AMERICAN INDIAN AND ALASKA NATIVE

MEDICARE

PROGRAM AND POLICY STATISTICS

Summary Report
December 2009

MEDICARE 2006
Enrollment & Utilization

for the

Centers for Medicare & Medicaid Services
Tribal Technical Advisory Group

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Funded by

Center for Medicaid and Medicare Services (CMS)

through the Indian Health Service (IHS) and

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TABLE OF CONTENTS

SUMMARY

This report was commissioned by the Centers for Medicaid and Medicare Services (CMS) to investigate Medicare enrollment and utilization data available for American Indians and Alaska Natives (AIAN) using criteria set out in the CMS AIAN Strategic Plan of 2006. The goal is to demonstrate the strengths and limitations of Medicare data in providing useful information for Medicare program planning and policy analysis that affects the health and health care of AIAN.

A major strength of Medicare data is that the Enrollees identified as 'AIAN' in Medicare data are very similar to the 'IHS AIAN' defined in the Strategic Plan. We found that 99.9% of enrollees identified as 'AIAN' in the Medicare master enrollment database are identified during the on-going linkages of Medicare enrollment and IHS registry data. Thus AIAN in Medicare data are recognized as AIAN by the IHS and have at some point in their lives been in the user population of the IHS health care delivery system. The major difference between this group and 'IHS AIAN' defined in the Strategic Plan is that it is not known whether the AIAN in Medicare data are currently users of IHS system providers. We found that 13.4% of AIAN in Medicare data for 2006 did not live in an IHS service delivery area ('CHSDA') county.

A major limitation of Medicare data is that it does not identify the groups of AIAN or the IHS providers defined in the CMS AIAN Strategic Plan of 2006 for program planning and policy analysis. The Strategic Plan defined three groups of AIAN (Racial, IHS and Tribal) and three groups of Indian Health Service (IHS) health care delivery system providers (IHS, Tribal and Urban). Medicare could better identify IHS and Tribal AIAN, and health care delivery system providers in their data. Medicare currently links its master enrollment data with IHS registry data several times each year for the purposes of identifying 'AIAN' in Medicare data. In the recommendations we emphasize that additional information should be retained by Medicare from the on-going Medicare-IHS data linkages. Information could be retained that identifies 'IHS AIAN' and 'Tribal AIAN' and their IHS, Tribal and Urban providers according to the definitions included in the CMS AIAN Strategic Plan of 2006.

We build on the strength of the Medicare data that exists for IHS AIAN to present in this report analysis of Medicare enrollment and health care utilization data for AIAN. We present findings for three relevant service areas: the United States, IHS Administrative Areas, and a consolidated Urban Service Area.

Enrollment Data

Enrollment data categories in this report are those that the annual CMS reports highlight because they are particularly useful in planning and tracking programs and policies. They include age, gender, IHS and urban service areas, eligibility groups, hospital and medical service coverage, managed care coverage and state Medicaid program purchase of Medicare premiums. We provide an analysis of AIAN enrollment data from the annual Denominator file of beneficiaries for 2006 which was finalized in 2009. Wherever possible we present the comparative information for all Medicare enrollees in the same year so that it can be better predicted how programs and policies that CMS devises might affect AIAN differently from Medicare enrollees generally. Among key findings in the report:

- **Age**. AIAN Medicare enrollees are younger than Medicare enrollees. This is true within both the Aged and Disabled eligibility groups. Among Aged AIAN nearly two-thirds (65%) are under age 75 compared with only half of all Aged Medicare enrollees (52%). Among Disabled AIAN one-third (33%) are under age 45 compared with only a quarter of all

Disabled Medicare enrollees (25%). This is important because health and health care are age dependent, and programs and policies have differential effects depending on age.

- **Eligibility**. Proportionately fewer AIAN are in the Aged eligibility group, and more in the Disabled eligibility group than Medicare enrollees generally. The fraction of AIAN enrollees who are Disabled (29%) is nearly twice as large as that for all Medicare enrollees (16%).

- **Hospital and Medical Coverage**. In the U.S. as a whole, 91% of all AIAN enrollees have both Hospital and Medical Medicare coverage (Parts A and B). This is almost the same as the 92% rate for all Medicare beneficiaries.

- **Managed Care**. The fraction of AIAN Medicare enrollees who are in Managed Care (9%) is less than half as large as that of all Medicare enrollees (20%). Managed care penetration varied a great deal among the IHS Areas with a low of 0% in Alaska Area to 20% in the Tucson Area. In the Urban Service Area the proportion of AIAN enrollees in managed care was 20%.

- **Medicaid Payment of Medicare Premiums**. State Medicaid programs paid premiums for Medicare coverage for 39% of AIAN enrollees who have Hospital and Medical Medicare coverage (Parts A and B). The rate is essentially the same for the IHS Areas (40%) and for the Urban Area (39%), but the rate varies a great deal among the IHS Areas from a low of 29% in Oklahoma Area to a high of 61% in Navajo Area. A major determinant of this variation across the IHS Areas is the difference in rates that Medicaid programs paid premiums for Aged and Disabled eligibility groups.

AIAN in the 12 IHS Areas and the Urban Service Area vary in their demographics, eligibility and coverage. No single Area dominates the characteristics associated with better or worse health and health care, but the Areas vary substantially in all characteristics. This variation in enrollment among areas needs to be considered in Medicare program planning and policy analysis.

Utilization Data

Medicare health care utilization data is divided among numerous data files that are classified according to service or provider type. Unlike enrollment data, there is no annual summary file. Since essentially all enrollees are covered for hospital care (Medicare Part A), and payments to hospital facilities constitute the highest paid Medicare benefit category, we analyzed the AIAN data in the hospitalizations (MedPAR) file for Short Stay and Long Stay hospitals in 2006. Wherever possible we compare information AIAN data to that for all Medicare enrollees in the same year.

Key indicators of hospital service utilization are, 1) the rates at which populations are hospitalized (hospitalization rates), 2) their average days of hospital care, and 3) their average length of stay. Higher values for any of these indicators can reflect lower health status, while low values can reflect barriers to care. We found for Short Stay hospital utilization:

- **Hospitalization Rates.** Hospitalization rates are higher for AIAN (390 stays per 1000 enrollees with hospital coverage) than for all Medicare enrollees (349 stays per 1000). Rates across IHS Service Areas range from a low of 300 per 1000 in Alaska and California Areas, to a high of 561 per 1000 in the Tucson Area. For AIAN living in the Urban Service Area the hospitalization rate was 419 stays per 1000.

- ◊ **Hospital Days and Stays**. AIAN Medicare enrollees average more total hospital days, but shorter length of days per stay, than Medicare enrollees. The hospital Days of Stay averaged 2,086 days per 1,000 AIAN enrollees with hospital coverage, while Medicare enrollees had 1,981 days per 1,000. The average length of stay for AIAN enrollees was shorter (5.4 days per stay) than the comparable rate for Medicare enrollees (5.7 days per stay). Total hospital days of stay were more than twice as high in the Tucson Area than the Portland Area, and longest lengths of stay were in the Alaska Area (6.9 days per stay).

Medicare payments to hospitals for care of AIAN enrollees in Short and Long Stay hospitals totaled $550 million in 2006. Medicare hospital payments generally constitute the single largest category of Medicare benefit payments (62% of Part A benefit payments), 2.1 times as large as payments for physicians and other professionals, and 2.5 times as large as payments for medications. For care in Short Stay hospitals:

- ◊ **Per Capita Medicare Payments**. Medicare pays more for hospital care of AIAN enrollees on a per capita basis ($3,299 per enrollee with hospital coverage) than for Medicare enrollees in general ($3,008 per enrollee). With age adjustment the difference would be even greater because of the younger AIAN population covered. The lowest per capita payment is in the Albuquerque Area ($2,532), less than half the highest in the Tucson Area ($5,468). The large variation in Medicare per capita payments is important to take into account in determining equity of federal health care coverage for IHS user population across IHS areas. Adjustments are needed for age, medical costs and other factors affecting health care coverage as has been done in the past with IHS funding across IHS areas.

- ◊ **Medicare Payments per Hospital Stay**. Medicare payments per stay for AIAN are lower ($8,469 per stay) than the Medicare national average ($8,669 per stay). Medicare payments vary from a low in the Oklahoma Area of $7,377 per stay to 50% to 100% higher payments in California ($10,301 per stay) and Alaska ($13,588 per stay) Areas. Medicare payments for the Urban Service Area ($9,645 per stay) were higher than the national average.

- ◊ **Medicare Payments per Hospital Day**. Medicare payment rates per day to hospitals are a little higher for AIAN ($1,582 per day of stay) than the Medicare national average ($1,519 per day of stay). Medicare payments vary from a low in the Nashville Area ($1,448 per day) to comparable highs in the Alaska ($1,982 per day), Portland ($1,943 per day), and California ($1,915 per day) Areas. Medicare payments for the Urban Service Area ($1,712) per day of stay are higher than the national average.

- ◊ **Enrollee Payments**. When all payments made for AIAN hospitalizations are totaled, Medicare pays 89% of the total, while AIAN enrollees pay about 7% for Deductibles and Coinsurance. The balance is paid by other payers (4%). Enrollee payments vary from a low of 5% of total hospital payments in the Alaska area, to a high of 8% in Oklahoma Area. AIAN enrollees paid 8% for Deductibles and Coinsurance in the Urban Service Area.

Recommendations

Medicare Data for AIAN and IHS System Providers. Recommended strategies that could improve Medicare data for program planning and policy analysis include:

- ◊ **Racial AIAN**. Medicare Beneficiary Surveys and Social Security Administration activities have had little impact on increasing the identification of the self-declared AIAN Medicare enrollee population, alternative recommended strategies would be:
  - o Contact Medicare enrollees (particularly those in 'Other' Race category) to update their Medicare demographic information;
  - o Advertise the importance of responding to this demographic 'Update' initiative in cultural groups and events of AIAN;
- ◊ **IHS AIAN**. Medicare does not retain information on the year(s) in which the Medicare enrollees were identified as current (active) users of IHS system providers.
  - o Have the IHS identify the year(s) of confirmed IHS active user status during the quarterly linkages of Medicare enrollment data with IHS active user data;
  - o During the demographic 'Update' initiative, give enrollees the opportunity to provide a Geographic zip code for where they physically live in addition to any zip code they may have on record for mailing purposes;
- ◊ **Tribal AIAN**. Medicare does not have any information on tribal affiliation for the individual tribes who are requesting analysis of the Medicare data of their tribal members.
  - o Survey tribal leadership of federally recognized tribes to see which tribes want to have Medicare data;
  - o Have the IHS identify the tribal affiliation of IHS active users during the quarterly linkages of Medicare enrollment data with IHS active user data;
  - o Have AIAN Medicare enrollees provide tribal affiliation(s) and status as 'enrolled or registered' during the demographic 'Update' initiative;
- ◊ **IHS, Tribal or Urban Providers** (I/T/U). Medicare does not have codes developed that would identify IHS health care delivery system providers and their status as IHS, tribal or urban Indian operated institutions.
  - o Have IHS identify the I/T/U provider(s) (that is, IHS Service Units) used during the quarterly linkages of Medicare enrollment data with IHS active user data.
- ◊ **Medicare Enrollment and Health Care Utilization Data.** This report specifies further work to be done with Medicare enrollment and utilization data files to investigate health status, access to care, and variation in care as a function of provider and payer policies and practices**.**

Introduction

Purpose of this Report

This report was commissioned to investigate Medicare enrollment and utilization data available for American Indian and Alaska Native (AIAN) using criteria set out in the Center for Medicare and Medicaid Services (CMS) AIAN Strategic Plan of 2006. The goal is to demonstrate the strengths and limitations of Medicare data to provide useful information for Medicare program planning and policy analysis that affects the health and health care of AIAN. In this report we provide findings from the analysis of three primary Medicare data files with the following specific aims:

- Investigate how well the data can identify the three groups of AIAN and the three groups of IHS health care delivery system providers in the CMS AIAN Strategic Plan.
- Analyze enrollment data available for AIAN in the data files, including the demographics, eligibility and coverage of the AIAN enrollees in Medicare.
- Analyze health care utilization data for Medicare paid hospitalizations of AIAN regardless of hospital provider.
- Present findings for three relevant service areas: the United States, Indian Health Service (IHS) Administrative Areas, and a consolidated Urban Service Area.
- Evaluate the strengths and limitations of the enrollment and utilization data for Medicare program planning and policy analysis from the point of view of the three groups of AIAN and the three groups of IHS health care delivery system providers in the CMS AIAN Strategic Plan.
- Recommend highest priority strategies that could improve Medicare data for program planning and policy analysis through coordinated actions of the CMS, IHS and the Social Security Administration.

Background

Since 2005 the CMS has convened a Tribal Technical Advisory Group (TTAG) to provide consultation to CMS on the impact of CMS programs and policies on AIAN populations, their health and health care. The CMS TTAG is constituted primarily by representatives from each of the 12 Administrative Areas served by the health care delivery system of the IHS. In 2009, representation from the Urban Indian Health Programs funded by the Indian Health Service was added to the CMS TTAG. The IHS administers a health care delivery system owned and operated by the federal and tribal governments.

Introduction

The CMS TTAG regularly reviews CMS programs and policies for their impact on AIAN and the health care delivery system that they depend on.

A fundamental problem preventing informed CMS program planning and policy analysis has been a lack of data on AIAN enrollees in CMS programs, and their utilization of different CMS provider, service and payment options. To address the lack of information the CMS AIAN Strategic Plan for 2006-2010 called for a Data Project:[1]

- To evaluate gaps in the databases for their usefulness for policy analysis and measuring performance of the CMS Medicare, Medicaid and SCHIP programs;
- To make specific recommendations on strategies for reducing gaps in databases, generating useful program and policy reports, and training data users for AIAN populations and IHS, Tribal and Urban (I/T/U) providers.

To implement the plan Office for Tribal Affairs of CMS began contracting with CRIHB in 2007:

- Perform a data inventory and analysis of AIAN demographic, enrollment and utilization data through coordinated review of CMS, IHS, Social Security Administration (SSA) and other data resources;
- Develop strategies that make CMS data systems capable of reporting AIAN enrollment, service utilization, health status and payment data from Medicare, Medicaid and SCHIP programs that would facilitate program planning and evaluation, performance measurement, health status monitoring and targeted enrollment efforts.

With oversight from the CMS TTAG and its Data Subcommittee, CRIHB has produced three major reports that use data inventories and analyses to develop strategies to achieve the goals of the plan:

1. *Gaps and Strategies to improve American Indian and Alaska Native Data in Medicare, Medicaid and SCHIP Databases (August 2007)*
2. *American Indian and Alaska Native Medicaid Program and Policy Data (February 2009)*
3. *American Indian and Alaska Native Medicare Program and Policy Data (this report)*

The first report was a systematic analysis of published materials about Medicaid, SCHIP and Medicare data available for program performance and policy analysis. In that report, we: 1) Identified the key criteria for evaluating the extent to which CMS databases have data from the point of view of the three definitions of AIAN and their IHS healthcare delivery system defined in the AIAN CMS Strategic Plan; 2) Performed a systematic inventory of CMS data sets to assess the extent to which useful data sets are available and adequate for identifying and monitoring AIAN and IHS system provider enrollment and

[1] *CMS AIAN Strategic Plan for 2006-2010*. Available at: www.cmsttag.org/policy.html

utilization data; and 3) Identified gaps in the available data sets and a wide range of strategies that could improve the data for CMS program planning and policy analysis.

The second report was a systematic analysis of Medicaid and SCHIP data readily available online in a web State Summary Data Mart developed and sustained by CMS. The report included findings from analysis of the online data for AIAN and IHS program data for the 35 states of the IHS healthcare delivery system. In that report we, 1) Described the Medicaid and SCHIP data available for AIAN and IHS program in the online data; 2) Demonstrated the gaps that arise using state level data to represent AIAN and I/T/U in the 12 Administrative Areas of the IHS healthcare delivery system; 3) Used the best available data for AIAN and their IHS healthcare delivery system based on the AIAN CMS Strategic Plan definitions, and compared Medicaid and SCHIP enrollment and utilization data for AIAN to that of 'All Others' within each state and to the average for all 35 states; and from that analysis we, 4) Identified three high priority gaps in the available data, and recommended three high priority strategies that could improve Medicaid and SCHIP data for program planning and policy analysis.

This is the third major report designed to be a systematic analysis of Medicare data for AIAN and IHS system providers in three Medicare electronic data files for demographics, enrollment (including eligibility and coverage) and utilization (including services and payments). The progress made and need for additional reports are in the 'Conclusions and Recommendations' section of this report. For the explanation of Medicare terms used in the report, see the CMS Glossary in Appendix E.

Key Criteria for AIAN Program and Policy Data

The CMS AIAN Strategic Plan provided the relevant definitions of AIAN groups for whom data was needed for CMS program planning and policy analysis: these included a Racial (called 'Census'), IHS and tribal group of AIAN.

AIAN

Racial AIAN. In the 'Racial AIAN' group, individuals are allowed to declare their race to be AIAN either alone or in combination with any other races in response to a demographic question on race in a form or survey (Table 1). Additionally, in this group it does not matter how the individuals responded to any question about Hispanic ethnicity. These criteria meet the 1997 Office of the Management of the Budget (OMB) standards for collecting racial information. The Strategic Plan referred to this group as 'Census AIAN' because it was in the 2000 Census that individuals nationally were given the opportunity to declare all of the races in their heritage. From Census data the CMS Strategic Plan estimated there

were 4.5 million AIAN in this group in the United States. The number includes people who declared they were of more than one race. In fact, the single major racial group with the highest portion of people declaring more than one race was AIAN.[2]

Table 1
CMS AIAN Strategic Plan Definitions of American Indians and Alaska Natives (AIAN)

Definition	Who is Included	How Inclusion Determined
'Racial AIAN'	Race is AIAN either as the only Race or in addition to any other Races, regardless of Hispanic Ethnicity	Self-declared
Indian Health Service 'IHS AIAN'	Member of federally recognized Tribe or their descendants who use an IHS funded provider facility	Federal IHS
'Tribal AIAN'	Member of federally recognized Tribe	Tribes

IHS AIAN. In the 'IHS AIAN' group the Strategic Plan included enrolled members of federally recognized tribes, or their descendants included in the federal trust responsibility, who live on or near tribal lands and are active patients of the IHS health care delivery system. IHS determines whether AIAN reported to them by providers meet criteria as 'AIAN Active Users' through the IHS National Patient Information Registry System (NPIRS).[3] These AIAN are enrolled members of federally recognized tribes of American Indians and corporations of Alaska Natives have federal trust rights to health care. The IHS AIAN user population was about 1.4 million with a service population of 1.8 million in 2006. This political designation stemming from legal history and government-to-government relationships is distinct from a racial group. These particular tribes and corporations numbering more than 560 are updated and published in the Federal Register in a list every year.[4] In addition, specified descendants of American Indians also have rights to health care.[5] To be an 'Active' user the individual

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

must have had a medical or dental visit reportable to IHS within the last three fiscal years. 'IHS AIAN' live in a service area on or around tribal lands. In the case of an Urban Indian program, 'IHS AIAN' live in an urban service area.

Tribal AIAN. In the 'Tribal AIAN' group, the Strategic Plan included enrolled members of federally recognized tribes, or their descendants included in the federal trust responsibility, whether or not they live near their tribal lands (Table 1). Tribes maintain their own registries of members and as sovereign nations need not provide the registries to any U.S. governmental agency. To obtain health care tribal members who do not live near tribal lands may visit a provider in IHS health care delivery system, but system providers are only required to provide direct services, and no referrals or contract health services to these tribal AIAN.

IHS, Tribal and Urban Providers

The CMS AIAN Strategic Plan also provided the relevant definitions of three IHS health care delivery system provider groups for whom data was needed for CMS program planning and policy analysis: IHS, Tribal and Urban Indian providers (I/T/U) of the IHS funded health care delivery system.

IHS Direct Service ('I'). IHS services are provided directly by IHS at hospitals, health centers and health stations owned by IHS. Staff providers of health care at the I/T/U facilities include physicians, nurses, pharmacists, dentists, and a variety of allied health professionals, such as nutritionists, physician assistants and medical assistants. Some tribes who own their facilities contract with IHS to operate their facilities and provide them services. Medicare services provided by IHS vary by facility but generally include inpatient, outpatient primary care, ancillary and specialty care services, and pharmacy services (Table 2). Only a limited number of the hospitals have surgeons or anesthesiologists to provide surgical services.

Tribally-operated Health Programs ('T'). In recent decades tribes have become increasingly responsible for providing their own health care through Tribally-operated Health Programs. Under the 1975 Indian Self-Determination Act (PL 93-638), federally-recognized Indian tribes were granted the opportunity to assume responsibility for the health of their own people under contracts and compacts with IHS, and

Table 2
CMS AIAN Strategic Plan Definitions of the Indian Health Service (IHS) healthcare delivery system I/T/U provider organizations, with examples of services and facility types

Label	Providers Included	Examples of Services	Facilities 2006
Indian Health Service (**I**)	IHS Direct Service Providers	Primary Care (Medical, Dental, Vision), Ancillary (laboratory, pathology, imaging, emergency transportation), Behavioral Health, Limited Hospital and some Specialty services	33 Hospitals 52 Health Centers 38 Health Stations 2 School Health Centers
Tribal (**T**)	Tribally Operated Health Programs	Primary Care (Medical, Dental), Ancillary (Limited laboratory, pathology, emergency transportation), Behavioral Health, Tribal Hospital may have some Specialty services	15 Hospitals, 216 Health Centers 162 Alaska Village Clinics 97 Health Stations 9 School Health Centers
Urban Indian (**U**)	Urban Indian Health Organizations (Most are in IHS system, some are also FQHC)	Primary Care, Ancillary (Limited laboratory, pathology), Behavioral Health	34 Urban clinic programs

many tribes have chosen to do so. Tribes either alone or in consortia with one another operate hospitals, health centers and stations, and Alaska village clinics.[6] The Medicare eligible services they provide also vary by facility. Services may include inpatient care and specialty care, but usually include comprehensive primary care, ancillary services, and limited pharmacy services (Table 2). Only a small number of tribal hospitals have surgical services.

Urban Indian Health Programs (U). As many as 70% of Census AIAN live in urban areas.[7] The number of Urban programs that operate with IHS funding vary slightly from year to year, but in 2006 there were 34 that Urban Indian Health Programs that operated 41 main and satellite sites in 21 states to provide health services to this population. A number of the Urban Indian programs provide only behavioral health treatment or referral services, others offer both medical and behavioral health services, and still others provide only the medical services. None operate hospitals.

[6] Indian Health Service Year 2006 Profile. Available at zip codeinfo.ihs.gov/Files/ ProfileSheet-June2006.pdf.
[7] National Council of Urban Indian Health. *Urban Indian Health Program Profiles 2006.* Available at www.ncuih.org/Profile%20page.html

Methods

Data Sources

For this report Medicare Enrollment Data was obtained from CMS in two data files: an Enrollment Data Base ("workbench" version for 1991 to 2007) and the Denominator File for 2006. Utilization data was obtained from the Medicare Provider Analysis and Review (MedPAR) file of hospital stays in Short Stay and Long Stay hospitals ending (discharges) in 2006 regardless of the year of admission. These three files are described and analyzed below. Three other Medicare data files provided to us by CMS (Inpatient, Outpatient and Carrier Standard Analytical Files) are files of information collected from claims paid Medicare for health care services provided to enrollees. Claims files are variable in record length requiring different data processing methods than those used in this study, and will therefore be investigated in the next AIAN Medicare report.

"Enrollment Data Base" (Master Enrollees File for 1991 to 2007). We received from CMS a 'workbench' version of this master enrollment data file created just for this study that included the source of the race information for each enrollee. All enrollees were AIAN of Race Code = 6 (that is, 'North American Indian and not Hispanic') or Race Source Code = B (that is 'IHS registry linkage to Medicare enrollment data') who had ever been enrolled in Medicare during year 1991 to 2007. We asked only for 'stem' variables that do not change (Race, Race Source Code, Date of Birth, Sex, Accretion Year, Date of Death, Death Source Code) and the most recent data for the address variables that can change (State, County, Zipcode of Residence).

"Denominator File" (Annual Beneficiary File for 2006). The Denominator File we received contained enrollment information about AIAN enrollees in Medicare who were beneficiaries (that is they either used a service or paid a premium) during the calendar year 2006. Information in the Denominator File is 'frozen' in March of the following calendar year (March 2007). Information in this file includes state and county codes, zipcode, race, age, sex, monthly entitlement indicators (Parts A and B), reasons for entitlement, state buy-in indicators, and monthly managed care indicators. The Denominator File can be used to determine beneficiary demographic characteristics, entitlement, coverage, participation in Medicare Managed Care organizations, and state Medicaid participation in paying beneficiary premiums.

