBE CODE	Patient's Tribe of Membership code
20	BLOOD QUANTUM CODE	Code to designate whether the patient is American Indian/Alaska Native and, if so, to what degree.
21	COMMUNITY OF RESIDENCE CODE	Code for the State/County/Community of Residence of the patient.
22	COMMUNITY OF RESIDENCE START DATE	Date when the patient first moved to this community of residence.
23	MAILING ADDRESS 1	First line of the street address portion of this patient's mailing address, P.O. box, or rural route address of the patient.
24	CITY	City or town portion of this patient's mailing address.
25	STATE ABBREVIATION CODE	Two-character United States Postal Service state code for this patient's mailing address.
25	ZIP CODE	Zip code for this patient's mailing address.
26	ZIP CODE EXTENSION	Zip code extension for this address, if available.
27	FATHER'S FIRST NAME	Father's first name.
28	FATHER'S MIDDLE NAME	Father's middle name.
29	FATHER'S LAST NAME	Father's last name.
30	MOTHER'S FIRST NAME	Mother's first name.
31	MOTHER'S MIDDLE NAME	Mother's middle name.
32	MOTHER'S MAIDEN LAST NAME	Mother's maiden last name.
33	SERVICE ELIGIBILITY CODE	Code that specifies the types of services for which this patient was eligible. (Note: Native Americans cannot be coded as ineligible.)
34	VETERAN FLAG	Identifies a person who has previously served in the US military. Veterans generally receive special veterans' assistance for medical bills. Note: This flag indicates if the patient is a veteran. It is NOT intended to identify all patients who are eligible for veterans' benefits.
35	INSURANCE CATEGORY CODE (1)	Type of eligibility .
36	COVERAGE TYPE CODE (1)	Type of third-party coverage for which the patient is eligible.

Attachment F:

Standard Code Book (SCB) Tables

SCB Tables

Standard Code Book Tables		
Table Name	Records	Updated
<u>Admission</u>	5	10/02/2012
<u>APC Recodes</u>	214	10/02/2012
<u>Area</u>	53	10/02/2012
<u>Blood Quantum</u>	7	10/02/2012
<u>Cause of Injury (External Cause)</u>	1291	10/02/2012
<u>Classification (Beneficiary)</u>	31	10/02/2012
<u>Clinic</u>	131	10/02/2012
<u>Clinical Services</u>	23	10/02/2012
<u>Community</u>	13976	10/02/2012
<u>County</u>	2008	10/02/2012
<u>Facility</u>	8094	10/02/2012
<u>Facility Type</u>	20	10/02/2012
<u>Patient Education Protocol (Education Topics)</u>	1107	10/02/2012
<u>Place of Injury</u>	12	10/02/2012
<u>Reservation</u>	329	10/02/2012
<u>Service Unit</u>	570	10/02/2012
<u>Services Rendered By (Provider)</u>	139	10/02/2012
<u>State</u>	71	10/02/2012
<u>Tribe</u>	865	10/02/2012
<u>Type of Provider (Vendor)</u>	19	10/02/2012
20 Record(s)		

Source: Standard Code Book (SCB)

http://www.ihs.gov/scb/index.cfm?module=disp_tablesSCB&newquery=1

**Attachment G:
Classification (Beneficiary): Codes**

Classification (Beneficiary)

1-25 of 31 items displayed		page 1: records 1-25	go	>>
<u>Code</u>	<u>Classification</u>			
01	Indian or Alaskan Native			
02	PHS Field Employees			
03	PHS Commissioned Officer			
04	PHS Commissioned Officer Dependent			
05	BEC Beneficiary			
06	Non-Indian Emergency			
07	VISTA			
08	Other			
09	Military			
10	Retired Military			
11	Federal Employee (Non-PHS)			
12	Coast Guard			
13	Coast Guard Dependents			
14	American Seaman			
15	Foreign Seaman			
16	Immigration Detainee			
17	National Guard			
18	Non-Indian Elective			
19	NOAA Personnel			
20	NOAA Personnel Dependent			
21	Special Duty			
22	Alaska Handicapped Children's Program Applicants			
23	Military Active Duty Personnel Dependents			
24	Military Retired Personnel Dependents			
27	U. S. Coast Guard Retired Personnel			
31 Record(s)				
<u>Code</u>	<u>Classification</u>			
28	U. S. Coast Guard Retired Personnel Dependents			
29	U. S. Military Academy Candidates			
30	U. S. PHS Retired Commissioned Officers			
31	U. S. PHS Retired Commissioned Officers Dependents			
32	Dependent of Indian			
33	Non-Indian (charged a fee for Services provided)			
31 Record(s)				
26-31 of 31 items displayed		<<	page 2: records 26-31	go

Source:

http://www.ihs.gov/scb/index.cfm?module=W_BENEF_CLASS&option=list&num=80&newquery=1

Attachment H:

IHS Assessment of National Data Warehouse

ITDASHBOARD

IHS - National Patient Information Reporting System (NPIRS) - - Maintenance and Enhancements

Investment Description

The National Patient Information Reporting System (NPIRS) is the national data repository of the Indian Health Service (IHS). It is a steady-state investment in the O&M life-cycle. NPIRS produces specific reports that are required by statute and reg [More..](#)

Evaluation by Agency CIO

Current Evaluation

5



Evaluation Explanation

Sound management controls are in place to sustain strong overall performance and mitigate risk. Cost and schedule performance is within HHS +/- 10% v [More..](#)

Operational Performance

Metric Description	Frequency	Unit of Measure	FY2012 Target	Most Recent Actual	Met/Not Met	Updated Date of Most Recent Actual
Results: Effective customer contact management processes and reporting - percent of initial custom More..	Monthly	percentage	95	100	Met	2012-07-23
Results: User Population and Workload Reports delivered as scheduled - percent of reports are deli More..	Monthly	percentage	95	97.5	Met	2012-07-23
Results: User Population and Workload Reports are delivered with acceptable accuracy - percent of More..	Monthly	percentage	99	100	Met	2012-07-23
Activities and Technology: Data Integrity Verification Results - percent of reported results are d More..	Monthly	percentage	100	100	Met	2012-07-23
Activities and Technology: Security Certification and Accreditation - percent of security requirem More..	Monthly	percentage	95	100	Met	2012-07-23
Activities and Technology: Data mart availability except during scheduled maintenance - percentage More..	Monthly	percentage	95	100	Met	2012-07-23

Note: All descriptions, dates, and costs are as reported by agencies.