"MedPAR File" (Annual Short and Long-term Hospital Stays in 2006). In this data file the record unit is an inpatient stay of a beneficiary in a facility. The MedPAR File we were given contains final action stay records for Short and Long-term inpatient hospitals, but not Skilled Nursing Facilities. Each MedPAR record represents a stay in an inpatient hospital. An inpatient "stay" record summarizes all services rendered to a beneficiary from the time of admission to a facility through discharge. Each MedPAR record may represent one claim or multiple claims, depending on the length of a beneficiary's stay and the amount of inpatient services used throughout the stay. If a non-institutional provider provides a service to a patient in an institution the claims for that service is in the MedPAR file. Files are finalized 3 years following the close of the calendar year, that is any adjustments to claims or further information that Medicare receives is used to revise the file for a period of 3 years after which no changes are made. The 2006 MedPAR file we analyzed was a 2008 version of the file for 2006 stays.

Service Area Assignments

In each data file demographic (race, age, gender and service area), enrollment (entitlement/eligibility and coverage) and utilization (services and payments) data items were selected and analyzed using SAS statistical software. In addition to the original variables in the data files, new variables were processed to characterize IHS Service Areas that included the CMS AIAN Strategic Plan definitions of two AIAN groups, 'Racial AIAN' and 'IHS AIAN,' and the three IHS provider types: I/T/U.

We constructed four service areas: 'All U.S.,' 'IHS Areas,' 'Non-IHS Area,' and 'Urban' (which included some counties from the IHS Area). For Racial AIAN all 50 states and the District of Columbia are potential service areas (All U.S.). For non-Urban IHS AIAN we built the Service Areas of each of the 12 IHS Administrative Areas by assembling the counties of the Contract Health Service Delivery Area (CHSDA) associated with the IHS and Tribal (I/T) providers in each Area (see the Map of IHS Areas and Urban Indian Health Programs). AIAN who are members of tribes served by an I/T provider may live outside these counties and obtain direct services from the provider, but they would not be entitled to services provided through Contract Health Services because they lived outside the CHSDA. To construct the 12 IHS Areas we used state and county data as well as zip codes for 14 counties split between 2 IHS Areas. For IHS AIAN who are Urban Indians served by Urban Indian Health Program providers (U providers) we used the counties that the programs themselves report as their service areas.

IHS Service Area

The IHS Service Area is composed of the combined CHSDA counties of the 12 IHS Administrative Areas. All counties in the United States (50 states and the District of Columbia) in Geographic Information System spatial files were assigned to one of three IHS Area groups:[8] 1) CHSDA counties in one IHS Area (611 counties in 35 states); 2) CHSDA counties that are split between two IHS Areas (14 counties in 4 states); or 3) Non-CHSDA counties that are all other counties outside the IHS Areas (2,516 counties in 15 states and the District of Columbia). To assign parts of CHSDA counties that were 'split' between two IHS Areas to their appropriate IHS Area, we obtained zip codes for all 14 counties in their own Geographic Information System file. Zip codes that did not belong exclusively to one IHS Area were examined individually to assign zip codes to a nearby IHS Area. For each zip code within a 'split' CHSDA county we identified four characteristics and then assigned each to an IHS Area. First and most important was to link the zip codes to the Communities served by IHS Service Units in the IHS Standard Code Book. This information was supplemented by information from the National Atlas Populated Places (NAPP), and the Geographic Names Information System (GNIS). Larry Layne, Biostatistician with IHS National Epidemiology Program performed a linkage between data from the IHS Standard Codebook and one of the other databases based upon community name, county and state. In assigning which zip codes belonged to which IHS Service Area, preference was given to a match to the NAPP database. Both the NAPP and GNIS databases contained latitude and longitude location information. In the case of unresolved zip codes: proximity to a reservation or other tribal land or another non-split IHS Area, CHSDA County, or non-split CHSDA zip code was used to assign the zip code taking into account barriers to travel (such as rivers, lakes, mountain ranges).

Once all counties (or zip codes for 'split' CHSDA counties) were assigned to IHS Areas, the same criteria used for the Geographic Information System files were then applied to Medicare files. It was first necessary to convert all state and county codes assigned by the Social Security Administration in the Medicare files to the Federal Information Processing (FIPS) state and county codes of the Geographic Information System files using the CMS 'crosswalk file.' We assigned all records by beneficiary counties of residence in the United States[9] to one of the three IHS Area groups by the same criteria used for Geographic Information System files: 1) CHSDA counties in one IHS Area, 2) CHSDA counties that are split between two IHS Areas; and 3) Non-CHSDA counties outside the IHS Areas.

[8] 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***,** Vol. 72, No. 119, June 21, 2007.
[9] A small number of these AIAN Medicare enrollees (8) were found to live outside the territorial United States in 2006.

Table 3
Definitions of Medicare Service Areas for the AIAN and Provider groups defined in the CMS AIAN Strategic Plan, 2006

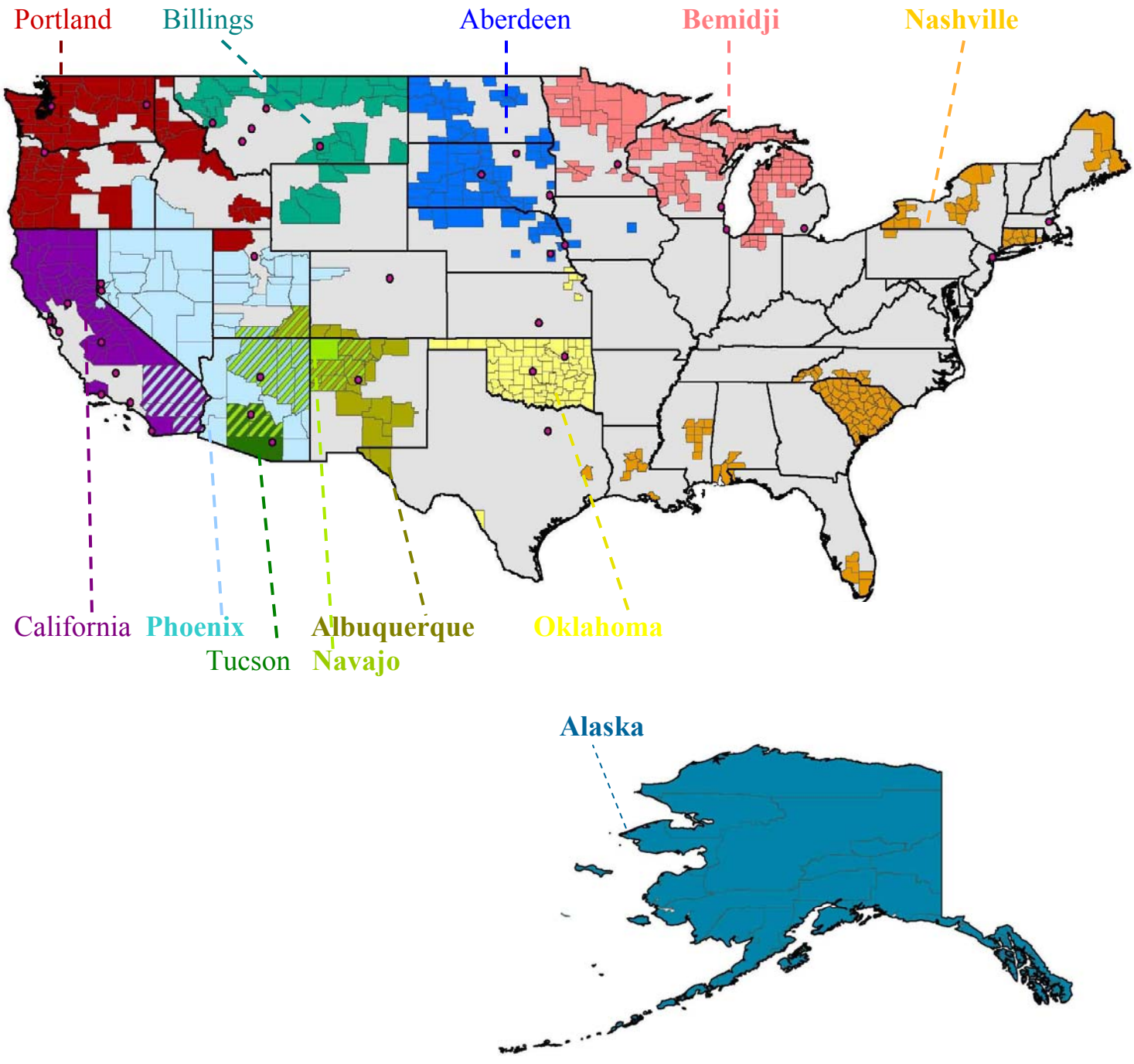
Strategic Plan AIAN	Service Area Included	How Inclusion Determined
'Racial AIAN'	50 States, and the District of Columbia	Self-evident
Indian Health Service 'IHS AIAN'	Non-Urban: Contract Health Service Delivery Area (CHSDA) Counties in 12 IHS Administrative Areas; **** Urban: 98 counties served by the 34 Urban Indian Health Programs	Federal IHS

We then processed records with 'invalid' county or zip codes not found in the geographic files. Within the 'split' CHSDA counties, 4.4% of Denominator file enrollee records were found to have invalid or non-residential zip codes. For these records we could impute the most likely IHS Area from the IHS information on the Service Population splits between the two IHS Areas for each county.[10] After the following imputations in the four states with split CHSDA counties, only 0.1% of all Denominator File records could not be assigned to an IHS Area or Non-CHSDA county:

> *Arizona*. Of 4,306 enrollees with invalid zip codes in Arizona's 'Split' counties, 3,781 enrollees in Apache, Coconino, or Navajo County were assigned to IHS Navajo Area because there are 99/1, 97/3, and 73/27 splits with Phoenix Area. Then 525 enrollees with Maricopa and Pinal County codes were assigned to IHS Phoenix Area because of a 100/0, 93/7 splits with Tucson Area.
>
> *California*. Enrollees in Riverside County (148 enrollees) were assigned to IHS California Area because there is a 99/1 split of the IHS Service Population of that county with Phoenix Area, while enrollees in Imperial County (10 enrollees) were assigned to IHS Phoenix Area because there is a 93/7 split with California Area. There were no enrollees with invalid zip codes in San Bernardino County to be assigned to the California Area because of a 98/2 split of the IHS Service Population with Phoenix Area.
>
> *New Mexico*. Of 2,365 enrollees with invalid zip codes in New Mexico's 'Split' counties, 574 enrollees in Cibola, Rio Arriba, or Sandoval County were assigned to IHS Albuquerque Area because there are 99/1, 99/1 and 78/22 splits with Navajo Area respectively. Then 1,791

[10] *Bureau of Indian Affairs, Department of the Interior. "Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs." Federal Register March 22, 2007; Vol. 72, No. 55: pages 13648-52.*

Map of IHS Areas & Urban Indian Health Programs



enrollees in McKinley County were assigned to IHS Navajo Area because of an 84/16 split in the IHS Service Population with Albuquerque Area in that county.

Utah. Of 219 enrollees with invalid zip codes in Utah's 'Split' counties, all 219 enrollees were in San Juan County and were assigned to IHS Navajo Area because there is a 96/4 split of the IHS Service Population with Phoenix Area. There were no enrollees with invalid zip codes in Kane County to be assigned to Phoenix Area which was a 62/38 split with Navajo Area.

Only 0.1% of all Denominator File records could not be assigned to an IHS Area or Non-CHSDA county. Most (86%) of the Denominator File records were for AIAN enrollees in CHSDA counties (64% in Non-split Counties and 22% in 'Split' Counties), 14% of the records were for AIAN in Non-CHSDA counties.

Finally we processed the invalid county codes in the MedPAR File: about 4.5% of hospital records in the MedPAR data file were found with invalid county codes. For 20 states, however, we could still assign records in to an IHS Area or Non-IHS area by their state codes. In 5 states all counties are CHSDA counties of only one IHS Area (Alaska, Connecticut, Oklahoma, South Carolina and Nevada). In 15 states all counties in the state are Non-CHSDA counties (the 14 states in the Map that do not have a colored CHSDA county, plus the state of Hawaii). This allowed assignment of 4.3% of the records with invalid county codes.

In the end only 0.2% of all MedPAR File records could not be assigned to an IHS Area or Non-IHS Area. In the final file of hospital stays, AIAN enrollees in CHSDA counties accounted for 86% of records and AIAN in Non-CHSDA counties accounted for 14% of records. Among AIAN enrollees in CHSDA counties, 71% of records were for Non-split Counties and 15% in Split Counties.

Urban Service Area

For IHS AIAN who are Urban Indians we approximated the service area of the Urban Indian Health Program providers (U) that provide medical and other ambulatory care services with the help of funding from the IHS. These 'U' providers receive IHS funding *through Title V of the Indian Health Care Improvement Act, but in some years* one or two of the providers do not. The Title V status of Urban programs can change from year to year. The master list of Urban Indian Health Programs of the Urban Indian Health Institute (UIHI) was used to designate all potential 'U' providers in any given year, and a recently published list of the counties *each 'U' provider serves was used to designate* all potential *98*

counties of the Urban Service Area.[11] Whether or not each urban provider had IHS funding through Title V in a particular year was determined from the IHS website for the National Council for Urban Indian Health (NCUIH) and consultations with IHS.[12] Some of the counties partially served by *'U' providers* are CHSDA counties partially served by non-Urban I/T providers. Although an attempt was made to subdivide these counties by zip code, the IHS has not established criteria within such counties were Urban provider communities and which were not. Therefore an Urban Service Area that did not include any CHSDA counties of the 12 IHS Administrative Areas could not be established.

[11] *Urban American Indian/Alaska Native Maternal, Infant and Child Health Capacity Needs Assessment*, January 2008; *Appendix C*. Available from www.UIHI.org website.
[12] National Council for Urban Indian Health, List of clinics 2009 www ncuih.org/programsarial html ; Map 2009 www.ncuih.org/map.pdf

Medicare Enrollment Findings

Demographic Data

AIAN

There was a cumulative total of 280,419 AIAN Medicare enrollees in the master Enrollment Data Base for 1991 to 2007 (Table 4). Of those enrollees 161,087 were beneficiaries who used a Medicare service or paid a premium in the annual Denominator data file for 2006. The source of the AIAN Race Code in the data reveals that almost none of the AIAN in the data fit the CMS Strategic Plan criterion of "Racial AIAN,' but nearly all fit the criterion of 'IHS AIAN" at least one time in their lives.

Racial AIAN. Medicare data has very few enrollees with AIAN as their self-declared racial identification. Of the three ways that racial data is added to the Medicare master Enrollment Data Base, only two involve self-declaration of race by an enrollee: through the Social Security Administration or the Special Survey of Beneficiaries. Racial information for less than 0.09% (249 enrollees) of the AIAN Medicare enrollees in the Enrollment Data Base came from the Social Security Administration through a process in which beneficiaries could self-declare their racial identification. The main reason that so little AIAN racial information comes from the Social Security Administration is that master beneficiary records store data for only four racial categories, none of which is AIAN.[13]

Table 4
Source of Race Information for Medicare enrollees with AIAN Race Code, 1991 to 2007 (Enrollment Data Base)

	AIAN Enrollees	
Source of Race Information	Number	Percent
Total Enrollees	280,419	100.00%
Social Security Administration	249	0.09%
Special Survey of Beneficiaries*	10	0.00%
Indian Health Service	280,160	99.91%

**One-time 1995 survey of enrollees with 'Unknown or 'Other' Race, or a Hispanic surname who self-reported 'North American Indian' as their race, and no Hispanic ethnicity.*

[13] The four racial categories are: White, Black, Other and Unknown. Prior to 1980. For more information see *Gaps and Strategies to improve American Indian and Alaska Native Data in Medicare, Medicaid and SCHIP Databases (August 2007).* Available from the CRIHB.org website: 'Policy in Action, Research' webpage.

Enrollment Findings

Only 10 enrollees self declared their racial identification as AIAN in a one-time Beneficiary Survey in 1995. That Medicare survey was conducted to improve racial information in the Enrollment Data Base. Medicare undertook a one-time survey begun in 1995 of beneficiaries with data codes of 'Other' or 'Unknown' for the 'Beneficiary Race Code' data item, and to those with a Hispanic surname to reduce the incompleteness of the Social Security Administration racial data. Enrollees who responded that their single and only race was 'North American Native,' and reported no Hispanic ethnicity, were classified as AIAN in Medicare racial data. The national survey secured the response of only 10 AIAN.

IHS AIAN. Essentially all AIAN in the Medicare master Enrollment Data Base with a race code 'AIAN' are in fact AIAN who more closely meet the CMS AIAN Strategic Plan criterion of 'IHS AIAN.' Although AIAN in the Enrollment Data Base are classified with 'racial data,' more than 99.91% of the AIAN in that data were determined to be AIAN by IHS through an interagency data linkage (Table 4).[14] Not all these AIAN, however, meet the CMS AIAN Strategic Plan criterion of 'IHS AIAN' in every year. To be an 'Active User' of IHS, AIAN must live on or near tribal lands and use an IHS delivery system facility for a medical or dental visit at least once in a three-year period. To be in the IHS active user population in 2006, for example, the AIAN would need to use an IHS funded provider facility within two years before 2006.

The interagency Medicare data linkage with IHS is performed to determine racial classification in the Medicare data and there is no information captured on the year(s) in which the AIAN Medicare enrollees were in the IHS active user population, because racial classification is not considered time dependent.[15] Once a Medicare enrollee is found in the IHS Registry with an 'AIAN' code: they are an AIAN in Medicare data until they die or their Medicare coverage is terminated, *regardless of whether they use an IHS provider or not, and regardless of where they live.* Only through special analyses of provider claims data could Medicare potentially determine if they used an IHS provider service in the appropriate time period.

Tribal AIAN. There is no tribal information in Medicare data. No tribal information is requested by Social Security Administration or the Beneficiary Survey. No tribal information is retained by Medicare because of the IHS interagency data linkages.

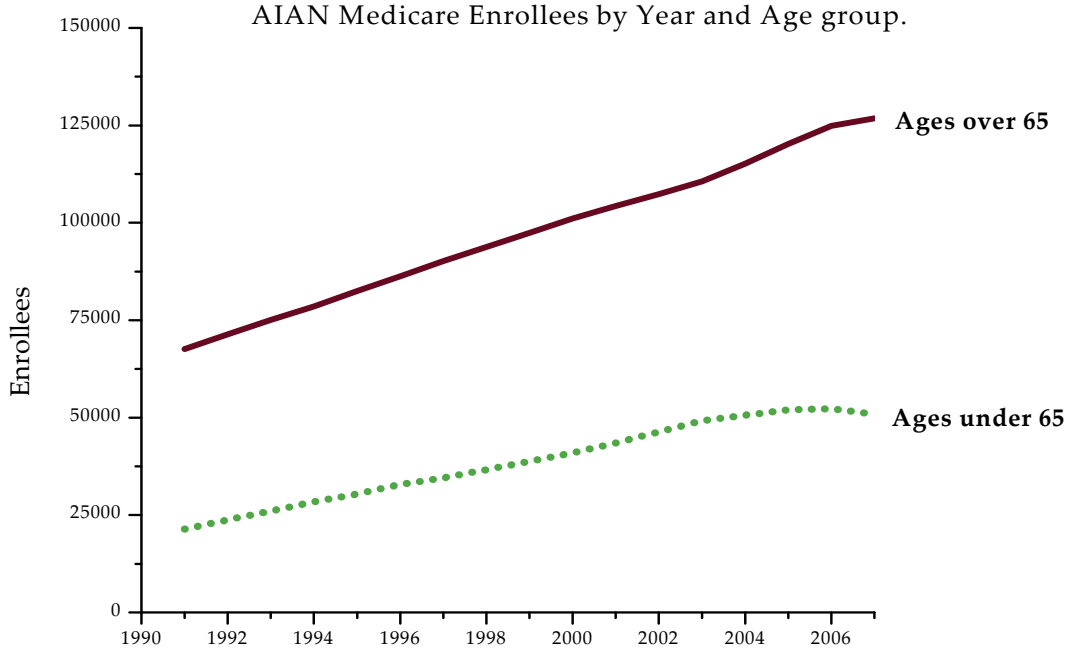
[14] Medicare began in 1999 to conduct periodic updates of AIAN racial information in its own Enrollment Data Base with data from the IHS. Through an interagency agreement for data file exchange, IHS identifies in a file sent by Medicare to IHS which of its beneficiaries meet the IHS criteria for AIAN in their National Patient Information Registry System (NPIRS). The racial information from the IHS overrides any other racial information which may have been on Medicare file.

[15] For more information on the linkage see *Gaps and Strategies to improve American Indian and Alaska Native Data in Medicare, Medicaid and SCHIP Databases (August 2007).* Available from the www.CRIHB.org website: 'Policy in Action, Research' webpage.

Age

The Medicare master Enrollment Data Base accumulates over time all people who could be entitled to become a beneficiary of Medicare coverage, but not all enrollees in the database are a Medicare covered beneficiary. Data is entered on changes in their Medicare status over time, including whether or not the enrollee has died. The time trend in numbers of AIAN enrollees by major age group who were alive in each year from 1991 to 2007 are shown in Figure 1. The numbers of living enrollees in the data who were 65 years of age and over nearly doubled from 67,580 in 1991 to 126, 786 in 2007 (Appendix Table A.1). Those under age 65 more than doubled from 21,383 to 50,873. Three-quarters of AIAN enrollees (76%) in the data were over age 65, but this fraction has fallen slightly over the years to 71% as more disabled AIAN under age 65 have enrolled (Appendix Table A.1).

Figure 1
AIAN Medicare Enrollees by Year and Age group.

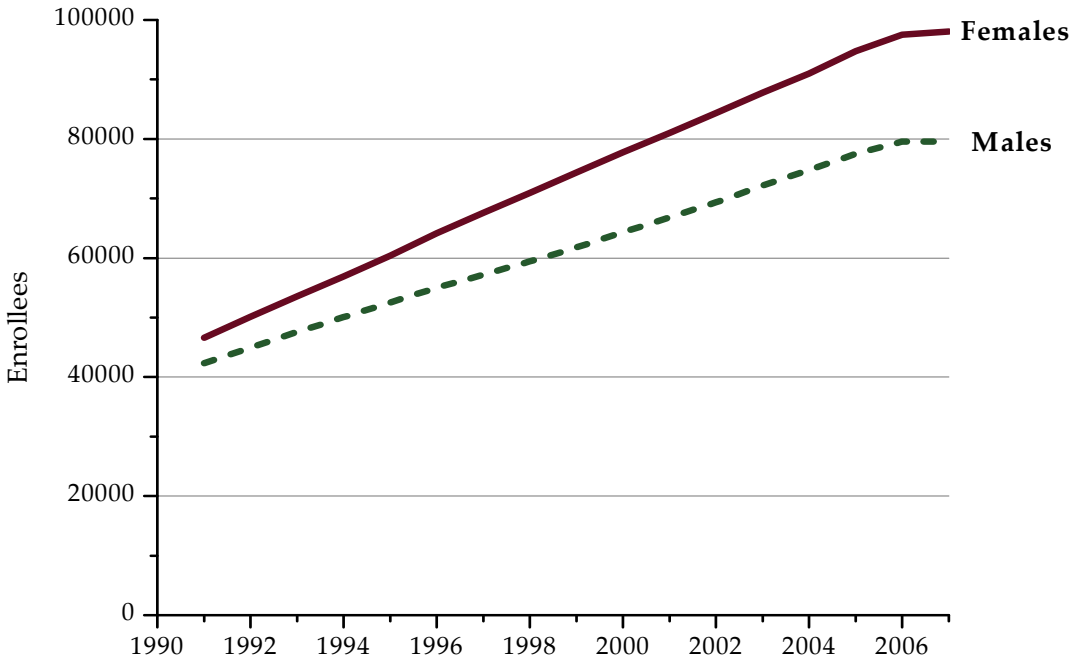


Gender

The numbers of men and women in the master Enrollment Data Base over time are shown in Figure 2. Around 45% of AIAN Medicare enrollees in the data (79,577) were men, and 55% were women (98,082) in 2007 (Figure 2 and Appendix Table A.2). Over time there has been a slight increase in the proportion of women (from 52% in 1991 to 55% in 2007) which is likely from an increase in AIAN women who have

been employed and paid into the Social Security system, but can also be in part from any greater improved life expectancy of AIAN women relative to AIAN men.

Figure 2
AIAN Medicare Enrollees by Year and Gender, 1991 to 2007



IHS Areas

To determine whether enrollment numbers of AIAN in Medicare are reasonable it is important to have data that determines the percent of the AIAN population groups who are over age 65 or disabled who actually are enrolled in Medicare. Since the major group of AIAN in the data were IHS provider users at some time in their lives, it is the IHS user population numbers that are most appropriate for comparison of Medicare enrollment numbers. To do the analysis most accurately requires electronic files of both Medicare and the AIAN population groups, however. A reasonable estimation of the percent of the IHS AIAN population enrolled in Medicare is to determine the Ratio of AIAN Medicare enrollees living in the IHS Area to the IHS AIAN Active User counts for the same year in the Area. For AIAN Medicare enrollees we use the Denominator File of enrollees who used any Medicare paid service in 2006. There were 139,363 such enrollees assigned to 12 IHS Areas (see Methods). In 2006, the ratio of Medicare enrollees to Active Users of all ages varied from a low of 6.3 per 100 in the Tucson Area, to a high of 13.1 per 100 in the California Area (Table 5). The smallest number of AIAN Medicare enrollees was in the Tucson Area (1,834). The

largest numbers of AIAN enrollees in IHS Areas, however, were in Navajo (19,861), Oklahoma (41,461) and Portland (12,506) Areas (Table 5).

To adjust in part for the large difference in age distributions between IHS Active Users and Medicare enrollees, it is important to determine the Ratio after limiting the IHS user and Medicare enrollee

Table 5
Ratio of AIAN Medicare enrollees per 100 IHS AIAN Active Users by Service Area**

	IHS AIAN Active Users Federal Fiscal Year 2006 Number*	Medicare AIAN Enrollees Calendar Year 2006 Number^	Medicare AIAN Enrollees Ratio per 100 IHS AIAN Active Users
All IHS Areas	1,448,226	139,363	9.6
Aberdeen	118,347	8,202	6.9
Alaska	130,682	9,581	7.3
Albuquerque	86,504	6,039	7.0
Bemidji	98,825	10,365	10.5
Billings	70,384	5,371	7.6
California	74,248	9,735	13.1
Nashville	47,356	4,906	10.4
Navajo	236,893	19,861	8.4
Oklahoma	309,542	41,461	13.4
Phoenix	150,886	9,502	6.3
Portland	100,395	12,506	12.5
Tucson	24,164	1,834	7.6

*Active User numbers Include Urban Indian Health Program users, while the Medicare CHSDA counties in Appendix B tables exclude most urban counties and therefore Urban Indian enrollees

^From Medicare 2006 Denominator Data File, all eligibility groups.

populations to similar age groups. With IHS Active User data files for AIAN over age 65 the ratios should come close to 100 for Medicare enrollees in the Aged eligibility group if there are no barriers to obtaining Social Security insurance and Medicare coverage in the population. Since we do not have an electronic data file for IHS AIAN Active User population we use instead the most recent published data for AIAN in each IHS Area: percents of the user populations over age 55, though most people between the ages of 55 and 65 are not eligible for Medicare unless they are disabled.[16] We present the ratio for Medicare enrollees over age 55 regardless of eligibility group in Table 6.

All enrollment numbers are lower than IHS user population numbers even when restricted to comparable

[16] Indian Health Service, Office of Public Health Support, Division of Program Statistics. *Regional Differences in Indian Health 2002-2003 Edition.* Numbers rounded to nearest 100.

age groups, which indicates the reasonableness of the enrollment numbers for IHS Areas. Low ratios of Medicare enrollees to IHS Active Users over age 55 potentially indicating barriers to enrollment are found for four Areas: Albuquerque (0.49), Phoenix (0.50), Aberdeen (0.51) and Alaska (0.52). The highest ratios indicating areas with potentially better access to or use of Medicare were found for Portland (0.80), Oklahoma (0.77) and California (0.74) Areas are 50% higher than the lowest ratios.

Table 6
Ratio of AIAN Medicare enrollees per 100 IHS AIAN Active Users for AIAN over Age 55 by Service Area**

	IHS AIAN Active Users Estimated, 2006	Medicare AIAN Enrollees Calendar Year 2006	Ratio per 100 IHS AIAN Active Users over 55
	Number over age 55*	Number over age 55^	
All IHS Areas	178,100	113,517	63.7
Aberdeen	12,400	6,371	51.4
Alaska	15,700	8,121	51.7
Albuquerque	10,200	4,986	48.9
Bemidji	11,600	8,016	69.1
Billings	8,200	4,474	54.6
California	10,500	7,774	74.0
Nashville	5,400	3,868	71.6
Navajo	30,300	17,029	56.2
Oklahoma	44,600	34,220	76.7
Phoenix	14,500	7,286	50.2
Portland	12,500	10,017	80.1
Tucson	2,700	1,355	50.2

*Calculated by multiplying IHS AIAN Active Users in 2006 in Table 5 by the percent over age 55 in *Regional Differences in Indian Health 2002-2003 Edition*, Indian Health Service, Office of Public Health Support, Division of Program Statistics and rounding to nearest 100.
^From Medicare 2006 Denominator file, all Eligibility Groups.

Eligibility Data

Medicare was originally established to provide health care coverage for people aged 65 and older as part of the Social Security system. To be eligible for Medicare coverage people paid through their employment into a Social Security Insurance system. Medicare later expanded eligibility (entitlement) to people with disabilities who participated in the Social Security Disability Insurance or Social Security Insurance system, and to people with End-Stage Renal Disease (ESRD) or Lou Gehrig's disease (amyotrophic lateral sclerosis, ALS). The Medicare Denominator File for 2006 was analyzed for the enrollment data of AIAN enrollees of the master Enrollment Data Base who were eligible for Medicare in 2006.

Aged Eligibility

The largest eligibility (entitlement) group of AIAN Medicare enrollees is that of the Aged, who were 71.5% of AIAN enrollees in the U.S. in 2006 (Figure 3 and Appendix Table B.1). This fraction is much lower than the 83.6% figure for all Medicare beneficiaries nationwide in the Aged eligibility category in 2006.[17] Eligibility criteria for the Aged entitlement program of Medicare include being 65 years of age or older with at least 40 quarters (10 years combined) of employment contributing to the Old-Age Survivor's Insurance (OASI) program. For AIAN beneficiaries living in the CHSDA counties of the 12 IHS Areas, 72.5% were in the Aged eligibility group in 2006. The lowest portion of Aged AIAN Medicare enrollees in the IHS Areas was found for the Tucson Area (63.3%) and the highest for Alaska (78.2%). For AIAN living in the non-IHS counties, 65.4% were in the Aged eligibility group.

AIAN in the Aged eligibility group are younger than Medicare enrollees nationally, particularly AIAN women. Among Aged AIAN nearly two-thirds (64.5%) were under age 75 (Appendix Table B.5) compared with only half of all Medicare enrollees (51.6%).[18] The gap in older AIAN among Medicare enrollees was greater for AIAN women than for men. The difference in proportions of men under age 75 between all Medicare Aged enrollees (56.3%) and AIAN Aged enrollees (67.5%; Appendix Table B.8) was 11.2%, but for women was 14.4%. Among all Medicare Aged women enrollees 48.1% were under age 75, while among AIAN Aged women enrollees 62.5% were under age 75. The age distributions for AIAN men in the Aged Eligibility group were the same in the IHS Areas and the rest of the U.S. ('Non-IHS Counties' Appendix Table B.8). The age distributions for women were also similar whether in the IHS Areas or not. But across the IHS Areas, there was variation in the percentages of men and women in the youngest age group of Aged enrollees. For men the highest values were in Aberdeen (72.2%), Bemidji (72.0%), and Nashville (71.8%), and the lowest in Navajo (64.3%) and California (64.6%). For women the highest values were in Billings (68.5%) and Tucson (66.6%) and the lowest in California (60.6%) and Navajo (61.0%).

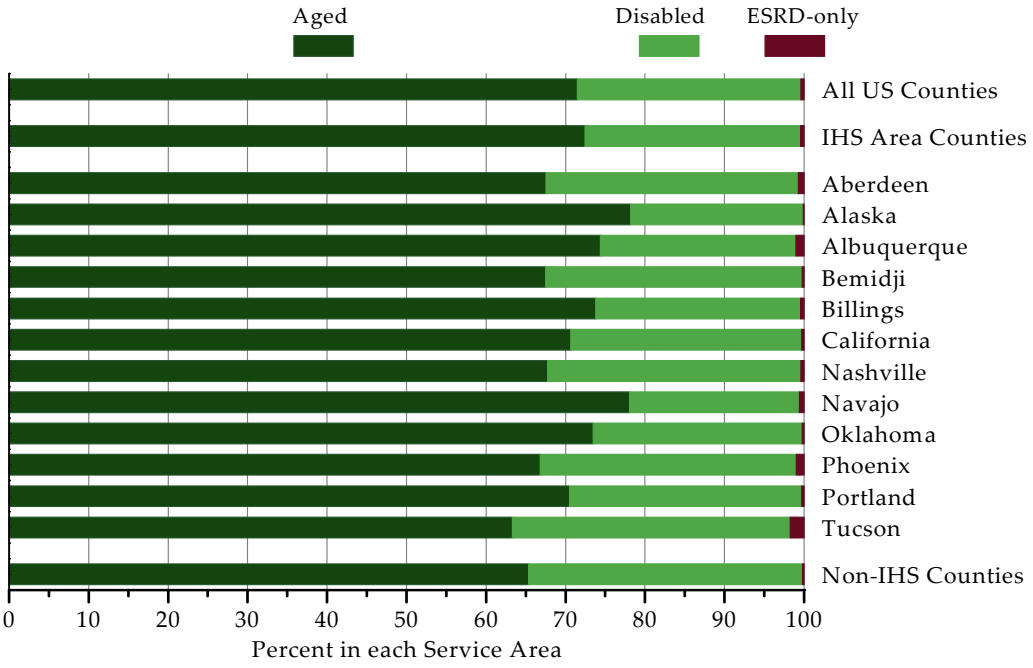
Disabled Eligibility

Some 28.1% of AIAN Medicare beneficiaries were entitled to Medicare because of a disability in 2006 (Figure 3 and Appendix Table B.1). This is considerably higher proportion than the 16.4% figure for all Medicare beneficiaries nationwide. People under age 65 who receive Social Security Insurance benefits for 2 years are eligible for the Medicare Disability entitlement. Less than half as many AIAN enrollees are

[17] *2008 CMS Statistics*, Table I.1. Available at www.cms hhs.gov/ResearchGenInfo/02_CMSStatistics.asp
[18] *2008 CMS Statistics*, Table I.3. Available at www.cms hhs.gov/ResearchGenInfo/02_CMSStatistics.asp

entitled to Medicare benefits because of Disability, as are entitled because they were Aged. For AIAN beneficiaries living in the IHS Areas in 2006, 27.1% were in the Disabled eligibility group (Appendix Table B.1). The lowest portion of Disabled AIAN in the IHS Areas was found for the Navajo (21.4%) and Alaska Areas (21.7%), and the highest for Tucson (35.0%). For AIAN living in non-IHS counties around the country, a higher fraction was in the Disabled group (34.4%).

Figure 3
Percent of AIAN Medicare Enrollees in each Service Area
by Eligibility (Entitlement) group*



* Appendix Table B.1

AIAN in the Disabled Eligibility group are younger than Medicare enrollees nationally, particularly AIAN living outside the IHS Areas, and AIAN men regardless of service area. Among Disabled AIAN one-third (34.5%) were under age 45 (Appendix Table B.6) compared with only a quarter of all Disabled Medicare enrollees (24.9%).[19] The gap in ages of the Disabled between AIAN and all Medicare enrollees was greater outside the IHS Areas. For AIAN in Non-IHS counties 37.1% were under age 45 while in the IHS Areas 34.0% were in this youngest age group. The gap in ages of the Disabled between AIAN and all Medicare enrollees was greater for men than for women. For Disabled men AIAN enrollees, 35.1% were under age 45 compared with 25.5% of all Disabled men Medicare enrollees (Appendix Table B.9). An even higher fraction of men was under age 45 in the Non-IHS counties (39.6%). For Disabled women AIAN enrollees, 31.5% were under age 45 compared with 24.2% of all Disabled women Medicare enrollees (Appendix

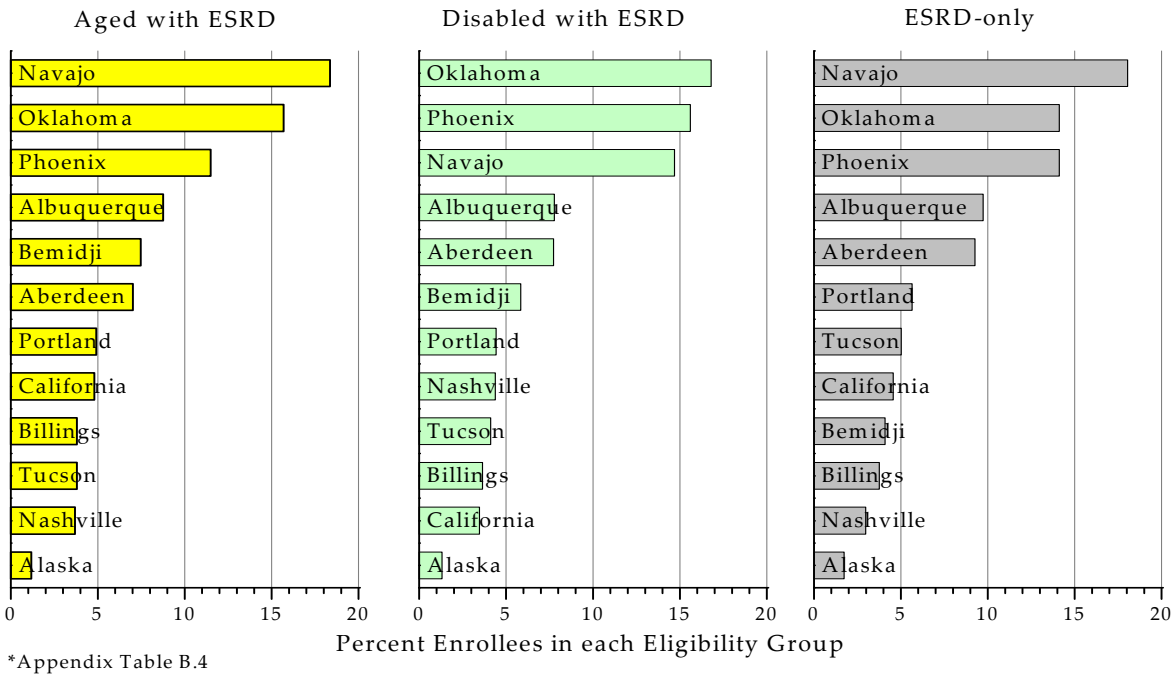
[19] *2008 CMS Statistics*, Table I.3. Available at www.cms hhs.gov/ResearchGenInfo/02_CMSStatistics.asp

Table B.9). Only a slightly higher fraction of Disabled women AIAN under age 45 was found for the Non-IHS counties (32.4%).

End-Stage Renal Disease (ESRD) Eligibility

The small fraction of remaining AIAN Medicare enrollees not eligible for Aged or Disability programs (0.4%) were entitled to Medicare through 'ESRD-only' criteria (Figure 3 and Appendix Table B.1). This third Eligibility group is that of people with certain specified life threatening conditions for which there is treatment, including End-Stage Renal Disease (ESRD) and Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's disease). ESRD in particular is a serious complication of diabetes and other conditions and includes chronic kidney disease requiring renal dialysis or a kidney transplant. Both the IHS and tribes operate renal dialysis units because of the high prevalence of ESRD among AIAN. For AIAN to be eligible for Medicare an individual with ESRD or ALS must be insured under Social Security or be the dependent of an insured. Eligibility begins the third month after renal dialysis begins, or sooner if the individual participates in an approved self-care training program. Eligibility can also start on admittance to a hospital to receive a transplant or renal dialysis before the transplant. While the ESRD-only entitlement program does not include people in the Aged or Disability entititlement programs who have ESRD (or ALS), AIAN enrollees with ESRD are more reliably analyzed by combining those with ESRD in the Aged and Disability groups with the small numbers of people in the ESRD-only entitlement group.

Figure 4
Percent of AIAN Medicare Enrollees with End Stage Renal Disease (ESRD)
in each Eligibility Group by IHS Area *



*Appendix Table B.4

Enrollment Findings

When all AIAN Medicare enrollees with ESRD in all three eligibility groups were combined (Aged with ESRD, Disabled with ESRD, and those with ESRD-only), there were 4,958 AIAN enrollees with ESRD (Appendix Table B.3). Only 12.8% of these enrollees were entitled to Medicare because of their disease condition alone ('ESRD-only'). Half of them (51.0%) were entitled to Medicare because of the Disability entitlement program ('Disabled with ESRD') and more than a third (36.1%) because they qualified for the Aged program ('Aged with ESRD').

The IHS Areas accounted for 91.0% of Aged enrollees with ESRD (Figure 4, Appendix Table B.4) which is not surprising since Aged enrollees in the IHS Areas account for 87.7% of the AIAN enrollees in the Aged group (Table Appendix B.2). The Areas with largest numbers of AIAN enrollees were the Navajo Area which had 16.5% of the Medicare enrollees with ESRD, Oklahoma had 16.1% and Phoenix had 13.9%. The same concentration of enrollees in IHS Areas, and most particularly Navajo, Oklahoma and Phoenix Areas, was reflected in the other two eligibility groups with enrollees with ESRD as well: Disabled with ESRD and ESRD-only as well (Figure 4). The age and gender characteristics of the three ESRD groups for all Service Areas are presented in Appendix Tables B.7 and B.10.

Coverage Data

The enrollment data file provides information on three kinds of Medicare health care coverage:

- Part A is hospital insurance.
- Part B is insurance for medical services that Part A does not cover
- Managed care overage for beneficiaries who have Parts A and B and choose to receive all health care through a provider organization like a health maintenance organization or group health plan.

Hospital Insurance

As with Medicare enrollees generally, essentially all AIAN enrolled in Medicare have Hospital Insurance (Part A) whether in the Aged (99.8%), Disabled (100%) or ESRD-only (100%) Eligibility groups (Table 7). Hospital insurance through Medicare helps cover inpatient care in hospitals and care in skilled nursing facilities, hospice care and some home health care (but not custodial care). Enrollees must meet certain conditions to get these benefits. Most people do not pay a premium for hospital coverage because they (or their spouse) already paid for it through their employment payroll taxes.

Table 7
AIAN Medicare Enrollees with Hospital and Medical (physician) Coverage by Eligibility Group

	Aged		Disabled		ESRD*	
Type of Coverage	Number	Percent	Number	Percent	Number	Percent
Total Enrollees	115,088	100.0%	45,238	100.0%	4,958	100.0%
Both Hospital & Medical	104,562	90.9%	41,117	90.9%	4,717	95.1%
Hospital	114,913	99.8%	45,236	100.0%	4,958	100.0%
Medical	104,737	91.0%	41,119	90.9%	4,717	95.1%

*Includes all enrollees with ESRD or ALS in the Aged, Disabled and ESRD-only eligibility groups.

Medical Insurance

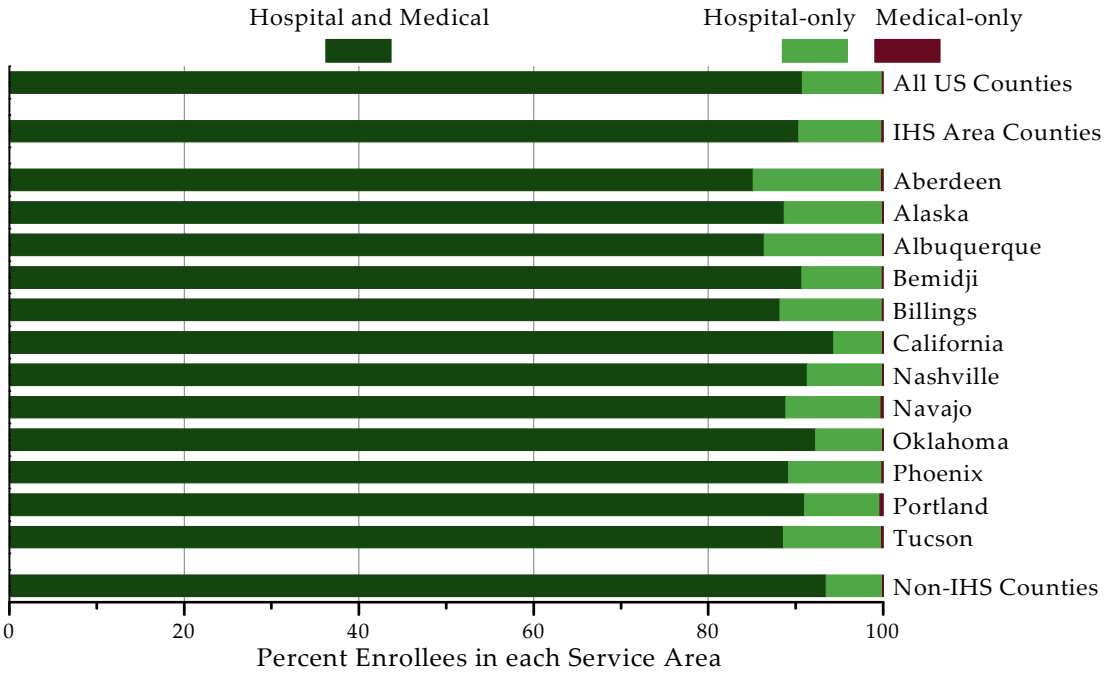
Although, not all AIAN enrollees have Medical Insurance (Part B), the level of Medical coverage of AIAN compares favorably for that of all Medicare enrollees. Nationally 93.0% of all Aged enrollees have Medical coverage, and 90.9% of AIAN Aged enrollees have Medical coverage (Table 7). Nationally 87.7% of all Disabled enrollees have Medical coverage, and 90.9% of AIAN Disabled enrollees have Medical coverage. Among AIAN enrollees with ESRD, a higher percentage (95.1%) has Medical Insurance than in the other two groups (Table 7). The Medical Insurance (Part B) through Medicare includes coverage of physician services and outpatient care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary. Smaller proportions of AIAN Medicare beneficiaries have coverage of medical services through Medicare Part B than have coverage of inpatient services through Part A, mainly because there is a monthly premium for Medical Insurance.

Both Hospital and Medical Insurance

In the U.S. as a whole, 90.8% of all AIAN Medicare enrollees have both Hospital and Medical Insurance coverage for at least one month (Figure 5, Appendix Table B.11). The rate is only slightly lower in IHS Areas as a whole (90.3%) than in non-IHS counties of the country (93.5%). Across the IHS Areas, although most AIAN Medicare enrollees have both Hospital and Medical Insurance Coverage, the fraction varies. The lowest fractions are in Aberdeen (85.1%) and Albuquerque (86.4%) Areas. The highest fractions are in California (94.4%) and Oklahoma (92.3%) Areas. Variation among the IHS Areas, however, differs by Eligibility group. The lowest fractions of Hospital and Medical Coverage for the Aged are in Aberdeen (83.2%) and Albuquerque (84.9%) Areas, but not for Disabled (Tucson 88.8% and Aberdeen 89.3%) or ESRD (Billings 91.8% and Alaska 92.3%) (Appendix Table B.12).

While most enrollees who become entitled to Medicare maintain Hospital coverage with essentially no interruption, some enrollees lose Medical coverage from time to time, mainly because premiums are not paid. We found that of the 146,092 AIAN with Hospital and Medical coverage for at least one month in 2006 (Appendix Table B.11), however, nearly all (96.8%) had both Hospital and Medical coverage all year (12 months) (Appendix Table B.13).

Figure 5
Percent of AIAN Medicare Enrollee with Hospital Coverage,
Medical Coverage or Both for at least one month in each Service Area*



*Appendix Table B.11

Managed Care Coverage

Only 10.4% of Aged AIAN beneficiaries were enrolled in a Medicare Managed Care plan available in their area (Table 8). Only 5.6% of Disabled AIAN beneficiaries have Managed Care coverage. These rates are much lower than the rate nationally of 19.8% for all Medicare enrollees.[20] The Medicare Advantage health plan program replaced the Medicare+Choice program after 2003. To enroll in Medicare managed care Medicare enrollee must be entitled to Hospital coverage, and enroll in Medical coverage for which there is a monthly premium to be paid. Medicare beneficiaries with ESRD cannot be enrolled in Medicare managed

[20] *2008 CMS Statistics*, Table I.9. Available at zip code www.cms hhs.gov/ResearchGenInfo/02_CMSStatistics.asp

care except in the case of Special Need Plans. Only 2.9% of AIAN Medicare enrollees with ESRD were enrolled in Medicare Managed Care in 2006 (Table 8).