Source: <http://www.itdashboard.gov/investment?buscid=334>

Attachment I:

Sample of HHS/ASPE Reports on IHS Patient Registration System Data

TITLE: Indian Health Service Patient Registration System

ACRONYM: IHS-PTREG

AGENCY/PROGRAM: Office of Executive Management, Office of Public Health, Indian Health Service

DESCRIPTION: The purpose of this activity is to collect demographic data on American Indians and Alaska Natives (AIs/ANs) receiving health care provided/funded by the Indian Health Service (IHS). This is an active continuous data collection system. It is used for program planning and management. All AIs/ANs who access the IHS system are registered at the facility when they present themselves for service. A patient's record is updated when he/she reports changes, and patient records are periodically purged because of death or long periods of inactivity. Individual records are maintained for each patient with demographic and third-party eligibility information in an IHS central computer database. This IHS-developed system was first implemented in FY 1984; however, the database contains only the latest data for each registrant and only current registrants. The data can be analyzed to the community of residence or facility level and by any age group. The data file for a fiscal year is available within three months of the close of the fiscal year.

RACE AND ETHNICITY: American Indian and Alaska Native records only. The Patient Registration System uses the Bureau of Indian Affairs (BIA) list of Federally Recognized Indian Tribes, which is published in the Federal Register, as categories of subpopulations of AI/ANs.

STATUS: This continuous data collection is active.

HOW TO ACCESS DATA: Requests for access to the data are handled on a request by request basis in accordance with appropriate confidentiality provisions. The requestor is required to sign an agreement regarding the use of the data and publication of results.

IHS has a Home Page which includes IHS statistical publications (e.g., Trends in Indian Health and Regional Differences in Indian Health). These publications contain summary information from the various IHS databases. .

WEB SITE: www.ihs.gov

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Source: <http://www.itdashboard.gov/investment?buscid=334>

Attachment J:

Exchange Application for Health Coverage (Revised/Issued 4/29/2013)

On April 29, 2013, CMS issued revised applications for use in the Federally-facilitated Exchanges (FFE). There are three versions of the applications that will be available to enrollees through an FFE and to enrollees through a state Exchange if the state uses the CMS-issued versions.

1. "Application for Health Coverage and Help Paying Costs (Short Form)"
 - o This three page application is for use by single adults who do not have dependents and cannot be claimed as a dependent on someone else's tax returns.
 - o On the cover page, AI/ANs are directed to use "a different form to make sure you get the most benefits possible."
2. "Application for Health Coverage and Help Paying Costs"
 - o This seven page application (with additional attachments) is to be used by individuals and families who are seeking financial assistance.
 - o In Step 3 of the application, applicants that identify themselves as AI/AN are asked to go to Appendix B.
 - o Appendix B to this form is titled "American Indian or Alaska Native Family Member (AI/AN)".
 - o Appendix B includes questions to determine if an applicant (or family member) is 1) a member of a Federally-recognized Tribe and / or 2) is a user of IHS services or is eligible to use IHS services.
3. "Application for Health Coverage"
 - o This three page application may be used by enrollees that are not requesting financial assistance.
 - o Questions are included in Step 3 of the application to identify AI/ANs who are members of Federally-recognized Tribes. Questions are not included to identify persons who are IHS users or eligible for IHS services.

For each application version, the portion of the application that address AI/AN-specific issues is shown below:

1. Application for Health Coverage and Help Paying Costs (Short Form)

Who can use this application?

Single adults who:

- Aren't offered health coverage from their employer
- Don't have any dependents and can't be claimed as a dependent on someone else's tax return

NOTE: If any of the following apply, you need to fill out a different form to make sure you get the most benefits possible:

- You're married or have dependent children.
- You were in the foster care system, and you're under age 26.
- You have items that can be deducted from your income. If your only deduction is student loan interest, you can use this form.

-	• You're American Indian or Alaska Native. -
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2. Application for Health Coverage and Help Paying Costs

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

- If No, skip to Step 4.
- Yes. If yes, go to Appendix B.

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2								
1. Name (First name, Middle name, Last name)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">First</td> <td style="width: 50%;">Middle</td> </tr> <tr> <td colspan="2">Last</td> </tr> </table>	First	Middle	Last		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">First</td> <td style="width: 50%;">Middle</td> </tr> <tr> <td colspan="2">Last</td> </tr> </table>	First	Middle	Last	
First	Middle									
Last										
First	Middle									
Last										
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No								
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No								
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance 	\$ _____ How often? _____	\$ _____ How often? _____								

3. Application for Health Coverage

STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

No. If no, skip to Step 4.

Yes. If yes, continue. If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1		AI/AN PERSON 2	
2. Name (First name, Middle name, Last name)	First	Middle	First	Middle
	Last		Last	
3. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name _____		<input type="checkbox"/> Yes If yes, tribe name _____	
	<input type="checkbox"/> No		<input type="checkbox"/> No	