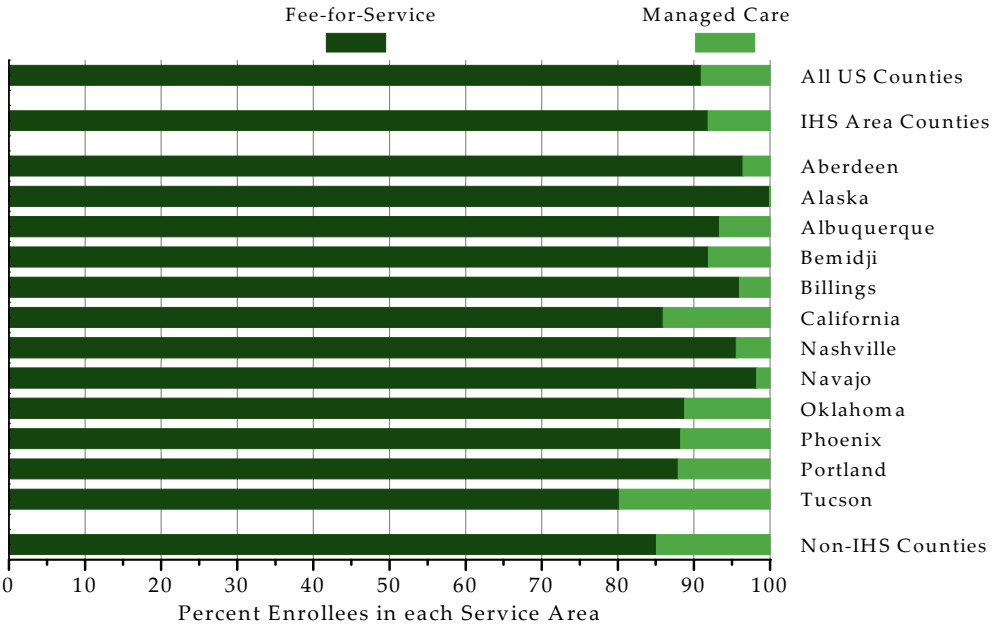
Table 8
AIAN Medicare Enrollees with Fee-for-Service and Managed Care Coverage by Eligibility Group

	Aged		Disabled		ESRD*	
Managed Care	Number	Percent	Number	Percent	Number	Percent
Total Enrollees	115,088	100.0%	45,238	100.0%	4,958	100.0%
Fee-For-Service	103,080	89.6%	42,705	94.4%	4,815	97.1%
Managed Care	12,008	10.4%	2,533	5.6%	143	2.9%

*Includes all enrollees with ESRD or ALS in the Aged, Disabled and ESRD-only eligibility groups.

The fraction of AIAN Medicare enrollees who are in Managed Care (9.0%) is less than half as large as that of all Medicare enrollees (19.8%)[21] (Figure 6, Appendix Table B.14). The fraction of AIAN in Managed Care is lower in IHS Areas as a whole (8.1%) than in non-IHS areas of the country (14.9%). Across the IHS Service Areas the fraction in Managed Care varies from zero to nearly one-fifth of AIAN Medicare enrollees. The lowest fractions are in Alaska (0%) and Navajo (1.8%) Areas. The highest fractions are in Tucson (19.8%) and California (14.1%) Areas.

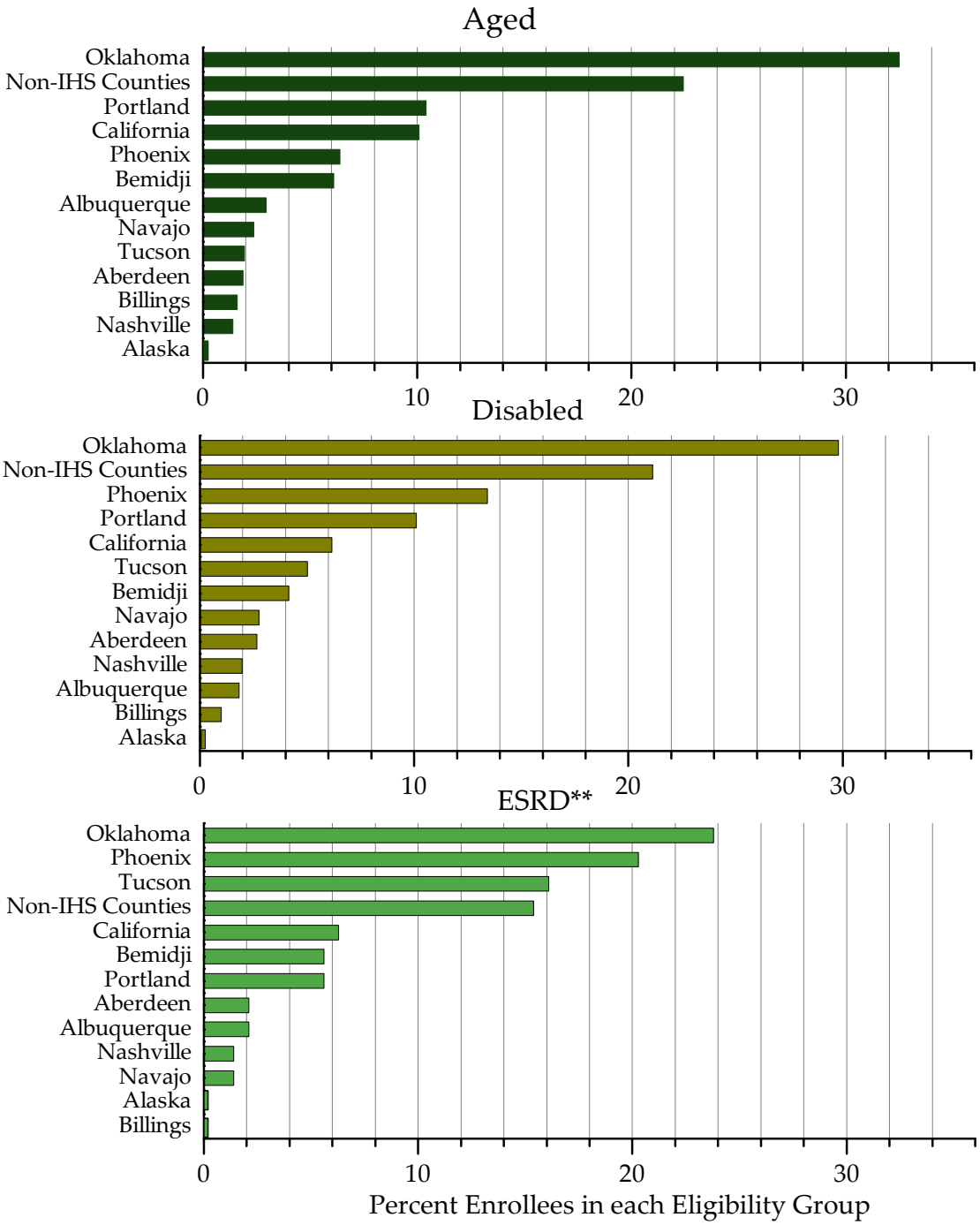
Figure 6
Percent of AIAN Medicare Enrollees with Fee-for-Service or Managed Care Coverage in each Service Area*



* Appendix Table B.14

[21] *2008 CMS Statistics*, Table 1.9. Available at: www.cms hhs.gov/ResearchGenInfo/02_CMSStatistics.asp

Figure 7
Percent of AIAN Enrollees with Managed Care Coverage
in each Eligibility Group by Service Area *



* Appendix Table B15

** Includes Aged and Disabled with ESRD and ESRD-only

When the distribution of AIAN Managed Care enrollees is examined by IHS Area, in the Aged eligibility group most such enrollees are in the Oklahoma Area (32.5% of all Aged AIAN Medicare enrollees with Managed Care coverage) (Figure 7, Appendix Table B.15). None are in the Alaska Area (0%) and the next

are from the Nashville Area (1.4%). In the Disabled eligibility group most again are in the Oklahoma Area (29.8% of all Disabled AIAN Medicare enrollees with Managed Care coverage). While no Disabled AIAN Medicare enrollees with Managed Care are found in Alaska Area (0%), the next lowest fraction is from the Billings Area (1.0%). Most AIAN enrollees with ESRD in Managed Care are also from the Oklahoma Area (29.8% of AIAN Medicare enrollees with ESRD and Managed Care coverage), Alaska still has no such enrollees in Managed Care (0%), and neither does the Billings Area (0%).

State Medicaid Program "Buy In" to Medicare Coverage. For Medicare enrollees who are also eligible for Medicaid ('Dual Eligibles') state Medicaid programs are allowed to pay premiums for coverage of Medicare Hospital or Medical Insurance. States pay premiums for coverage of more than a quarter (28.5%) of Aged AIAN enrollees and more than half (53.9%) of Disabled AIAN enrollees (Table 8). States pay premiums for coverage of more than half (55.2%) of AIAN with ESRD (Table 9).

Table 9
AIAN Medicare Enrollees with Hospital Coverage (alone or with Medical) with Premiums Paid by State Medicaid Programs, by Eligibility Group

	Aged		Disabled		ESRD*	
Medicaid Paid Premium	Number	Percent	Number	Percent	Number	Percent
Total Enrollees	115,347	100%	45,308	100.0%	4,958	100.0%
Yes	32,867	28.5%	24,410	53.9%	2,732	55.2%
No	82,480	71.5%	20,898	46.1%	2,226	44.8%

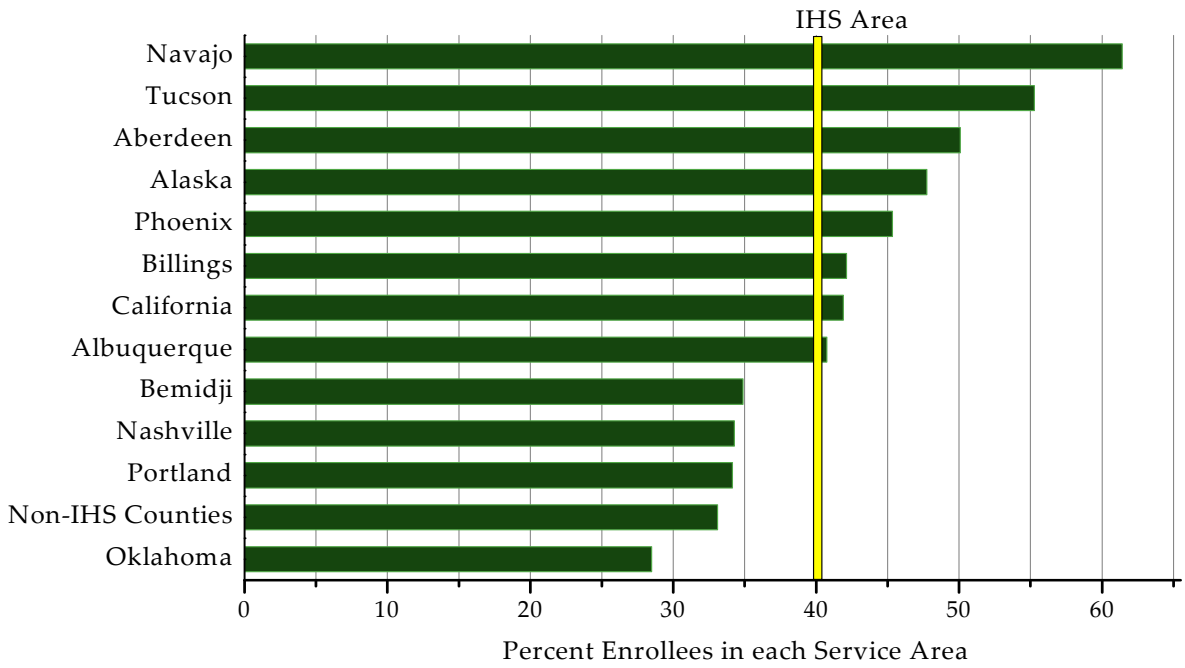
*Includes all enrollees with ESRD or ALS in the Aged, Disabled and ESRD-only eligibility groups.

When the variation in percentages of AIAN Medicare enrollees with Medicaid paid premiums who have Hospital and Medical coverage is examined across IHS Areas, the lowest fraction of AIAN is in Oklahoma Area (28.5%) and the highest in Navajo Area (61.4%) (Figure 8, Appendix Table B.17).

Across the IHS Areas the percentages of AIAN enrollees in each Area with Medicaid paid premiums differs most for the three groups of enrollees: Aged, Disabled and ESRD (Appendix Table B.18). Highest percentages are paid for the Disabled eligibility group regardless of IHS Area, lowest levels for the ESRD group (Figure 9). The range in percentages of the Disabled with Medicaid paid premiums is from the lowest value in Oklahoma Area (49.2%) to the highest in Alaska (71.3%). For those AIAN with ESRD the range in percentages with Medicaid paid premiums is from Alaska Area (2.1%) to Tucson Area (22.5%). For the Aged the range in percentages with Medicaid paid premiums is from a low in the Oklahoma Area (21.2%) to a high in the Navajo Area (59.2%).

Figure 8

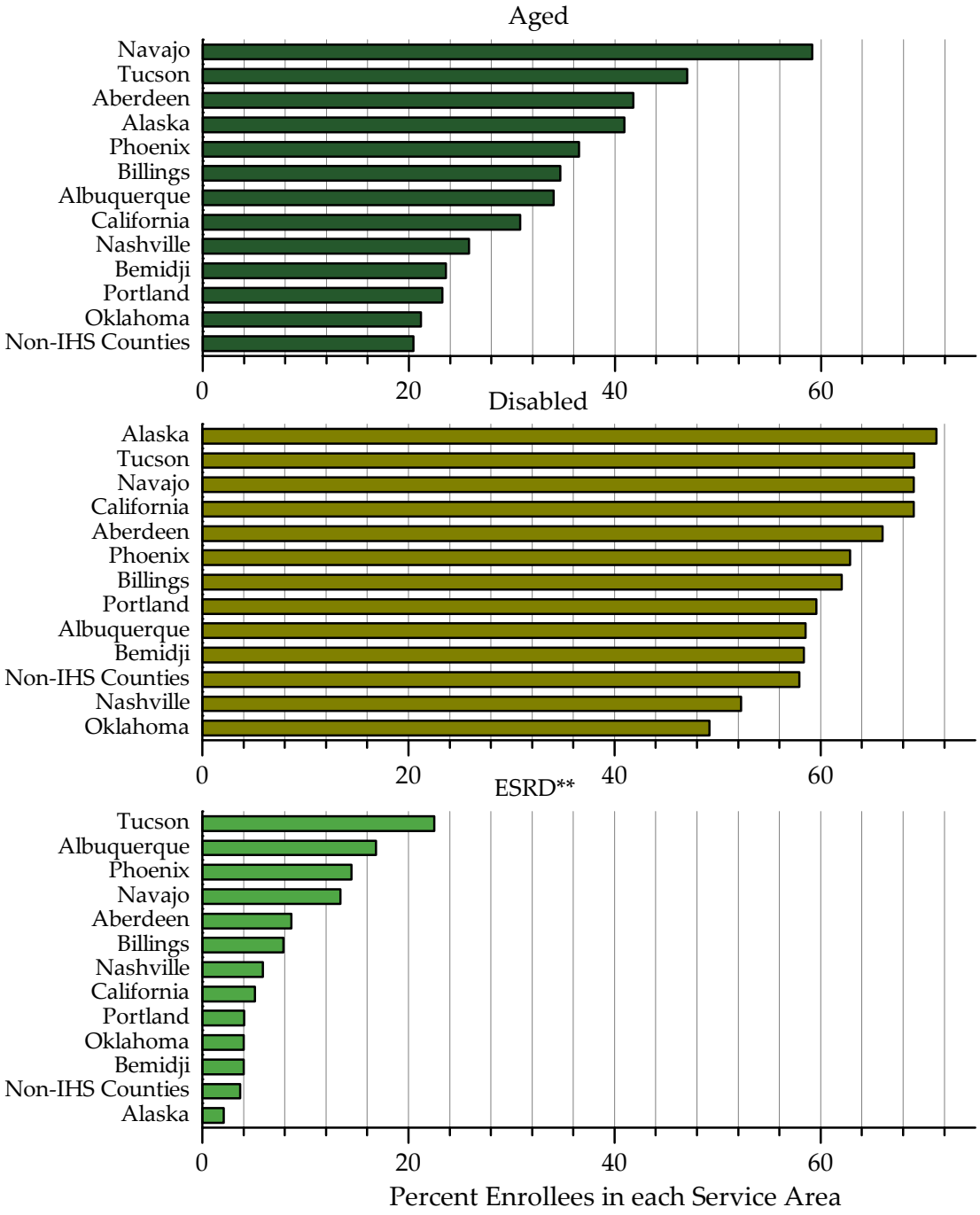
Percent of AIAN Medicare Enrollees with one or more months of Hospital and Medical coverage for whom their State Medicaid Program paid Premiums (Buy-In) in each Service Area*



* Appendix Table B.17

Figure 9

Percent of AIAN Medicare Enrollees with Hospital and Medical Coverage for whom Medicaid paid Premiums in each Service Area and Eligibility Group*



* Appendix Table B.18

** Includes Aged and Disabled with ESRD and ESRD-only

Medicare Utilization Findings

Service Data: Hospitalizations

Since Medicare covers hospitalizations for essentially all enrollees, and hospital inpatient payments are the single largest Medicare benefit payment category,[22] in this report we analyze utilization data for hospital stays of AIAN Medicare enrollees. The MedPAR file we were provided included information on hospital stays for AIAN discharged from both 'Short Stay' and 'Long Stay' Hospitals during Calendar Year 2006. Hospital stays paid by managed care plans are not included. Hospitalization services in the data included those furnished by a hospital provider to a patient while in the facility, including: room and board, nursing and related services, diagnostic and therapeutic services, and medical and surgical services. Institutional services of medical professionals hired by the hospitals provided to people while patients in the hospitals are included. Services of hospital staff are generally included in the facility claim (including hospitalist physician services billed on UB-92/04 forms), but services of surgeons and anesthesiologists may be billed separately from the facility (on CMS-1500 forms) and thus are not included. Institutional services that are not included are those of Skilled Nursing Facilities, Home Health Agencies and Hospice. Non-institutional services that are not included are those provided by individuals such as physicians, laboratories and other suppliers, including suppliers of Durable Medical Equipment.

In 2006 there were 64,331 hospital stays for AIAN Medicare enrollees. The hospital stay records had 34,513 unique identification numbers, for an estimated 1.9 hospital stays per hospitalized AIAN enrollee. This calculation based on identification is likely to a slight overestimate of hospital stays per enrollee since there may be more than one beneficiary per identification number in the data base (for example a spouse, or other dependent). To resolve this requires a unique Beneficiary ID. We were able to assign 99.8% of those hospital stays (64,198) to a service area (U.S. All Counties, IHS Area CHSDA Counties, or non-CHSDA counties) and it is those hospital stays that are analyzed here from and in Appendix C. Whenever possible we provide comparative Medicare data on hospital stays. We found CMS published hospital data for Medicare paid hospital stays in Short Stay, but not Long Stay hospitals.

[22] *2008 CMS Statistics*, Table III.6. FFY 2008 Benefit Payments. Available at: www.cms hhs.gov/ResearchGenInfo/02_CMSStatistics.asp

Hospital Providers

Short Stay Hospitals. AIAN Medicare enrollees had a much lower portion of hospital stays in Short Stay Hospitals (88.7%, 56,960 out of 64,198 total stays Table 10) relative to Long Stay Hospitals when compared to all Medicare enrollees (97.2 %).[23] Medicare considers 'Short Stay' or acute care hospitals to be those with average lengths of stay that are less than 30 days. General and specialty hospitals (like Children's Hospitals) can be Short Stay hospitals. General hospitals are those maintained primarily for short-term inpatient care of acute illness or injury, or for obstetrics. Also included in the category are Psychiatric Hospital Units, and Rehabilitation Hospital Units (Appendix Table E.1). When hospital stays are analyzed for the IHS Areas, 88.4% of hospital stays are in Short Stay rather than Long Stay hospitals, with a high in Tucson (94.9%) and Albuquerque (93.4%) and a low in Billings (76.1%) (Appendix Table C.1).

Table 10
Number and Percent of Hospital Stays (discharges) by Eligibility group for AIAN Medicare enrollees in each Type of Hospital

Eligibility of Hospitalized Enrollees	Hospital Stays			
	Short Stay Hospitals		Long Stay Hospitals	
	Number	Percent	Number	Percent
All Groups	56,960	100.0%	7,238	100.0%
Aged	38,355	67.3%	4,982	68.8%
Disabled	16,291	28.6%	2,164	29.9%
ESRD-only	2,314	4.1%	92	1.3%

While nationally Aged enrollees account for 81.1% of hospital stays in the Short Stay hospitals,[24] Aged AIAN enrollees account for only two-thirds of the hospital stays (67.3%, Table 10). Disabled AIAN enrollees accounted for more than a quarter, 28.6%, and those with 'ESRD-only' the rest, 4.1%. When enrollees with ESRD are analyzed by themselves, nearly equal portions of hospital stays are divided among those in the Aged, the Disabled and the ESRD-only eligibility groups (35.4%, 32.3%, 32.3% respectively, Table 11). Medicare combines the ESRD-only group with the Disabled group in their analyses of hospital stays, and we will aggregate groups in that way from this point on in the report.

[23] Marshall McBean, *CMS 101, Introduction to the Use of Medicare Data for Research*, ResDAC, University of Minnesota, 2008.
[24] *Medicare and Medicaid Statistical Supplement, Short Stay Hospitals, 2007*. Table 5.3 Available at: www.cms.hhs.gov/medicaremedicaidstatsupp/lt/ItemDetail.asp?ItemID=CMS1199282

Table 11
Number and Percent of Hospital Stays by Eligibility group for AIAN Medicare enrollees with ESRD in each Type of Hospital

Eligibility of Hospitalized Enrollees	Hospital Stays			
	Short Stay Hospitals		Long Stay Hospitals	
	Number	Percent	Number	Percent
All ESRD	7,170	100.0%	327	100.0%
Aged with ESRD	2,541	35.4%	130	39.8%
Disabled with ESRD	2,315	32.3%	105	32.1%
ESRD-only	2,314	32.3%	92	28.1%

Long Stay Hospitals. AIAN Medicare enrollees had 7,238 stays (11.3% of hospital stays) in Long Stay Hospitals in 2006. Medicare considers hospitals with average lengths of stay greater than 25 days as 'Long Stay' hospitals. This length of stay criterion is within the allowable Short Stay Hospital limit of 30 days of stay, but the range of care of 'Long Stay' hospitals is much more limited. Long Stay hospitals include Long Term Care, Psychiatric, and Rehabilitation hospitals (Appendix Table E.1). They may qualify for higher facility payment rates than 'Short Stay' hospitals because of the different mix of resources needed by their patients. Unfortunately in 2006 Medicare began to include Critical Access Hospitals in this category even though these specially certified rural hospitals must maintain an annual average length of stay of less than 4 days for acute inpatient care. Critical Access Hospitals are likely to be particularly important to AIAN because as a population they are more likely than others to live in areas where such hospitals exist. Separate analysis of Critical Access Hospitals would require further analysis of provider codes.

Aged AIAN enrollees account for two-thirds of AIAN hospital stays in Long Stay hospitals (68.9%), Disabled AIAN account for 29.9%, and AIAN in the ESRD-only group account for the balance of 1.3% (Table 10). When enrollees with ESRD are analyzed by themselves, comparable fractions of hospital stays occur among the Aged (39.8%), Disabled (32.1%) and ESRD-only (28.1%) eligibility groups (Table 11). We could find no published CMS data for comparison of AIAN and all Medicare enrollees in Long Stay hospitals. We provide the AIAN Medicare enrollee findings for Long Stay hospitals by IHS Area and Eligibility group along with those of Short Stay hospitals in Appendix C.

Hospitalization Rates

Hospitalization rates were higher for AIAN than for all Medicare enrollees in Short Stay hospitals. For AIAN the hospitalization rate was 390 hospital stays (or discharges) per 1000 enrollees with hospital coverage (Table 12), while the comparable national rate for all Medicare enrollees was 349 per 1000 in

2006 (Figure 10, "National" red vertical bar).[25] Rates of hospital utilization are determined by CMS for enrollees with hospital coverage in fee-for-service care systems, but not in managed care. The average IHS Area hospitalization rate was 386 per 1000 (Figure 10, "IHS Area" yellow vertical bar). Hospitalization rates varied in the IHS Areas from a low of 300 per 1000 enrollees with hospital coverage in Alaska and California areas, to a high of 561 per 1000 in Tucson (Figure 10, Appendix Table C.5). The hospitalization rate for all the rest of the counties in the U.S. was 412 hospital stays per 1000 enrollees (Figure 10, "Non-IHS Counties" green horizontal bar).

Table 12
Hospitalization Rates per 1,000 AIAN Enrollees with Hospital Coverage (either alone or with Medical Coverage) and not in Managed Care* by Type of Hospital in each Eligibility Group

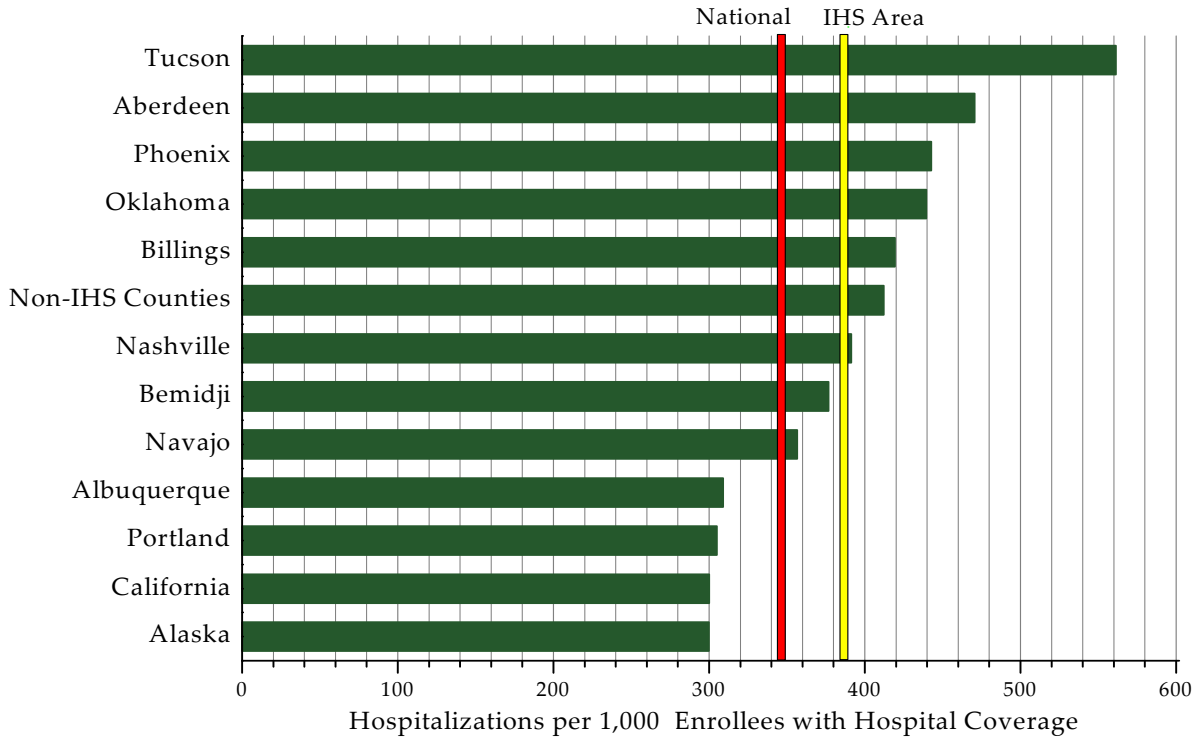
	Enrollees		Hospital Stays*			
	With Hospital Coverage	In Managed Care	Short Stay Hospitals		Long Stay Hospitals	
Eligibility of Hospitalized Enrollees	Number	Number	Stays	Rate per 1000 Enrollees**	Stays	Rate per 1000 Enrollees**
All Groups	160,786	14,559	56,960	390	7,238	49
Aged	114,913	12,008	38,355	373	4,982	48
Disabled/ESRD-only***	45,873	2,551	18,605	429	2,256	52

*Hospital Stays of Beneficiaries in Managed Care plans that are paid by the plans are not included in the Hospital Stays (MedPAR database).
** Medicare enrollees in managed care plans are not included in the denominator used to calculate utilization rates.
***The Disability and ESRD-only eligibility groups of Table 10 are combined in tables from this point on. Aged eligibility group is as in Table 10 and includes Aged persons with or without ESRD. The Disability elig bility group now includes disabled persons with or without ESRD, and persons with ESRD-only.

The AIAN hospitalization rates were 373 stays (discharges) per 1000 for the Aged and 429 for the Disabled (Table 12), while comparable Medicare the rates were lower, 343 for Aged and 376 for the Disabled (with ESRD-only eligible enrollees included in the Disabled group). The hospitalization rates for the Eligibility groups by IHS Area are provided in Appendix Table C.8. Hospitalization rates in Long Stay hospitals for AIAN were 50 stays per 1000 with 48 per 1000 for the Aged and 52 for the Disabled (Table 12). The hospitalization rates for the Eligibility groups by IHS Area in Long Stay hospitals are also provided in Appendix Table C.8.

[25] *Medicare and Medicaid Statistical Supplement, Short Stay Hospitals, 2007*. Table 5.3 Available at: www.cms.hhs.gov/medicaremedicaidstatsupp/lt/ItemDetail.asp?ItemID=CMS1199282

Figure 10
Hospitalization Rate per 1,000 AIAN Medicare Enrollees in Short-Stay Hospitals in each Service Area*



*Appendix Table C.5

Length of Hospital Stays

Length of hospital stays in CMS data are expressed in terms of total days, days per person and days per stay. Total days of hospital stay of Medicare enrollees include days that are covered by Medicare and days not covered by Medicare. Days of Stay that are not covered in full or part by Hospital coverage include days prior to the person's entitlement to hospital benefits and days after exhaustion of benefits. A Medicare enrollee with Part A Hospital coverage has 90 days of inpatient hospital care covered per benefit period and a non-renewable lifetime reserve of 60 days of inpatient hospital care to draw on when the covered days are exhausted. To compare Total Days of Stay among different populations in CMS data the total days are divided by either the number of hospital stays (discharges) for the enrollees with Hospital coverage who are not in Managed Care (Days per Stay, Table 13), or by the number of enrollees with Hospital coverage who are not in Managed Care in thousands (Days per 1000 enrollees with Hospital Coverage, Table 14).

AIAN had more total hospital days, but fewer hospital stays, than Medicare enrollees generally in Short Stay hospitals and therefore their lengths of stay were longer. The Total Days of Stay for AIAN was 304,974 (Table 13). The average length of stay for AIAN enrollees in Short Stay hospitals was 5.4 days per

stay (Table 13, Figure 11 "National" red vertical bar). For Medicare enrollees the average length of stay was longer (5.7 days per stay).[26]

Table 13
Total Hospital Days and Average Days per Stay of AIAN Medicare beneficiaries by Type of Hospital in each Eligibility Group

Eligibility of Hospitalized Enrollees	Days of Stay					
	Short Stay Hospitals			Long Stay Hospitals		
	Days	Percent	Days Per Stay	Days	Percent	Days Per Stay
All Groups	304,974	100.0%	5.4	63,260	100.0%	8.7
Aged	202,947	66.5%	5.3	35,760	56.5%	7.2
Disabled/ESRD-only	102,027	33.5%	5.5	27,500	43.5%	12.7

Figure 11
Average Days per Stay of AIAN Medicare Enrollees in Short-Stay Hospitals in each Service Area *

* Appendix Table C.7

Lengths of hospital stay varied in the IHS Areas from 4.8 days per stay in Portland Area to 6.9 days per stay in Alaska (Figure 11, Appendix Table C.7) with an average of 5.3 (Figure 11, "IHS Area" yellow vertical

[26] *Medicare and Medicaid Statistical Supplement, Short Stay Hospitals, 2007*. Tables 5.3 & 5.4. Available at: www.cms.hhs.gov/medicaremedicaidstatsupp/lt/ItemDetail.asp?ItemID=CMS1199282

bar). The length of stay for Aged AIAN enrollees was 5.3 days per stay (compared to 5.6 for all Medicare enrollees), and for Disabled/ESRD-only AIAN enrollees 5.5 days per stay (6.0 for all Medicare enrollees).

Variation in days per stay in Short Stay hospitals by IHS Area and eligibility group is provided in Appendix Table C.8. In Long Stay hospitals the length of stay was longer than in Short Stay hospitals as expected, 8.7 days per stay (Table 13). For Aged the average stay in Long Stay hospitals was 7.2 days per stay, for the Disabled/ESRD-only, 12.7 days per stay. The variation in lengths of stay in Long Stay hospitals by IHS Area and eligibility group is provided in Appendix Tables C.7 and C.8.

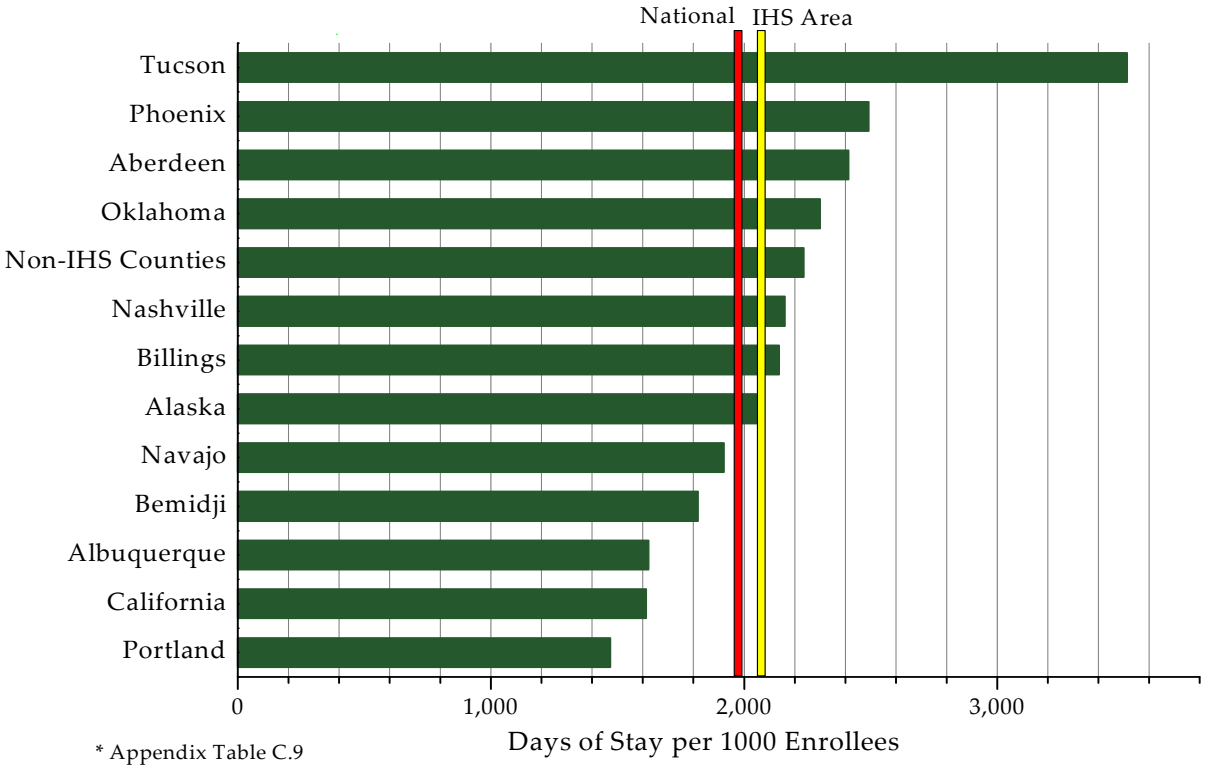
When length of stay is expressed in terms of days per enrollee instead of days per stay, AIAN had more days of stay per enrollee in Short Stay hospitals than Medicare enrollees generally. AIAN had 2,086 days per 1000 enrollees with Hospital coverage not in managed care (Table 14), while nationally Medicare enrollees had 1,981 days per 1000 (Figure 12).

Table 14
Total Days of Stay per 1,000 AIAN Enrollees with Hospital Coverage and not in Managed Care by Type of Hospital in each Eligibility Group

	Enrollees		Days of Stay			
	With Hospital Coverage	In Managed Care	Short Stay Hospitals		Long Stay Hospitals	
Eligibility of Hospitalized Enrollees	Number	Number	Days	Days per 1000 Enrollees	Days	Days per 1000 Enrollees
All Groups	160,786	14,559	304,974	2,086	63,260	433
Aged	115,172	12,014	202,947	1,967	35,760	178
Disabled/ESRD-only	45,614	2,545	102,027	2,369	27,500	276

Lengths of hospital stay per person varied in the IHS Areas from a low of 1,472 days per 1000 enrollees in Portland Area to a high of 3,514 days per 1000 enrollees in Tucson Area (Figure 12, Appendix Table C.9) with an average of 2,064 days per 1000 enrollees for all IHS Areas (Figure 12, "IHS Area" yellow vertical bar). The variation in lengths of hospital stay per person for all IHS Areas by eligibility group, both Short Stay and Long Stay hospitals, is provided in Appendix Table C.10.

Figure 12
Days of Stay per 1,000 AIAN Medicare Enrollees in Short-Stay Hospitals in each Service Area *



* Appendix Table C.9

Payment Data: Hospitalizations

Medicare Payments

Medicare payments to hospitals for care of AIAN enrollees totaled $550 million in 2006. Medicare hospital payments constitute the single largest category of Medicare benefit payments for beneficiaries (62% of Part A benefit payments), 2.1 times as large as payments for physicians and other professionals, and 2.5 times as large as payments for medications (Appendix Table E.2). Medicare hospital payments include all withdrawals from the Medicare hospital trust fund to pay providers for hospital services rendered for covered hospital services to Medicare enrollees under the fee-for-service payment system.

Medicare paid amounts to hospitals are only part of what hospital providers charge for hospital stays of Medicare beneficiaries. In Short Stay hospitals Medicare paid only 33.8% of hospital provider charges, and in Long Stay hospitals, 46.2% of charges (Table 15).

Table 15
Amounts and Percent of Total Charges (in thousands of dollars)
Paid by Medicare by Type of Hospital in each Eligibility Group

Eligibility of Hospitalized Enrollees	Total Charges		Medicare Payments	
	Amount in 1000's	Percent	Amount in 1000's	Percent
Short Stay Hospitals				
All Groups	$ 1,428,446	100.0%	$ 482,368	33.8%
Aged	$ 928,569	100.0%	$ 325,501	35.1%
Disabled/ESRD-only	$ 499,876	100.0%	$ 156,867	31.4%
Long Stay Hospitals				
All Groups	$ 144,642	100.0%	$ 66,740	46.1%
Aged	$ 90,565	100.0%	$ 45,247	50.0%
Disabled/ESRD-only	$ 54,077	100.0%	$ 21,494	39.7%

Part of the difference between charges and payments is because Medicare does not cover all days of a hospital stay. Medicare covered 96.0% of AIAN Total Days of Stay in Short Stay Hospitals, and 89.5% of days in Long Stay Hospitals in 2006 (Table 16).

Table 16
Days of Stay Covered by Medicare expressed as the
Percent of Total Days of Stay by Type of Hospital in each Eligibility Group

Eligibility of Hospitalized Enrollees	Covered Days of Stay			
	Short Stay Hospitals		Long Stay Hospitals	
	Days	Percent of Total Days	Days	Percent of Total Days
All Groups	292,853	96.0%	56,625	89.5%
Aged	197,372	97.3%	33,861	94.7%
Disabled/ESRD-only	95,481	93.6%	22,764	82.8%

Another part of the gap between charges and payments is that Medicare does not cover all services claimed by a provider for a hospital stay. Total charges include room, board and ancillary services as recorded on the billing form (claim) but not all services charged are covered by Medicare. Medicare covered 98.7% of AIAN Short Stay hospital charges, and 96.8% of Long Stay hospital charges (Table 17).

Table 17
Amounts and Percent of Total Charges (in thousands of dollars)
Covered by Medicare by Type of Hospital in each Eligibility Group

Eligibility of Hospitalized Enrollees	Total Charges		Covered Charges	
	Short Stay Hospitals		Short Stay Hospitals	
Short Stay Hospitals	Amount in 1000's	Percent	Amount in 1000's	Percent
All Groups	$ 1,428,446	100.0%	$ 1,410,141	98.7%
Aged	$ 928,569	100.0%	$ 921,452	99.2%
Disabled/ESRD-only	$ 499,876	100.0%	$ 488,688	97.8%
Long Stay Hospitals				
All Groups	$ 144,642	100.0%	$ 139,982	96.8%
Aged	$ 90,565	100.0%	$ 88,948	98.2%
Disabled/ESRD-only	$ 54,077	100.0%	$ 51,034	94.4%

Enrollee Payments

Hospitalized Medicare enrollees have a potential liability for a Coinsurance and Deductible payments to hospital facilities as part of "Cost Sharing." When all payments made for AIAN hospitalizations were totaled, Medicare paid 89.4% of payments to Short Stay hospitals, and AIAN enrollees paid 7.0% (Table 18). The balance was paid by other payers (3.6%). Medicare paid 90.5% of the total paid to Long Stay hospitals, Enrollees 8.3%, and other payers 1.3%. In Short Stay hospitals, AIAN Enrollees paid $37,947,000 for hospital care (Figure 13). The lowest dollar amount paid by enrollees was in Tucson Area, $590,000 and the highest in Oklahoma Area $10,502,000 (Figure 13, Appendix Table C.11). The percent of the total paid in an Area that AIAN Enrollees paid varied from a low in Alaska of 5.1% of total payments, to a high of 7.8% of total payments in Nashville (Appendix Table C.11). Hospital paid amounts by Medicare, AIAN enrollees and other payers for the Aged and Disabled eligibility groups in each IHS Area are provided in Appendix Tables C.12 and C.13.

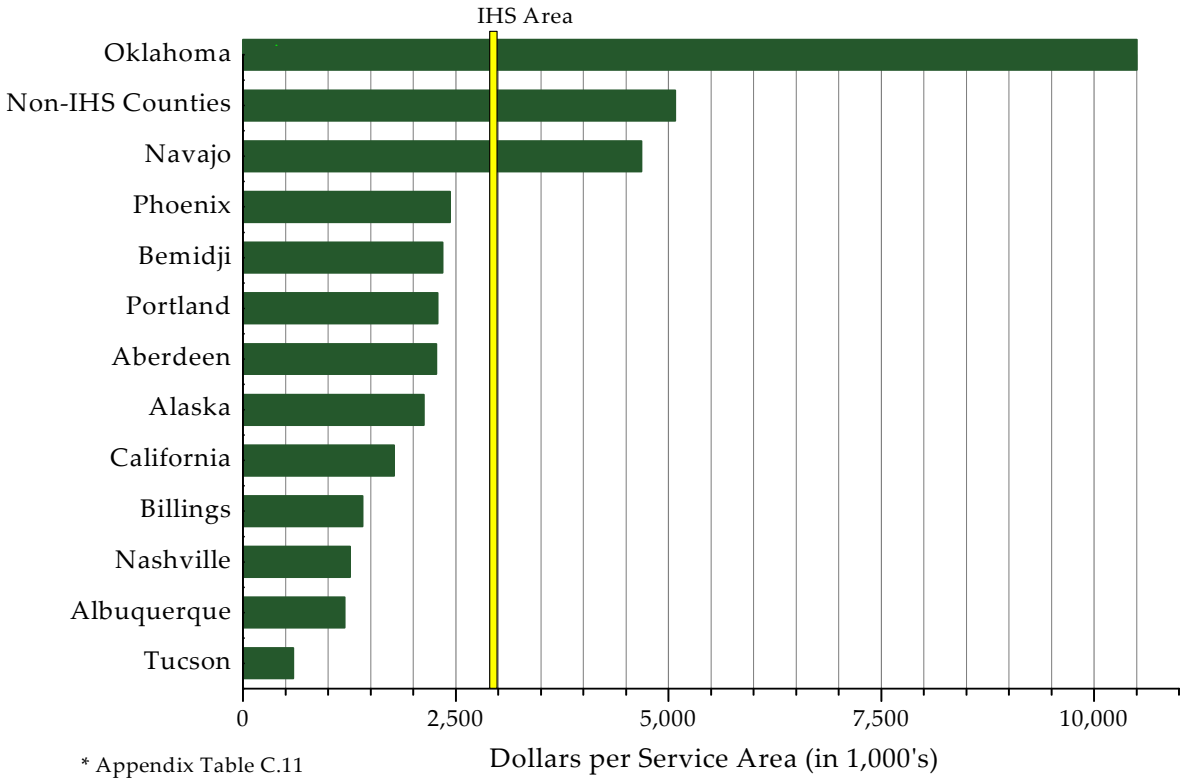
Deductibles accounted for 93.5% of AIAN Enrollee payments while Coinsurance accounted for only 6.5% (Table 19). The Medicare hospital coverage Deductible applies to each new Benefit Period, and is approximately the cost of a 1-day inpatient hospital stay ($981 in s Short Stay hospital in 2006). Coinsurance, on the other hand, does not start until the hospitalized enrollee has had 60 days of hospital stay in the Benefit Period. Medicare hospital Coinsurance is the portion of Medicare covered hospital expenses paid

by enrollee after Medicare covered days have been fully utilized, and the subtraction of any Deductible for which the enrollee is still responsible in the payment period. From the 61st to 90th day of hospital stay, the

Table 18
Amounts of Medicare, Enrollee and Other Payer Payments (in thousands of dollars) and the Percent of the Total Payment paid by each Payer by Type of Hospital in each Eligibility Group

Eligibility of Hospitalized Enrollees	Total Payments		Medicare Payments		Enrollee Payments*		Other Payer Payments**	
	Amount in 1000's	Percent	Amount in 1000's	Percent	Amount in 1000's	Percent	Amount in 1000's	Percent
Short Stay Hospitals								
All Groups	$ 539,719	100.0%	$ 482,368	89.4%	$ 37,947	7.0%	$ 19,404	3.6%
Aged	$ 362,035	100.0%	$ 325,501	89.9%	$ 25,697	7.1%	$ 10,837	3.0%
Disabled/ESRD-only	$ 177,684	100.0%	$ 156,867	88.3%	$ 12,250	6.9%	$ 8,567	4.8%
Long Stay Hospitals								
All Groups	$ 73,756	100.0%	$ 66,740	90.5%	$ 6,093	8.3%	$ 922	1.3%
Aged	$ 49,537	100.0%	$ 45,247	91.3%	$ 3,923	7.9%	$ 367	0.7%
Disabled/ESRD-only	$ 24,219	100.0%	$ 21,494	88.7%	$ 2,170	9.0%	$ 555	2.3%

Figure 13
For Short-Stay Hospitals: Total Enrollee Payments in each Service Area*



* Appendix Table C.11

daily Coinsurance amount is equal to one-fourth of the inpatient hospital Deductible. After 90 days enrollees can apply any of their 60 Lifetime Reserve Days towards un-covered days of stay, in which case the daily Coinsurance amount is equal to half of the Deductible. A Benefit Period begins the first day an enrollee is furnished inpatient hospital services and ends when the enrollee has not been an inpatient for 60 consecutive days. Besides Coinsurance and Deductibles, total potential Enrollee Cost-sharing could include co-payments and out-of-pocket payments for balanced billing on unassigned claims, though such payments are more likely to occur with medical Part B rather than hospital Part A benefits. Enrollee Cost Sharing does not include monthly premiums for Medical coverage, voluntary hospital coverage or any private supplemental insurance.

Table 19
Amounts of Enrollee Deductible and Coinsurance Payments as the Percent of the Enrollee Payment by Type of Hospital in each Eligibility Group

Eligibility of Hospitalized Enrollees	Total Enrollee Payments*		Enrollee Deductible Payment		Enrollee Coinsurance Payment	
	Amount in 1000's	Percent	Amount in 1000's	Percent	Amount in 1000's	Percent
Short Stay Hospitals						
All Groups	$ 37,947	100.0%	$ 35,480	93.5%	$ 2,467	6.5%
Aged	$ 25,697	100.0%	$ 24,580	95.7%	$ 1,117	4.3%
Disabled/ESRD-only	$ 12,250	100.0%	$ 10,899	89.0%	$ 1,351	11.0%
Long Stay Hospitals						
All Groups	$ 6,093	100.0%	$ 3,845	63.1%	$ 2,248	36.9%
Aged	$ 3,923	100.0%	$ 2,719	69.3%	$ 1,204	30.7%
Disabled/ESRD-only	$ 2,170	100.0%	$ 1,126	51.9%	$ 1,044	48.1%

Payment Rates per Stay, per Day and per Capita

Medicare payments were $8,469 per stay for AIAN in Short Stay hospitals (Table 20). This is only slightly lower than the national average of $8,669 for all Medicare enrollees in 2006.[27] AIAN enrollees paid an average of $666 per stay and Other Payers an average of $341 per stay. Medicare payments per stay for AIAN averaged $8,521 per stay for the IHS Areas and varied from a low in the Oklahoma Area of $7,377 per stay to high in the Alaska Area of $13,588 and in the California Area of $10,301 per stay (Figure 14, Appendix Table C.15). In Short Stay hospitals the amounts paid per hospital stay for Aged AIAN were

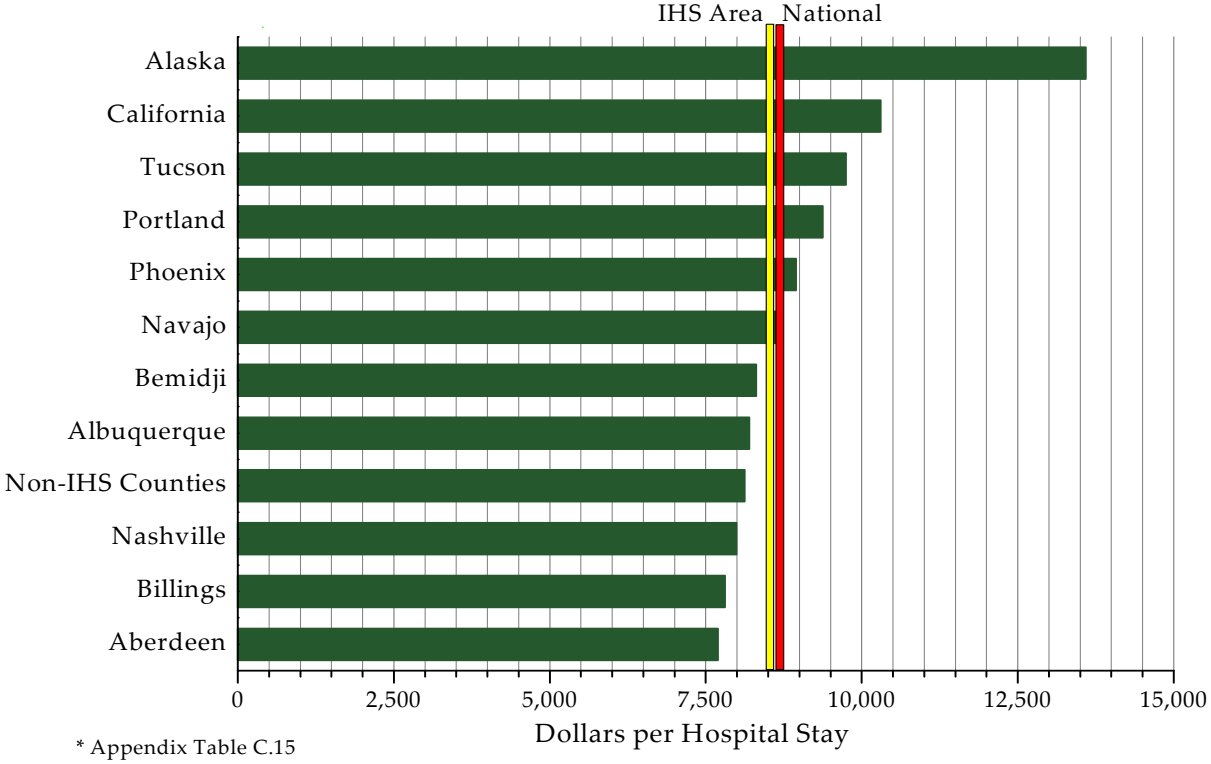
[27] CMS. *Health Care Financing Review, 2007 Statistical Supplement*, Tables 5.3 and 5.5.

comparable to those paid for the Disabled/ESRD-only AIAN whether paid by Medicare ($8,487 per stay and $8,431 per stay respectively) or by enrollees ($670 per stay and $658 per stay) (Table 20).

Table 20
Medicare, Enrollee and Other Payer Payments (in thousands of dollars) and the Amount per Hospital Stay by Type of Hospital in each Eligibility Group

Eligibility of Hospitalized Enrollees	Total Payments		Medicare Payments		Enrollee Payments		Other Payer Payments	
	Amount in 1000's	Amount Per Stay	Amount in 1000's	Amount Per Stay	Amount in 1000's	Amount Per Stay	Amount in 1000's	Amount Per Stay
Short Stay Hospitals								
All Groups	$ 539,719	$ 9,475	$ 482,368	$ 8,469	$ 37,947	$ 666	$ 19,404	$ 341
Aged	$ 362,035	$ 9,439	$ 325,501	$ 8,487	$ 25,697	$ 670	$ 10,837	$ 283
Disabled/ESRD-only	$ 177,684	$ 9,550	$ 156,867	$ 8,431	$ 12,250	$ 658	$ 8,567	$ 460
Long Stay Hospitals								
All Groups	$ 73,756	$ 10,190	$ 66,740	$ 9,221	$ 6,093	$ 842	$ 922	$ 127
Aged	$ 49,537	$ 9,943	$ 45,247	$ 9,082	$ 3,923	$ 787	$ 367	$ 74
Disabled/ESRD-only	$ 24,219	$ 10,735	$ 21,494	$ 9,527	$ 2,170	$ 962	$ 555	$ 246

Figure 14
For Short-Stay Hospitals: Medicare payment per Hospital Stay of AIAN Enrollees in each Service Area*



* Appendix Table C.15

The amount paid per stay was higher for Long Stay hospitals for both Medicare ($9,221 per stay) and AIAN enrollees ($842 per stay), but not for Other Payers ($127 per stay, Table 20). Medicare payments per stay for AIAN averaged $8,521 per stay for the IHS Areas and varied from a low in the Oklahoma Area of $7,377 per stay to a high of in the Alaska Area of $13,588 and in the California Area of $10,301 per stay (Appendix Table C.15). In Long Stay hospitals the amounts per stay for AIAN in the Aged group were lower for Medicare and enrollees than for those in the Disabled/ESRD-only group (Appendix Table C.17).

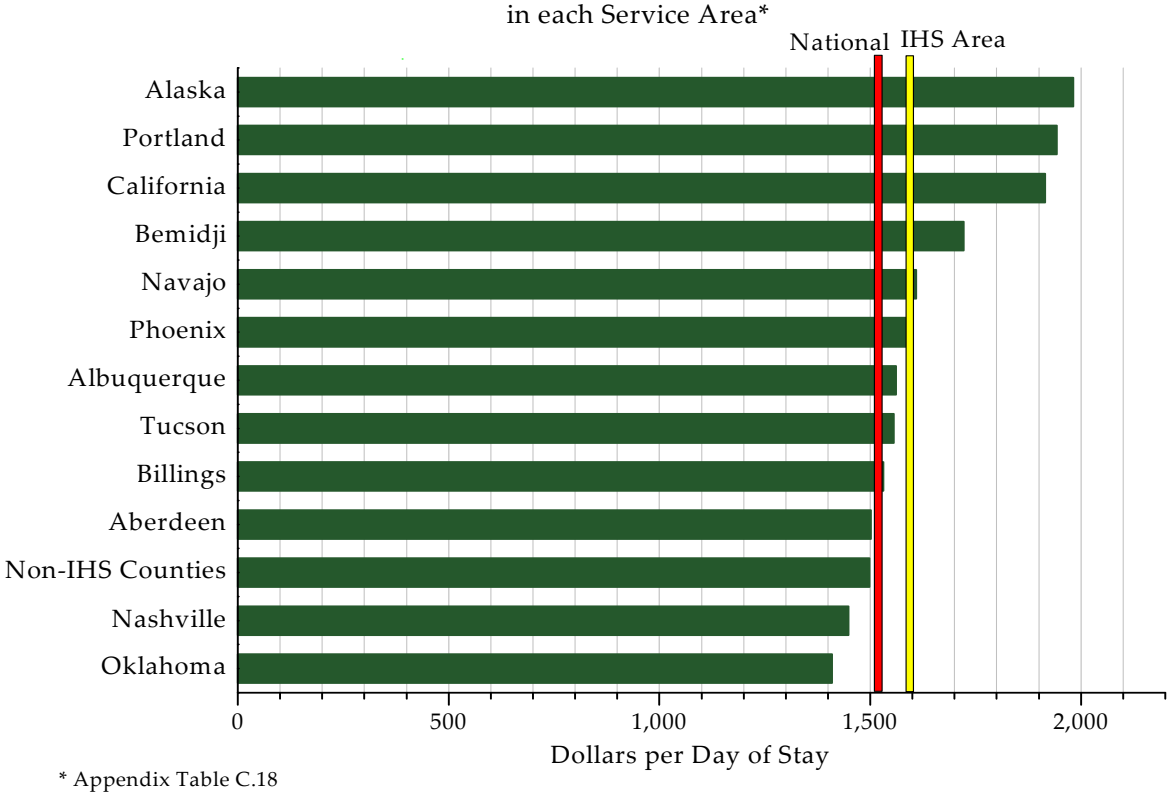
Table 21
Total and Medicare Payments (in thousands of dollars) and the Amount per Day of Stay by Type of Hospital in each Eligibility Group

Eligibility of Hospitalized Enrollees	Total Payments		Medicare Payments	
	Amount in 1000's	Amount Per Day	Amount in 1000's	Amount Per Day
Short Stay Hospitals				
All Groups	$ 539,719	$ 1,770	$ 482,368	$ 1,582
Aged	$ 362,035	$ 1,784	$ 325,501	$ 1,604
Disabled/ESRD-only	$ 177,684	$ 1,742	$ 156,867	$ 1,537
Long Stay Hospitals				
All Groups	$ 73,756	$ 1,166	$ 66,740	$ 1,056
Aged	$ 49,537	$ 1,385	$ 45,247	$ 1,266
Disabled/ESRD-only	$ 24,219	$ 881	$ 21,494	$ 782

Medicare daily payments were $1,582 per day of stay for AIAN enrollees (Table 21) which is only slightly higher than the national average for all Medicare enrollees of $1,519 per day in Short Stay hospitals.[28] Medicare payment rates averaged $1,595 per day of stay for the IHS Areas and varied from a low in the Aberdeen Area ($1,502 per day) to highs in the Alaska ($1,982), Portland ($1,943 per day), and California ($1,915 per day) Areas (Figure 15, Appendix Table C.18). Unlike the amounts per stay, average amounts per day were lower for Disabled than for Aged enrollees, and for Long Stay hospitals days than for Short Stay hospital days (Table 21). Higher payments for Disabled hospitalizations within Eligibility groups and hospital types were potentially explained by longer stays since hospital payments per day were lower.

[28] CMS. *Health Care Financing Review, 2007 Statistical Supplement*, Tables 5.3 and 5.5.

Figure 15
For Short-Stay Hospitals: Medicare Payment per Day of Stay of AIAN Enrollees in each Service Area*



* Appendix Table C.18

Medicare per capita payments (per enrollee with hospital coverage) for AIAN were $3,299 (Table 22) which is higher than the national average for hospital stays of $3,008 per enrollee in Short Stay hospitals.[29] With age adjustment the difference would be even greater because of the younger AIAN population covered. The lowest per capita payment is in the Albuquerque Area ($2,532) was less than half the highest in Tucson Area ($5,468) (Figure 16, Appendix Table C.21). The large variation in Medicare per capita payments across IHS areas is important to take into account in determining equity of federal health care coverage for IHS user populations. Adjustments are needed for age, medical costs and other factors affecting health care coverage as has been done in the past with IHS funding across IHS areas. Per capita payments for the Eligibility groups are provided by IHS Area in Appendix Table C.22. The Appendix C tables (C.21 and C.22) include Long Stay hospital per capita amounts as well.

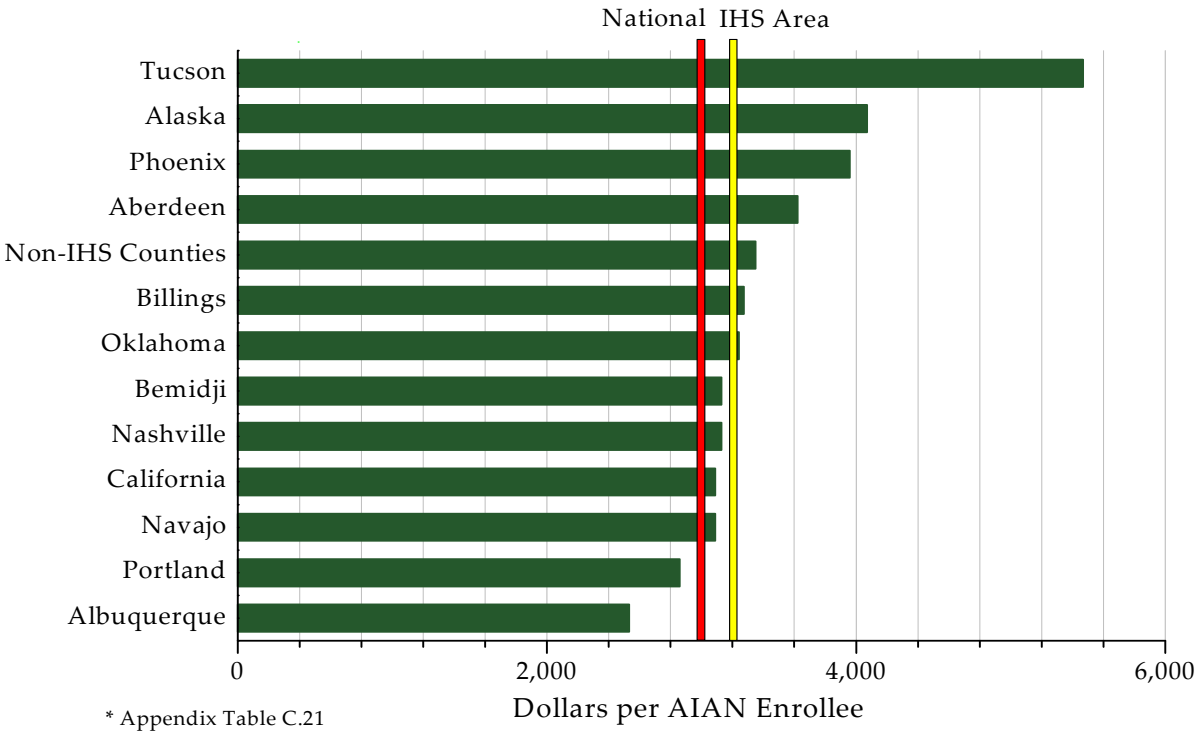
[29] CMS. *Health Care Financing Review, 2007 Statistical Supplement*, Tables 5.4.

Table 22

Medicare Per Capita Payment Rates (per AIAN Enrollee with Hospital Coverage either alone or with Medical Coverage) and not in Managed Care by Type of Hospital in each Eligibility Group

Eligibility of Hospitalized Enrollees	Enrollees		Medicare Payments			
	With Hospital Coverage	In Managed Care	Short Stay Hospitals		Long Stay Hospitals	
Short Stay Hospitals	Number	Number	Amount	Rate per Enrollee	Amount	Rate per Enrollee
All Groups	160,786	14,559	$ 482,368	$ 3,299	$66,740	$ 456
Aged	114,913	12,008	$ 325,501	$ 3,163	$45,247	$ 440
Disabled/ESRD-only	45,873	2,551	$ 156,867	$ 3,621	$21,494	$ 496

Figure 16
For Short-Stay Hospitals: Medicare Payment per AIAN Enrollee with Hospital Coverage*



* Appendix Table C.21

Urban Enrollment & Utilization Findings

In this section we present enrollment and utilization findings for AIAN Medicare enrollees living in the 98 counties Urban Indian Health Programs (U) state that they serve (Table 23). These counties in 21 states and 11 of the IHS Areas were aggregated into one 'Urban Service Area' to be compared to aggregated IHS Areas (CHSDA counties). Most of these counties are not CHSDA counties. Urban Service Area enrollment and utilization data is presented in Appendix D. We present selected data and tables here.

Table 23
Number of Urban Service Area AIAN Medicare enrollees in the IHS Areas

IHS Area	Urban Service Area AIAN Medicare Enrollees	States with Counties Served by Urban Indian Health Programs in the IHS Area			
Aberdeen	639	IA	NE	SD	
Albuquerque	1,874	CO	NM		
Bemidji	1,937	IL	MI	MN	WI
Billings	1,213	MT			
California	5,069	CA			
Nashville	90	MA	NY		
Navajo	2,616	AZ			
Oklahoma	8,416	KS	OK	TX	
Phoenix	4,325	AZ	NV	UT	
Portland	2,218	OR	WA		
Tucson	1,700	AZ			

Eligibility Data

The Urban Service Area counties had a total of 30,097 AIAN Medicare enrollees which was 18.7% of all 160,963 AIAN enrollees for 2006. These AIAN were either current users of an Urban Indian (U) program, or were past users of an I/T/U program who lived in one of the 98 Urban Service Area counties in 2006.

Table 24
AIAN Medicare enrollees in each Eligibility group in Urban and IHS Service Areas

	Urban Area		IHS Areas*	
Eligibility Group	Number	Percent	Number	Percent
Total Enrollees	30,097	100.0%	139,363	100.0%
Aged	20,399	67.3%	100,969	72.5%
Disabled	9,545	28.6%	37,801	27.1%
ESRD-only	153	4.1%	639	0.5%

*IHS Area Counties, all CHSDA combined, from Appendix Table B.1; Some CHSDA counties (such as San Diego) are also included in the 98 Urban Service Area counties.

Aged Eligibility

While the largest Medicare Eligibility group of AIAN enrollees in the Urban Service Area is that of the Aged, proportionately fewer enrollees are Aged compared to Disabled than in the IHS Areas. Two-thirds of urban AIAN enrollees (67.3%) were Aged, while nearly three-fourths (72.5%) of AIAN in IHS Areas were in the Aged group (Table 24). More than four-fifths (83.6%) of all Medicare beneficiaries nationwide, were in the Aged entitlement category in 2006.[30] For the Aged Eligibility group the age distributions of AIAN in the Urban and IHS Service Areas do not differ for men or for women (Appendix Table D.2). In both Areas there are slightly larger proportions of women in the older age groups reflecting in part the longer survival of women.

Disabled Eligibility

More than a quarter 28.6% of AIAN enrollees in the Urban Service Area were in the Disability entitlement program in 2006, similar to that of AIAN enrollees in the IHS Areas (27.1%), but considerably higher than the 16.4% figure for all Medicare beneficiaries nationwide (Table 23).

End-Stage Renal Disease (ESRD) Eligibility

The small fraction of AIAN Medicare enrollees eligible only because of ESRD was slightly higher in the Urban Service Area (4.5%) than in the IHS Areas (0.5%, Table 23). AIAN who are eligible for Medicare only because of ESRD are about 14.0% of all AIAN Medicare enrollees with ESRD just as in

[30] *2008 CMS Statistics*, Table I.1. Available at www.cms hhs.gov/ResearchGenInfo/02_CMSStatistics.asp

the IHS Areas (Table 25). Because of small numbers of people in the ESRD-only entitlement group, in analyses from this point on we do as CMS does in analyzing statistics, and combine enrollees in the ESRD-only group with the Disabled Eligibility group which has 53.6% of all AIAN Medicare enrollees with ESRD in the Urban Service Area.

Table 25
AIAN Medicare enrollees with ESRD in each Eligibility group in the Urban and IHS Service Areas

	Urban Area		IHS Areas*	
Eligibility Group	Number	Percent	Number	Percent
All ESRD	1,093	100.0%	4,496	100.0%
Aged with ESRD	353	32.3%	1,630	36.3%
Disabled with ESRD	587	53.7%	2273	50.6%
ESRD-only	153	14.0%	593	13.2%

**IHS Area Counties, all CHSDA combined, from Appendix Table B.1; Some CHSDA counties (such as San Diego) are also included in the 98 Urban Service Area counties.*

AIAN Men who are enrollees in the Disabled/ESRD-only Eligibility group in the Urban Service Area (38.7% under age 45) are younger than AIAN men in the IHS Areas (33.3%, Appendix Table D.4). A similar differential is found for AIAN women. AIAN women who are enrollees in the Disabled/ESRD-only Eligibility group in the Urban Service Area (33.3% under age 45) are younger than AIAN women in the IHS Areas (30.9%).

Coverage Data

Medicare Hospital and Medical coverage for AIAN enrollees in the Urban Service Area is comparable to that for AIAN in IHS Areas, but more enrollees have Managed Care coverage. Essentially all AIAN enrolled in Medicare in the Urban Service Area have Hospital Insurance (99.8%), whether alone (Part A only, 8.4%) or in combination with Medical Insurance (Parts A and B, 91.4%; Table 26). AIAN in the Urban Service Area have Medical Insurance (91.5%) at levels not very different from those in the IHS Areas (90.4%). Coverage was comparable for both the Aged and the Disabled/ESRD-only Eligibility groups (Appendix Table D.6).

Table 26
AIAN Medicare Enrollees with Hospital and Medical Coverage in the Urban and IHS Service Areas

	Urban Area		IHS Areas	
Coverage Type	Number	Percent	Number	Percent
Total Enrollees	30,097	100.0%	139,363	100.0%
Both Hospital & Medical*	27,519	91.4%	125,902	90.3%
Hospital-only	2,542	8.4%	13,298	9.5%
Medical*-only	36	0.1%	163	0.1%

There is a high level of Managed Care Coverage for AIAN in the Urban Service Area. The rate of 19.1% Managed Care Coverage for AIAN enrollees (Table 27) was essentially the same as the rate of 19.8% for all Medicare enrollees nationally. This Managed Care Coverage rate is much higher than the average rate of 8.1% for AIAN in the IHS Areas. Twice as many Aged (22.9%) and Disabled (11.1%) AIAN enrollees in the Urban Service Area were enrolled in managed care than in the IHS Area (Aged 10.4% and Disabled 5.6% respectively, Appendix Table D.8). About the same proportion of premiums for Hospital and Medical coverage were paid by state Medicaid Programs ('Buy-In') for AIAN in the Urban Service Area (38.5%) as in the IHS Areas (40.3%, Appendix Table D.9).

Table 27
AIAN Medicare Enrollees with Fee-For-Service and Managed Care Coverage in the Urban and IHS Service Areas

	Urban Area		IHS Areas	
Coverage Type	Number	Percent	Number	Percent
Total Enrollees	30,097	100.0%	139,363	100.0%
Fee-For-Service	24,359	80.9%	128,033	91.9%
Managed Care	5,738	19.1%	11,330	8.1%

Services Data: Hospitalizations

In 2006 of 10,936 hospital stays of AIAN enrollees living in the Urban Service Area 93.2% were in Short Stay hospitals (10,193 stays), the rest were in Long Stay hospitals (743 stays, Table 28). This is a larger fraction than that for IHS Areas where 88.4% of hospital stays were in Short Stay hospitals (49,392 stays), and closer to the proportion found for all Medicare enrollees (97.2 %). A higher proportion of stays were for Disabled AIAN enrollees in the Urban Service Area whether in Short

(41.3%) or Long (52.0%) Stay hospitals than for IHS Areas (31.5% of Short Stay hospital stays and 29.9% of Long Stay hospital stays respectively, Table 28).

Table 28
Hospital Stays by Type of Hospital for AIAN Medicare enrollees by Eligibility group in the Urban and IHS Service Areas

Eligibility of Hospitalized Enrollees	Short Stay Hospitals				Long Stay Hospitals			
	Urban Area		IHS Areas		Urban Area		IHS Areas	
	Stays	Percent	Stays	Percent	Stays	Percent	Stays	Percent
Both Groups	10,193	100.0%	49,392	100.0%	743	100.0%	6,474	100.0%
Aged	5,985	58.7%	33,813	68.5%	357	48.0%	4,539	70.1%
Disabled/ESRD-only	4,208	41.3%	15,579	31.5%	386	52.0%	1,935	29.9%

Hospitalization Rates. Hospitalization rates were higher for AIAN living in the Urban Service Area than for AIAN in IHS Areas or than for all Medicare enrollees. For AIAN living in the Urban Service Area the hospitalization rate in Short Stay hospitals was 419 stays per 1000 enrollees with hospital coverage (Table 28), whereas for AIAN living in the IHS Areas the rate was 386 stays per 1000 enrollees (Appendix Table C.5). The comparable rate for all Medicare enrollees was even lower at 349 per 1000 in 2006.31 In the Urban Service Area the hospitalization rate was much higher for the Disabled/ESRD-only group (488 stays per 1000 enrollees with hospital coverage), than for Aged (381 stays per 1000 enrollees with hospital coverage) (Table 29). The Long Stay hospitalization rate in the Urban Service Area of 31 per 1000 enrollees with hospital coverage was lower than for the IHS Areas (52 per 1000 enrollees, Appendix Table C.3).

Length of Hospital Stays. AIAN enrollees in the Urban Service Area had more hospital days and longer hospital stays than AIAN enrollees in IHS Areas or Medicare enrollees generally. The Total Days of Stay in Short Stay Hospitals for enrollees living in the Urban Service Area averaged 2,362 days per 1000 AIAN enrollees with hospital coverage (Table 30), a higher rate than the 2,064 days per 1000 AIAN enrollees for the IHS Areas (Appendix Table C.7), or 2,023 days per 1000 enrollees for Medicare in general. The average length of stay for AIAN enrollees was longer in the Urban Service Area (5.6 days per stay, Appendix Table D.11) than in the IHS Areas the average length of stay was (5.3 days per stay, Appendix Table C.4). This Urban Area length of stay was only slightly shorter than that for

31*Medicare and Medicaid Statistical Supplement, Short Stay Hospitals, 2007*. Table 5.3 Available at: www.cms.hhs.gov/medicaremedicaidstatsupp/lt/ItemDetail.asp?ItemID=CMS1199282

Medicare enrollees in general (5.7 days per stay). In urban Long Stay Hospitals, the length of stay was much longer for AIAN (17.0 days per stay, Table 35) than in Long Stay Hospitals in the IHS Areas (8.7 days per stay, Table C.4).

Table 29
Hospitalization Rates per 1,000 AIAN Enrollees with Hospital Coverage (either alone or with Medical Coverage) and not in Managed Care by Type of Hospital in each Eligibility Group in the Urban Service Area

	Enrollees		Hospital Stays			
	With Hospital Coverage	In Managed Care	Short Stay Hospitals		Long Stay Hospitals	
Eligibility of Hospitalized Enrollees	Number	Number	Stays	Rate per 1000 Enrollees	Stays	Rate per 1000 Enrollees
All Groups	30,061	5,738	10,193	419	743	31
Aged	20,364	4,663	5,985	381	357	23
Disabled/ESRD-only	9,697	1,075	4,208	488	386	45

Table 30
Number and Percent of Total Days of Stay, and the Average Days per 1000 AIAN Medicare enrollees by Type of Hospital in each Eligibility Group in the Urban Service Area

	Enrollees		Total Days of Stay			
	With Hospital Coverage	In Managed Care	Short Stay Hospitals		Long Stay Hospitals	
Eligibility of Hospitalized Enrollees	Number	Number	Days	Days per 1000 Enrollees	Days	Days per 1000 Enrollees
All Groups	30,061	5,738	57,439	2,362	12,613	519
Aged	20,364	4,663	33,278	2,119	5,364	342
Disabled/ESRD-only	9,697	1,075	24,161	2,802	7,249	841

Payments Data

Medicare paid $99.6 million to hospitals for hospitalizations of AIAN living in the Urban Service Area in 2006. Medicare payments were 89.7% of total payments for the stays to Short Stay hospitals (Appendix Table D.13). The AIAN enrollees paid 7.9% and the balance was paid by other payers (3.5%). For Long Stay Hospital stays Medicare paid 92.0% of the total payments, Enrollees paid 8.0% and other payers paid 0.7%.

Medicare payments per hospital stay were $9,645 for urban AIAN in Short Stay hospitals (Table 31) which is higher than both the average of $8,521 per stay for AIAN in IHS Areas (Appendix Table C.10)

Table 31
Amount and Percent of Medicare Payment, and the Average Payment per Hospital Stay of AIAN Medicare beneficiaries by Type of Hospital in each Eligibility Group in the Urban Service Area

Eligibility of Hospitalized Enrollees	Medicare Payments					
	Short Stay Hospitals			Long Stay Hospitals		
	Amount	Percent	Per Stay	Amount	Percent	Per Stay
Both Groups	$ 88,233	100.0%	$ 8,656	$ 11,393	100.0%	$ 15,334
Aged	$ 52,576	59.6%	$ 8,785	$ 5,964	52.3%	$ 16,705
Disabled/ESRD-only	$ 35,657	40.4%	$ 8,474	$ 5,430	47.7%	$ 14,066

and the national average of $8,669 per stay for all Medicare enrollees (Short Stay hospitals in 2006).[32] Medicare payments per day of stay for the AIAN were $1,712 per day (Table 32) which is higher than both the average of $1,595 per day for AIAN in IHS Areas (Appendix Table C.11) and the national average of $1,519 per day. Medicare Payments per enrollee with hospital coverage for AIAN in the Urban Service Area were $3,628 (Table 33) which is considerably higher than the national average of $3,008.

Table 32
Average Medicare Payment per Day of Hospital Stay of AIAN Medicare beneficiaries by Type of Hospital in each Eligibility Group in the Urban Service Area

Eligibility of Hospitalized Enrollees	Medicare Payments					
	Short Stay Hospitals			Long Stay Hospitals		
	Amount	Percent	Per Day	Amount	Percent	Per Day
Both Groups	$ 88,233	100.0%	$ 1,536	$ 11,393	100.0%	$ 903
Aged	$ 52,576	59.6%	$ 1,580	$ 5,964	52.3%	$ 1,112
Disabled/ESRD-only	$ 35,657	40.4%	$ 1,476	$ 5,430	47.7%	$ 749

[32] CMS. *Health Care Financing Review*, *2007 Statistical Supplement*, Tables 5.3 and 5.5.

Table 33
Medicare Payment Rates per AIAN Enrollees with Hospital Coverage (either alone or with Medical Coverage) and not in Managed Care by Type of Hospital in each Eligibility Group in the Urban Service Area

Eligibility of Hospitalized Enrollees	Enrollees		Medicare Payments			
	With Hospital Coverage	In Managed Care	Short Stay Hospitals		Long Stay Hospitals	
	Number	Number	Amount in 1000's	Rate per Enrollee	Amount in 1000's	Rate per Enrollee
All Groups	30,061	5,738	$ 88,233	$ 3,628	$ 11,393	$ 468
Aged	20,364	4,663	$ 52,576	$ 3,349	$ 5,964	$ 380
Disabled/ESRD-only	9,697	1,075	$ 35,657	$ 4,136	$ 5,430	$ 630

Conclusions & Recommendations

Medicare Data for AIAN and IHS System Providers

Medicare data does not identify the three groups of AIAN or the three groups of IHS health care delivery system providers specified for program planning and policy analysis in the CMS AIAN Strategic Plan. In this study we found enrollees identified as 'AIAN' in Medicare databases are people who the IHS classified as AIAN. The IHS regularly obtains registration information on current users of the system from IHS system providers. The IHS determines which users meet their criteria of AIAN. This registry of the IHS AIAN user population is linked regularly to CMS data to determine which Medicare enrollees are AIAN. In this study we found that other methods that Medicare has employed to improve the racial data in the master enrollment data yielded only a few hundred 'Racial' AIAN enrollees. Therefore we conclude:

- ◊ **Racial AIAN**. There are essentially no self-declared 'Racial' AIAN identified in the Medicare data.
- ◊ **IHS AIAN**. AIAN in Medicare data are AIAN who were at some time a user of the IHS health care delivery system. In the annual Medicare enrollment files it is not known if the AIAN are in the IHS AIAN active user population for that same year, however.
- ◊ **Tribal AIAN**. There are no 'Tribal' AIAN identified as such in Medicare data.
- ◊ **IHS, Tribal or Urban Providers** (I/T/U). Medicare data files do not appear to have provider categories that could be used to identify I/T/U provider types.

Medicare Enrollment Data

Medicare data that is available for AIAN in the annual enrollment ('Denominator') data file includes information on the demographics, eligibility and coverage of the AIAN enrollees in Medicare. Data categories that are particularly useful in program planning and policy analysis include: Age, Gender, Service Area, Eligibility group, Hospital or Medical service coverage, Managed Care coverage and State Medicaid program 'buy in' to Medicare enrollment premiums. Knowing the proportion of AIAN in each of the classifications within these enrollment data categories is particularly important when they differ between AIAN and other Medicare enrollee populations. Medicare programs and policies with particular effects on certain classifications of enrollees more prevalent among AIAN can be expected to have greater impact on AIAN. Identifying the proportions of AIAN in these classifications, and how the proportions vary among categories of AIAN, helps to predict how useful analysis of Medicare data could be in informing program

planning and policy analysis. For example this study revealed the following findings for the AIAN in Medicare enrollment data files for 2006:

- **Demographics**
  - **Gender**. There are more AIAN women than men enrolled in Medicare. As with Medicare enrollees generally, 59% of AIAN enrollees eligible because of their Age and 46% of AIAN enrollees eligible because of their Disability are women.
  - **Age**. AIAN in the Aged eligibility group are younger than Medicare enrollees in the Aged eligibility group. Among Aged AIAN nearly two-thirds (65%) were under age 75 compared with only half of all Medicare enrollees (52%). Among Disabled AIAN one-third (33%) were under age 45 compared with only a quarter of all Disabled Medicare enrollees (25%).
- **Eligibility**. About a quarter (29%) of AIAN Medicare beneficiaries were entitled to Medicare because of prolonged disability. This is considerably higher proportion than the 16% figure for all Medicare beneficiaries. The average rate is 27% for the IHS Areas and for the Urban Service Area as well. The lowest proportions of disabled enrollees were in Navajo (21.0%) and Alaska (21.7%) Areas. The highest proportion was in the Tucson Area (35.0%).
- **Hospital and Medical Coverage**. In the U.S. as a whole, 91% of all AIAN enrollees have both Hospital and Medical Medicare coverage (Parts A and B). This is almost the same as the 92% rate for all Medicare beneficiaries. The rates are only slightly lower for AIAN in the IHS Areas (90%) and the Urban Service Area (91%) than in non-IHS part of the country (94%). Though most AIAN Medicare enrollees had both Hospital and Medical coverage, the fraction varied among IHS Areas. The lowest fractions were in Aberdeen (85%) and Albuquerque (86%) Areas. The highest fractions were in California (94%) and Oklahoma (92%) Areas.
- **Managed Care Coverage**. AIAN enrollee managed care participation varies greatly by service area: In the Urban Service Area the proportion of AIAN in managed care was 20%, but across the IHS Areas the average was 8% (with a low from 0% in Alaska Area to 20% in Tucson Area). Only 10% of Aged AIAN beneficiaries were enrolled in Medicare managed care. Only 6% of Disabled AIAN beneficiaries had Managed Care coverage. Even in the Urban Service Area where managed care penetration was high, only 8% of Disabled AIAN beneficiaries had Managed Care coverage.
- **Medicaid Payment of Premiums**. State Medicaid programs paid premiums for Medicare coverage for 39% of AIAN enrollees who had the Medical Part B coverage in addition to Hospital Part A coverage. The rate was essentially the same for the IHS Areas (40%) and for the Urban Area (39%). The rate varied in the IHS Areas from a low of 29% in Oklahoma to a high of 61% in Navajo Area. More than a quarter (29%) of Aged AIAN enrollees, and more than half (54%) of Disabled AIAN enrollees had state paid premiums. States paid premiums for coverage of more than half (55%) of AIAN with End-Stage Renal Disease.
- **Prescription Medications (Part D)**. There is no information on the enrollment of AIAN Medicare enrollees in Part D. Databases for Part D participation have become available for analysis, but apparently they are not linked to the master Medicare enrollment data file and therefore will not have the 'Medicare AIAN' information from the regular data linkages done between IHS and the CMS.

Medicare enrollment data could be useful in determining whether there are barriers to AIAN enrollment in Medicare. A major factor likely to be a barrier to enrollment in Medicare for AIAN living on or near tribal lands is the availability of employment positions paying Social Security Insurance for 10 years (that is, 40 quarters). A common indicator calculated to measure access to enrollment in a program is to determine the proportion of people in the eligible population who actually are enrolled. If a single data file for the eligible population is not available, then a ratio is calculated instead. The ratio is the number of enrollees in the program divided by the number of people in the population estimated to be eligible for the program. In this study we used the best information we could find for the two numbers to analyze how the ratio varies across the 12 IHS Administrative Areas from which the AIAN were identified by CMS and IHS in the Medicare data with both groups restricted to people over age 55.

- ◊ **Potential Medicare Enrollment Barriers**. The variation in the ratios across IHS Areas is substantial: the ratios of the highest value Areas are 50% higher than the lowest ratios. Low ratios of Medicare enrollees to IHS Active Users potentially indicating barriers to enrollment are found for four Areas: Albuquerque (0.49), Phoenix (0.50), Aberdeen (0.51) and Alaska (0.52). The highest ratios indicating areas with potentially better access to or use of Medicare were found for Portland (0.80), Oklahoma (0.77) and California (0.70). Further investigation is needed with linked IHS user and Medicare databases to determine more accurate measures for potential barriers to enrollment.

Medicare Health Care Utilization Data

Medicare health care services and payments data can be very useful in determining how Medicare programs and policies affect how much care AIAN receive from which providers and at what costs to whom. Medicare utilization data is divided among numerous data files. Medicare does not have an annual summary file of all services and payments for enrollees. The utilization data is based on individual paid claims files that are combined in a limited number of summary files based on particular types of service. Since essentially all enrollees are covered for hospital care (Medicare Part A), and hospital facility care is the single service type for which Medicare payments are highest, in this study we provided analysis of hospitalizations (MedPAR) file for 2006. The file includes enrollee stays for two large categories of Medicare hospital facility providers: Short Stay hospitals (average stays less than 25 days per stay), and Long Stay Hospitals (average stays more than 25 days per stay).

- ◊ **Hospitalization Rates.** Hospitalization rates were higher for AIAN than for all Medicare enrollees in Short Stay hospitals. For AIAN the hospitalization rate was 390 per 1000 enrollees with hospital coverage, while the comparable rate for all Medicare enrollees was 349 per 1000.

- Across IHS Service Areas hospitalization rates averaged 386 per 1000 enrollees ranging from a low of 300 per 1000 in Alaska and California Areas, to a high of 561 per 1000 in Tucson Area.
- In the Urban Service Area hospitalization rates were higher for AIAN living than the average rate in the IHS Areas or the rate for all Medicare enrollees. For AIAN living in the Urban Service Area the hospitalization rate was 419 stays per 1000 enrollees with hospital coverage.

◊ **Hospital Days and Stays**. AIAN had more hospital days, but fewer hospital stays, than Medicare enrollees do generally in Short Stay hospitals. The hospital Days of Stay averaged 2,086 days per 1,000 AIAN enrollees with hospital coverage which was higher than the rate of 1,981 days per 1000 for Medicare enrollees with hospital coverage. The average length of stay for AIAN enrollees was, shorter (5.4 days per stay) than the comparable rate for Medicare enrollees (5.7 days per stay).

- Hospital days per 1000 enrollees averaged 2,086 for the IHS Areas and varied from a low in the Portland Area of 1,472 days per 1000 enrollees to a high in Tucson Area of 3,514 per 1000 enrollees.
- Lengths of stay averaged 5.3 days per stay for the IHS Areas and varied in the IHS Areas from 4.8 days per stay in the Portland Area to 6.9 days per stay in Alaska.
- Hospital days and lengths of stay were both high for AIAN in the Urban Service Area. These AIAN averaged 2,362 days per 1000 AIAN enrollees with hospital coverage. Their average length of was 5.6 days per stay.

◊ **Long Stay Hospital Utilization** can be compared for AIAN among IHS Areas and the Urban Service Area since comparative data for all Medicare enrollees was not available.

- For the IHS Areas hospitalization rates were higher (51 per 1000 AIAN enrollees with hospital coverage) than for the Urban Service Area (32 per 1000 AIAN enrollees).
- In the Urban Service Area hospital Days of Stay were higher (2,362 days per 1000 AIAN enrollees with hospital coverage) than in the IHS Areas (2,064 days per 1000 AIAN enrollees).
- In the Urban Service Area the average length of stay for AIAN was nearly twice as long (17.0 days per stay) as in the IHS Areas (8.4 days per stay).

Medicare hospital payments constitute the single largest category of Medicare benefit payments (62% of Part A benefit payments), 2.1 times as large as payments for physicians and other professionals, and 2.5 times as large as payments for medications. For care in Short Stay hospitals:

◊ **Per Capita Medicare Payments**. Medicare pays more for hospital care of AIAN enrollees on a per capita basis ($3,299 per enrollee with hospital coverage) than for Medicare enrollees in general ($3,008 per enrollee). The lowest per capita payment is in the Albuquerque Area ($2,532) was less than half the highest in Tucson Area ($5,468). The large variation in Medicare per capita payments is important to take into account in determining equity of federal health care coverage for IHS user population across IHS areas.

- **Medicare Payments per Hospital Stay**. Medicare payments per hospital stay for AIAN were lower ($8,469 per stay) than the national average ($8,669 per stay) for all Medicare enrollees in Short Stay hospitals.
  - Medicare payments averaged $8,521 per stay in the IHS Areas and varied from a low in the Oklahoma Area of $7,377 per stay to highs 50% to 100% higher in California ($10,301 per stay) and Alaska ($13,588 per stay) Areas.
  - Medicare payments for the Urban Service Area were $9,645 which was higher than the average for the IHS Areas.
- **Medicare Payments per Hospital Day**. Medicare payment rates per day to hospitals were a little higher for AIAN ($1,582 per day of stay) than the national average ($1,519 per day of stay) for all Medicare enrollees in Short Stay hospitals.
  - Medicare payments averaged $1,595 per day of stay for the IHS Areas and varied from a low in the Nashville Area ($1,448 per day) to highs in the Alaska ($1,982 per day), Portland ($1,943 per day), and California ($1,915 per day) Areas.
  - Medicare payments for the Urban Service Area ($1,712 per day of stay) were higher than the average for the IHS Areas.
- **Enrollee Payments**. When all payments made for AIAN hospitalizations in Short Stay hospitals were totaled, Medicare paid 89% of the total amount paid, and AIAN enrollees paid 7% for Deductibles and Coinsurance. The balance was paid by other payers (4%). Enrollee payments varied from a low of 5% of total hospital payments in the Alaska area, to a high of 8% in Oklahoma Area with an average of 7% for all IHS Areas. AIAN enrollees paid 8% for Deductibles and Coinsurance in the Urban Service Area.

Recommendations

Medicare Data for AIAN and IHS System Providers. Recommended strategies that could improve Medicare data for program planning and policy analysis through coordinated actions of the CMS, IHS and the Social Security Administration include:

- **Racial AIAN**. Medicare Beneficiary Surveys and Social Security Administration activities have had little impact on increasing the identification of the self-declared AIAN Medicare enrollee population, alternative recommended strategies would be:
  - Contact Medicare enrollees (particularly those in 'Other' Race category) to update their Medicare demographic information;
  - Advertise the importance of responding to this demographic 'Update' initiative in cultural groups and events of AIAN;
- **IHS AIAN**. Medicare does not retain information on the year(s) in which the Medicare enrollees were identified as current (active) users of IHS system providers.
  - Have the IHS identify the year(s) of confirmed IHS active user status during the quarterly linkages of Medicare enrollment data with IHS active user data;

- During the demographic 'Update' initiative, Give enrollees the opportunity to provide a Geographic zip code for where they physically live in addition to any zip code they may have on record for mailing purposes;

◊ **Tribal AIAN**. Medicare does not have any information on tribal affiliation for the individual tribes who are requesting analysis of the Medicare data of their tribal members.

- Survey tribal leadership of federally recognized tribes to see which tribes want to have Medicare data;
- Have the IHS identify the tribal affiliation of IHS active users during the quarterly linkages of Medicare enrollment data with IHS active user data;
- Have AIAN Medicare enrollees provide tribal affiliation(s) and status as 'enrolled or registered' during the demographic 'Update' initiative;

◊ **IHS, Tribal or Urban Providers** (I/T/U). Medicare does not have codes developed that would identify IHS health care delivery system providers and their status as IHS, tribal or urban Indian operated institutions.

- Have IHS identify the I/T/U provider(s) (that is, IHS Service Units) used during the quarterly linkages of Medicare enrollment data with IHS active user data.

Medicare Enrollment Data. There are further analyses to be done for AIAN with Medicare enrollment databases (Denominator files).

◊ **Barriers to enrollment analyses with IHS Active User electronic files**. Using currently published data on age and disability populations for IHS Areas it is difficult to make reliable estimates on the extent to which aged and disabled AIAN in the IHS user population are not participating in Medicare.

- With IHS registry electronic files that include age and disability information on the AIAN active user populations in each of the IHS Areas, it would be possible to better estimate the variation in enrollment ratios across IHS Areas.

◊ **Effects of Premiums on Medical Coverage**. One of the key issues in effects of Medicare policies on AIAN is the effect of premiums for medical care (Part B) coverage on AIAN participation in Part B. Using Medicare annual enrollment databases (Denominator files) it is possible to study how payment of Medicare Part B premiums by state Medicaid programs correlates with AIAN Medicare enrollment in Part B and the continuity of the enrollment through the year. The study could go further with IHS Active User electronic files that would allow determination of IHS AIAN user population participation rates in Medicare Part B with payment of premiums by state Medicaid programs.

◊ **Effects of Medicare Managed Care**. Managed Care participation among AIAN varied considerably across IHS Areas. Using Medicare annual enrollment databases (Denominator files) it is possible to study further how AIAN in managed care differ with respect to other AIAN in terms of such things as payment of Medicare Part B premiums by state Medicaid programs and continuity of the coverage through the year. There is limited if any health care utilization data on managed care enrollees in Medicare utilization data files, it is important to determine how characteristics of AIAN enrolled in Managed Care affect characteristics of AIAN in utilization data files across IHS Areas.

Medicare Health Care Utilization Data. There is much further work to be done with Medicare health care utilization data files to investigate health status, access to care, and variation in care as a function of provider and payer policies and practices**.**

- ◊ **Hospitalization Health Care**. With the MedPAR data file for hospital stays there is considerable information to be gained through the analysis of the diagnoses and procedures information. The diagnostic information, for example, can be used to investigate such things as morbidity and severity of illness of the hospitalized AIAN enrollees, and preventable hospitalizations that access to effective ambulatory care can prevent (a performance measure for access to health care, as well as clinic and physician care).

- ◊ **Hospital Payments**. With the MedPAR data file for hospital stays there is considerable information to investigate how changes in policies related to Diagnostic Related Groups (DRG) and the Medicare Prospective Payment System affect AIAN and IHS System Provider payments and DRG over time.

- ◊ **Total Medicare Payments**. To determine more complete Medicare benefit payments (medical as well as hospital care) for the AIAN in this study will take analysis of at least two other claims files provided for medical care: the Outpatient (hospital institutional clinics) and the non-institutional Carrier (clinics and individual health professional providers) Standard Accounting Files for 2006.

- ◊ **Care for Specific Diseases**. To determine medical as well as hospital care for the AIAN with hospitalizations for specific diseases will take combined analysis of the MedPAR hospital and at least the Outpatient (hospital institutional clinics) and the Carrier (clinics and individual health professional provider) Standard Accounting Files for 2006.

- ◊ **Care for Chronic Conditions.** To investigate AIAN health care utilizations for chronic conditions would require access to the Medicare Chronic Conditions Warehouse (CCW) data, or better yet CCW methodology. CCW data is based on a 5% sample of all Medicare enrollees and therefore the number of AIAN (5% of 161,000, or about 8,000 AIAN) is small. But CCW methodology for grouping enrollees by chronic diseases could be applied to 100% of the AIAN enrollee population.

- ◊ **Long-term Care.** To investigate AIAN utilization of long-term care will require access to the Skilled Nursing Facility MedPAR file, and combining that information with Long Stay Hospital information gained in this study. To determine medical as well as inpatient care for will take combined analysis of the MedPAR Long Stay and Skilled Nursing Facility data as well as the Outpatient (hospital institutional clinics) and the Carrier (clinics and individual health professional provider) Standard Accounting Files.

Appendix A
Enrollment Tables

With data from a 'workbench version' of the Enrollment Data Base
including Race Source Code, 1991 to 2007

Table A.1
Medicare enrollment of AIAN by year and age group

		Age			
	Total	Age 65 & Over		Less Than 65	
Year	Number	Number	Percent	Number	Percent
1991	88,963	67,580	76%	21,383	24%
1992	95,125	71,364	75%	23,761	25%
1993	101,108	75,103	74%	26,005	26%
1994	106,975	78,542	73%	28,433	27%
1995	112,973	82,523	73%	30,450	27%
1996	119,165	86,277	72%	32,888	28%
1997	124,780	90,191	72%	34,589	28%
1998	130,388	93,759	72%	36,629	28%
1999	136,164	97,424	72%	38,740	28%
2000	142,101	101,131	71%	40,970	29%
2001	147,829	104,340	71%	43,489	29%
2002	153,710	107,365	70%	46,345	30%
2003	159,936	110,684	69%	49,252	31%
2004	165,798	115,190	69%	50,608	31%
2005	172,284	120,270	70%	52,014	30%
2006	177,109	124,887	71%	52,222	29%
2007	177,659	126,786	71%	50,873	29%

Table A.2
Medicare enrollment AIAN by year and gender.

		Gender			
	Total	Males		Females	
Year	Number	Number	Percent	Number	Percent
1991	88,963	42,324	48%	46,639	52%
1992	95,125	45,006	47%	50,119	53%
1993	101,108	47,561	47%	53,547	53%
1994	106,975	50,070	47%	56,905	53%
1995	112,973	52,549	47%	60,424	53%
1996	119,165	55,047	46%	64,118	54%
1997	124,780	57,203	46%	67,577	54%
1998	130,388	59,453	46%	70,935	54%
1999	136,164	61,798	45%	74,366	55%
2000	142,101	64,332	45%	77,769	55%
2001	147,829	66,789	45%	81,040	55%
2002	153,710	69,347	45%	84,363	55%
2003	159,936	72,170	45%	87,766	55%
2004	165,798	74,782	45%	91,016	55%
2005	172,284	77,530	45%	94,754	55%
2006	177,109	79,579	45%	97,530	55%
2007	177,659	79,577	45%	98,082	55%

Appendix B
AIAN Enrollment Data
Eligibility and Coverage by IHS Area

Source Data File:
Denominator File for 2006

Demographic Data	**Tables**						
By Eligibility Group	B.1	B.2	B.3	B.4	B.5	B.6	B.7
By Age	B.5	B.6	B.7	B.8	B.9	B.10	
By Gender	B.8	B.9	B.10				

Eligibility Data	**Tables**			
Aged	B.1	B.2	B.5	B.8
Disabled	B.1	B.2	B.6	B.9
End Stage Renal Disease	B.1	B.2	B.7	B.10

Coverage Data	**Tables**		
Hospital-only	B.11	B.12	B.13
Medical-only	B.11	B.12	B.13
Hospital and Medical	B.11	B.12	B.13
Managed Care Coverage	B.14	B.15	B.16
Medicaid Paid Premiums	B.17	B.18	B.10

Table B.1
Number and Percent of AIAN Medicare Enrollees in each Service Area
by Eligibility (Entitlement) Group
Calendar Year 2006

	All		Aged		Disabled		ESRD-only	
IHS Area	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All US Counties	160,963	100%	115,088	71.5%	45,238	28.1%	637	0.40%
IHS Area Counties	139,363	100%	100,969	72.5%	37,801	27.1%	593	0.43%
Aberdeen	8,202	100%	5,540	67.5%	2,603	31.7%	59	0.72%
Alaska	9,581	100%	7,492	78.2%	2,078	21.7%	11	0.11%
Albuquerque	6,039	100%	4,494	74.4%	1,483	24.6%	62	1.03%
Bemidji	10,365	100%	6,994	67.5%	3,345	32.3%	26	0.25%
Billings	5,371	100%	3,964	73.8%	1,383	25.7%	24	0.45%
California	9,735	100%	6,880	70.7%	2,826	29.0%	29	0.30%
Nashville	4,906	100%	3,324	67.8%	1,563	31.9%	19	0.39%
Navajo	19,861	100%	15,496	78.0%	4,250	21.4%	115	0.58%
Oklahoma	41,461	100%	30,456	73.5%	10,915	26.3%	90	0.22%
Phoenix	9,502	100%	6,348	66.8%	3,064	32.2%	90	0.95%
Portland	12,506	100%	8,820	70.5%	3,650	29.2%	36	0.29%
Tucson	1,834	100%	1,161	63.3%	641	35.0%	32	1.74%
Non-IHS Counties	21,600	100%	14,119	65.4%	7,437	34.4%	44	0.20%

Table B.2
Number and Percent of AIAN Medicare Enrollees in each Eligibility Group by Service Area
Calendar Year 2006

	All		Aged		Disabled		ESRD-only	
IHS Area	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All US Counties	160,963	100%	115,088	100%	45,238	100%	637	100%
IHS Area Counties	139,363	86.6%	100,969	87.7%	37,801	83.6%	593	93.1%
Aberdeen	8,202	5.1%	5,540	4.8%	2,603	5.8%	59	9.3%
Alaska	9,581	6.0%	7,492	6.5%	2,078	4.6%	11	1.7%
Albuquerque	6,039	3.8%	4,494	3.9%	1,483	3.3%	62	9.7%
Bemidji	10,365	6.4%	6,994	6.1%	3,345	7.4%	26	4.1%
Billings	5,371	3.3%	3,964	3.4%	1,383	3.1%	24	3.8%
California	9,735	6.0%	6,880	6.0%	2,826	6.2%	29	4.6%
Nashville	4,906	3.0%	3,324	2.9%	1,563	3.5%	19	3.0%
Navajo	19,861	12.3%	15,496	13.5%	4,250	9.4%	115	18.1%
Oklahoma	41,461	25.8%	30,456	26.5%	10,915	24.1%	90	14.1%
Phoenix	9,502	5.9%	6,348	5.5%	3,064	6.8%	90	14.1%
Portland	12,506	7.8%	8,820	7.7%	3,650	8.1%	36	5.7%
Tucson	1,834	1.1%	1,161	1.0%	641	1.4%	32	5.0%
Non-IHS Counties	21,600	13.4%	14,119	12.3%	7,437	16.4%	44	6.9%

Table B.3
Number and Percent of AIAN Medicare Enrollees with End Stage Renal Disease (ESRD)
in each Service Area by Eligibility Group
Calendar Year 2006

	All		Aged with ESRD		Disabled with ESRD		ESRD-only	
IHS_AREA	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All US Counties	4,958	100%	1,791	36.1%	2,530	51.0%	637	12.8%
IHS Area Counties	4,496	100%	1,630	36.3%	2,273	50.6%	593	13.2%
Aberdeen	381	100%	126	33.1%	196	51.4%	59	15.5%
Alaska	65	100%	21	32.3%	33	50.8%	11	16.9%
Albuquerque	416	100%	157	37.7%	197	47.4%	62	14.9%
Bemidji	308	100%	134	43.5%	148	48.1%	26	8.4%
Billings	184	100%	68	37.0%	92	50.0%	24	13.0%
California	203	100%	86	42.4%	88	43.3%	29	14.3%
Nashville	196	100%	66	33.7%	111	56.6%	19	9.7%
Navajo	816	100%	329	40.3%	372	45.6%	115	14.1%
Oklahoma	796	100%	281	35.3%	425	53.4%	90	11.3%
Phoenix	691	100%	206	29.8%	395	57.2%	90	13.0%
Portland	236	100%	88	37.3%	112	47.5%	36	15.3%
Tucson	204	100%	68	33.3%	104	51.0%	32	15.7%
Non-IHS Counties	462	100%	161	34.8%	257	55.6%	44	9.5%

Table B.4
Number and Percent of AIAN Medicare Enrollees with End Stage Renal Disease (ESRD)
in each Eligibility Group by Service Area
Calendar Year 2006

IHS Area	All		Aged with ESRD		Disabled with ESRD		ESRD-only	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All US Counties	4,958	100%	1,791	100%	2,530	100%	637	100%
IHS Area Counties	4,496	90.7%	1,630	91.0%	2,273	89.8%	593	93.1%
Aberdeen	381	7.7%	126	7.0%	196	7.7%	59	9.3%
Alaska	65	1.3%	21	1.2%	33	1.3%	11	1.7%
Albuquerque	416	8.4%	157	8.8%	197	7.8%	62	9.7%
Bemidji	308	6.2%	134	7.5%	148	5.8%	26	4.1%
Billings	184	3.7%	68	3.8%	92	3.6%	24	3.8%
California	203	4.1%	86	4.8%	88	3.5%	29	4.6%
Nashville	196	4.0%	66	3.7%	111	4.4%	19	3.0%
Navajo	816	16.5%	329	18.4%	372	14.7%	115	18.1%
Oklahoma	796	16.1%	281	15.7%	425	16.8%	90	14.1%
Phoenix	691	13.9%	206	11.5%	395	15.6%	90	14.1%
Portland	236	4.8%	88	4.9%	112	4.4%	36	5.7%
Tucson	204	4.1%	68	3.8%	104	4.1%	32	5.0%
Non-IHS Counties	462	9.3%	161	9.0%	257	10.2%	44	6.9%

Table B.5
Number and Percent of Medicare Enrollees in the Aged Eligibility Group in each Service Area
by Age
Calendar Year 2006

IHS Area	All Ages		Ages 65 to 74*		Ages 75 to 84		Ages 85 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All US Counties	115,088	100%	74,248	64.5%	31,938	27.8%	8,902	7.7%
IHS Area Counties	100,969	100%	64,931	64.3%	28,104	27.8%	7,934	7.9%
Aberdeen	5,540	100%	3,778	68.2%	1,397	25.2%	365	6.6%
Alaska	7,492	100%	4,816	64.3%	2,133	28.5%	543	7.2%
Albuquerque	4,494	100%	2,878	64.0%	1,187	26.4%	429	9.5%
Bemidji	6,994	100%	4,756	68.0%	1,825	26.1%	413	5.9%
Billings	3,964	100%	2,761	69.7%	972	24.5%	231	5.8%
California	6,880	100%	4,277	62.2%	2,031	29.5%	572	8.3%
Nashville	3,324	100%	2,230	67.1%	824	24.8%	270	8.1%
Navajo	15,496	100%	9,678	62.5%	4,344	28.0%	1,474	9.5%
Oklahoma	30,456	100%	18,913	62.1%	8,998	29.5%	2,545	8.4%
Phoenix	6,348	100%	4,230	66.6%	1,685	26.5%	433	6.8%
Portland	8,820	100%	5,828	66.1%	2,427	27.5%	565	6.4%
Tucson	1,161	100%	786	67.7%	281	24.2%	94	8.1%
Non-IHS Counties	14,119	100%	9,317	66.0%	3,834	27.2%	968	6.9%

* Some enrollees are less than 65 at the beginning of the year

Table B.6
Number and Percent of AIAN Medicare Enrollees in the Disabled Eligibility Group
in each Service Area by Age
Calendar Year 2006

	All Ages		Ages under 45		Ages 45 to 54		Ages 55 to 64	
IHS Area	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All US Counties	45,238	100%	15,113	33.4%	14,062	31.1%	16,063	35.5%
IHS Area Counties	37,801	100%	12,355	32.7%	11,696	30.9%	13,750	36.4%
Aberdeen	2,603	100%	927	35.6%	774	29.7%	902	34.7%
Alaska	2,078	100%	746	35.9%	611	29.4%	721	34.7%
Albuquerque	1,483	100%	520	35.1%	436	29.4%	527	35.5%
Bemidji	3,345	100%	1,141	34.1%	1,060	31.7%	1,144	34.2%
Billings	1,383	100%	424	30.7%	403	29.1%	556	40.2%
California	2,826	100%	910	32.2%	925	32.7%	991	35.1%
Nashville	1,563	100%	479	30.6%	491	31.4%	593	37.9%
Navajo	4,250	100%	1,435	33.8%	1,178	27.7%	1,637	38.5%
Oklahoma	10,915	100%	3,321	30.4%	3,456	31.7%	4,138	37.9%
Phoenix	3,064	100%	1,075	35.1%	970	31.7%	1,019	33.3%
Portland	3,650	100%	1,152	31.6%	1,183	32.4%	1,315	36.0%
Tucson	641	100%	225	35.1%	209	32.6%	207	32.3%
Non-IHS Counties	7,437	100%	2,758	37.1%	2,366	31.8%	2,313	31.1%

Table B.7
Number and Percent of AIAN Medicare Enrollees with ESRD (including Aged and Disabled) in each Service Area by Age
Calendar Year 2006

IHS Area	All Ages		Ages under 35		Ages 35 to 64		Ages 65 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All US Counties	4,958	100%	347	7.0%	2,947	59.4%	1,664	33.6%
IHS Area Counties	4,496	100%	306	6.8%	2,676	59.5%	1,514	33.7%
Aberdeen	381	100%	31	8.1%	241	63.3%	109	28.6%
Alaska	65	100%	6	9.2%	39	60.0%	20	30.8%
Albuquerque	416	100%	15	3.6%	257	61.8%	144	34.6%
Bemidji	308	100%	22	7.1%	159	51.6%	127	41.2%
Billings	184	100%	9	4.9%	112	60.9%	63	34.2%
California	203	100%	14	6.9%	110	54.2%	79	38.9%
Nashville	196	100%	11	5.6%	123	62.8%	62	31.6%
Navajo	816	100%	54	6.6%	454	55.6%	308	37.7%
Oklahoma	796	100%	73	9.2%	461	57.9%	262	32.9%
Phoenix	691	100%	46	6.7%	455	65.8%	190	27.5%
Portland	236	100%	22	9.3%	131	55.5%	83	35.2%
Tucson	204	100%	3	1.5%	134	65.7%	67	32.8%
Non-IHS Counties	462	100%	41	8.9%	271	58.7%	150	32.5%

Table B.8
Number and Percent of Men and Women AIAN Medicare Enrollees in the Aged Eligibility Group in each Service Area by Age
Calendar Year 2006

Men

IHS Area	All Ages Number	All Ages Percent	Ages 65 to 74 Number	Ages 65 to 74 Percent	Ages 75 to 84 Number	Ages 75 to 84 Percent	Ages 85 and over Number	Ages 85 and over Percent
All US Counties	47,296	100%	31,904	67.5%	12,659	26.8%	2,733	5.8%
IHS Area Counties	42,032	100%	28,259	67.2%	11,314	26.9%	2,459	5.9%
Aberdeen	2,254	100%	1,628	72.2%	529	23.5%	97	4.3%
Alaska	3,424	100%	2,301	67.2%	927	27.1%	196	5.7%
Albuquerque	1,816	100%	1,204	66.3%	461	25.4%	151	8.3%
Bemidji	2,983	100%	2,147	72.0%	719	24.1%	117	3.9%
Billings	1,704	100%	1,213	71.2%	413	24.2%	78	4.6%
California	2,684	100%	1,733	64.6%	772	28.8%	179	6.7%
Nashville	1,310	100%	941	71.8%	304	23.2%	65	5.0%
Navajo	6,773	100%	4,354	64.3%	1,873	27.7%	546	8.1%
Oklahoma	12,338	100%	8,101	65.7%	3,548	28.8%	689	5.6%
Phoenix	2,593	100%	1,774	68.4%	680	26.2%	139	5.4%
Portland	3,650	100%	2,515	68.9%	965	26.4%	170	4.7%
Tucson	503	100%	348	69.2%	123	24.5%	32	6.4%
Non-IHS Counties	5,264	100%	3,645	69.2%	1,345	25.6%	274	5.2%

Women

IHS Area	All Ages Number	All Ages Percent	Ages 65 to 74 Number	Ages 65 to 74 Percent	Ages 75 to 84 Number	Ages 75 to 84 Percent	Ages 85 and over Number	Ages 85 and over Percent
All US Counties	67,792	100%	42,344	62.5%	19,279	28.4%	6,169	9.1%
IHS Area Counties	58,937	100%	36,672	62.2%	16,790	28.5%	5,475	9.3%
Aberdeen	3,286	100%	2,150	65.4%	868	26.4%	268	8.2%
Alaska	4,068	100%	2,515	61.8%	1,206	29.6%	347	8.5%
Albuquerque	2,678	100%	1,674	62.5%	726	27.1%	278	10.4%
Bemidji	4,011	100%	2,609	65.0%	1,106	27.6%	296	7.4%
Billings	2,260	100%	1,548	68.5%	559	24.7%	153	6.8%
California	4,196	100%	2,544	60.6%	1,259	30.0%	393	9.4%
Nashville	2,014	100%	1,289	64.0%	520	25.8%	205	10.2%
Navajo	8,723	100%	5,324	61.0%	2,471	28.3%	928	10.6%
Oklahoma	18,118	100%	10,812	59.7%	5,450	30.1%	1,856	10.2%
Phoenix	3,755	100%	2,456	65.4%	1,005	26.8%	294	7.8%
Portland	5,170	100%	3,313	64.1%	1,462	28.3%	395	7.6%
Tucson	658	100%	438	66.6%	158	24.0%	62	9.4%
Non-IHS Counties	8,855	100%	5,672	64.1%	2,489	28.1%	694	7.8%

Table B.9
Number and Percent of Men and Women AIAN Medicare Enrollees in the Disabled Eligibility Group in each Service Area by Age
Calendar Year 2006

Men

IHS Area	All Ages Number	All Ages Percent	Ages under 45 Number	Ages under 45 Percent	Ages 45 to 54 Number	Ages 45 to 54 Percent	Ages 55 to 64 Number	Ages 55 to 64 Percent
All US Counties	24,125	100%	8,456	35.1%	7,455	30.9%	8,214	34.0%
IHS Area Counties	20,374	100%	6,971	34.2%	6,283	30.8%	7,120	34.9%
Aberdeen	1,403	100%	514	36.6%	436	31.1%	453	32.3%
Alaska	1,138	100%	444	39.0%	340	29.9%	354	31.1%
Albuquerque	818	100%	297	36.3%	226	27.6%	295	36.1%
Bemidji	1,767	100%	614	34.7%	555	31.4%	598	33.8%
Billings	764	100%	259	33.9%	212	27.7%	293	38.4%
California	1,458	100%	500	34.3%	466	32.0%	492	33.7%
Nashville	858	100%	268	31.2%	276	32.2%	314	36.6%
Navajo	2,428	100%	842	34.7%	679	28.0%	907	37.4%
Oklahoma	5,939	100%	1,908	32.1%	1,899	32.0%	2,132	35.9%
Phoenix	1,577	100%	575	36.5%	501	31.8%	501	31.8%
Portland	1,903	100%	634	33.3%	591	31.1%	678	35.6%
Tucson	321	100%	116	36.1%	102	31.8%	103	32.1%
Non-IHS Counties	3,751	100%	1,485	39.6%	1,172	31.2%	1,094	29.2%

Women

IHS Area	All Ages Number	All Ages Percent	Ages under 45 Number	Ages under 45 Percent	Ages 45 to 54 Number	Ages 45 to 54 Percent	Ages 55 to 64 Number	Ages 55 to 64 Percent
All US Counties	21,113	100%	6,657	31.5%	6,607	31.3%	7,849	37.2%
IHS Area Counties	17,427	100%	5,384	30.9%	5,413	31.1%	6,630	38.0%
Aberdeen	1,200	100%	413	34.4%	338	28.2%	449	37.4%
Alaska	940	100%	302	32.1%	271	28.8%	367	39.0%
Albuquerque	665	100%	223	33.5%	210	31.6%	232	34.9%
Bemidji	1,578	100%	527	33.4%	505	32.0%	546	34.6%
Billings	619	100%	165	26.7%	191	30.9%	263	42.5%
California	1,368	100%	410	30.0%	459	33.6%	499	36.5%
Nashville	705	100%	211	29.9%	215	30.5%	279	39.6%
Navajo	1,822	100%	593	32.5%	499	27.4%	730	40.1%
Oklahoma	4,976	100%	1,413	28.4%	1,557	31.3%	2,006	40.3%
Phoenix	1,487	100%	500	33.6%	469	31.5%	518	34.8%
Portland	1,747	100%	518	29.7%	592	33.9%	637	36.5%
Tucson	320	100%	109	34.1%	107	33.4%	104	32.5%
Non-IHS Counties	3,686	100%	1,273	34.5%	1,194	32.4%	1,219	33.1%

Table B.10
Number and Percent of Men and Women AIAN Medicare Enrollees with ESRD (including Aged and Disabled) in each Service Area by Age

Men

IHS Area	All Ages Number	All Ages Percent	Ages under 35 Number	Ages under 35 Percent	Ages 35 to 64 Number	Ages 35 to 64 Percent	Ages 65 and over Number	Ages 65 and over Percent
All US Counties	1,957	100%	43	2.2%	250	12.8%	1,664	85.0%
IHS Area Counties	1,789	100%	39	2.2%	236	13.2%	1,514	84.6%
Aberdeen	139	100%	3	2.2%	27	19.4%	109	78.4%
Alaska	27	100%	2	7.4%	5	18.5%	20	74.1%
Albuquerque	174	100%	0	0.0%	30	17.2%	144	82.8%
Bemidji	138	100%	1	0.7%	10	7.2%	127	92.0%
Billings	76	100%	1	1.3%	12	15.8%	63	82.9%
California	94	100%	4	4.3%	11	11.7%	79	84.0%
Nashville	75	100%	1	1.3%	12	16.0%	62	82.7%
Navajo	352	100%	3	0.9%	41	11.6%	308	87.5%
Oklahoma	306	100%	11	3.6%	33	10.8%	262	85.6%
Phoenix	230	100%	7	3.0%	33	14.3%	190	82.6%
Portland	97	100%	5	5.2%	9	9.3%	83	85.6%
Tucson	81	100%	1	1.2%	13	16.0%	67	82.7%
Non-IHS Counties	168	100%	4	2.4%	14	8.3%	150	89.3%

Women

IHS Area	All Ages Number	All Ages Percent	Ages under 35 Number	Ages under 35 Percent	Ages 35 to 64 Number	Ages 35 to 64 Percent	Ages 65 and over Number	Ages 65 and over Percent
All US Counties	1,871	100%	50	2.7%	157	8.4%	1,664	88.9%
IHS Area Counties	1,700	100%	46	2.7%	140	8.2%	1,514	89.1%
Aberdeen	125	100%	6	4.8%	10	8.0%	109	87.2%
Alaska	24	100%	0	0.0%	4	16.7%	20	83.3%
Albuquerque	160	100%	2	1.3%	14	8.8%	144	90.0%
Bemidji	138	100%	3	2.2%	8	5.8%	127	92.0%
Billings	68	100%	1	1.5%	4	5.9%	63	92.6%
California	87	100%	3	3.4%	5	5.7%	79	90.8%
Nashville	65	100%	2	3.1%	1	1.5%	62	95.4%
Navajo	345	100%	12	3.5%	25	7.2%	308	89.3%
Oklahoma	292	100%	10	3.4%	20	6.8%	262	89.7%
Phoenix	221	100%	1	0.5%	30	13.6%	190	86.0%
Portland	100	100%	6	6.0%	11	11.0%	83	83.0%
Tucson	75	100%	0	0.0%	8	10.7%	67	89.3%
Non-IHS Counties	171	100%	4	2.3%	17	9.9%	150	87.7%

Table B.11
Number and Percent of AIAN Medicare Enrollees with Hospital Coverage, Medical Coverage or Both for at least one month in each Service Area
Calendar Year 2006

	Total		Hospital-only		Medical-only		Hospital and Medical	
IHS Area	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All US Counties	160,963	100.0%	14,694	9.1%	177	0.1%	146,092	90.8%
IHS Area Counties	139,363	100.0%	13,298	9.5%	163	0.1%	125,902	90.3%
Aberdeen	8,202	100.0%	1,205	14.7%	13	0.2%	6,984	85.1%
Alaska	9,581	100.0%	1,079	11.3%	3	0.0%	8,499	88.7%
Albuquerque	6,039	100.0%	817	13.5%	4	0.1%	5,218	86.4%
Bemidji	10,365	100.0%	957	9.2%	7	0.1%	9,401	90.7%
Billings	5,371	100.0%	629	11.7%	5	0.1%	4,737	88.2%
California	9,735	100.0%	544	5.6%	6	0.1%	9,185	94.4%
Nashville	4,906	100.0%	422	8.6%	3	0.1%	4,481	91.3%
Navajo	19,861	100.0%	2,168	10.9%	43	0.2%	17,650	88.9%
Oklahoma	41,461	100.0%	3,177	7.7%	18	0.0%	38,266	92.3%
Phoenix	9,502	100.0%	1,017	10.7%	12	0.1%	8,473	89.2%
Portland	12,506	100.0%	1,077	8.6%	46	0.4%	11,383	91.0%
Tucson	1,834	100.0%	206	11.2%	3	0.2%	1,625	88.6%
Non-IHS Counties	21,600	100.0%	1,396	6.5%	14	0.1%	20,190	93.5%

Table B.12

Number and Percent of AIAN Medicare Enrollees with Hospital Coverage, Medical Coverage or Both, for at least one month in each Service Area by Eligibility Group

Calendar Year 2006

Aged with and without ESRD

IHS Area	Total Number	Total Percent	Hospital-only Number	Hospital-only Percent	Medical-only Number	Medical-only Percent	Hospital and Medical Number	Hospital and Medical Percent
All US Counties	115,088	100.0%	10,488	9.1%	175	0.2%	104,425	90.7%
IHS Area Counties	100,969	100.0%	9,771	9.7%	161	0.2%	91,037	90.2%
Aberdeen	5,540	100.0%	921	16.6%	11	0.2%	4,608	83.2%
Alaska	7,492	100.0%	911	12.2%	3	0.0%	6,578	87.8%
Albuquerque	4,494	100.0%	675	15.0%	4	0.1%	3,815	84.9%
Bemidji	6,994	100.0%	628	9.0%	7	0.1%	6,359	90.9%
Billings	3,964	100.0%	499	12.6%	5	0.1%	3,460	87.3%
California	6,880	100.0%	353	5.1%	6	0.1%	6,521	94.8%
Nashville	3,324	100.0%	273	8.2%	3	0.1%	3,048	91.7%
Navajo	15,496	100.0%	1,783	11.5%	43	0.3%	13,670	88.2%
Oklahoma	30,456	100.0%	2,107	6.9%	18	0.1%	28,331	93.0%
Phoenix	6,348	100.0%	691	10.9%	12	0.2%	5,645	88.9%
Portland	8,820	100.0%	800	9.1%	46	0.5%	7,974	90.4%
Tucson	1,161	100.0%	130	11.2%	3	0.3%	1,028	88.5%
Non-IHS Counties	14,119	100.0%	717	5.1%	14	0.1%	13,388	94.8%

Disabled with and without ESRD

IHS Area	Total Number	Total Percent	Hospital-only Number	Hospital-only Percent	Medical-only Number	Medical-only Percent	Hospital and Medical Number	Hospital and Medical Percent
All US Counties	45,238	100.0%	4,119	9.1%	2	0.0%	41,117	90.9%
IHS Area Counties	37,801	100.0%	3,446	9.1%	2	0.0%	34,353	90.9%
Aberdeen	2,603	100.0%	276	10.6%	2	0.1%	2,325	89.3%
Alaska	2,078	100.0%	168	8.1%	0	0.0%	1,910	91.9%
Albuquerque	1,483	100.0%	130	8.8%	0	0.0%	1,353	91.2%
Bemidji	3,345	100.0%	326	9.7%	0	0.0%	3,019	90.3%
Billings	1,383	100.0%	121	8.7%	0	0.0%	1,262	91.3%
California	2,826	100.0%	185	6.5%	0	0.0%	2,641	93.5%
Nashville	1,563	100.0%	147	9.4%	0	0.0%	1,416	90.6%
Navajo	4,250	100.0%	371	8.7%	0	0.0%	3,879	91.3%
Oklahoma	10,915	100.0%	1,059	9.7%	0	0.0%	9,856	90.3%
Phoenix	3,064	100.0%	317	10.3%	0	0.0%	2,747	89.7%
Portland	3,650	100.0%	274	7.5%	0	0.0%	3,376	92.5%
Tucson	641	100.0%	72	11.2%	0	0.0%	569	88.8%
Non-IHS Counties	7,437	100.0%	673	9.0%	0	0.0%	6,764	91.0%

Appendix B Enrollment Data for the IHS Service Areas

With ESRD, including Aged and Disabled

IHS Area	Total		Hospital-only		Medical-only		Hospital and Medical	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All US Counties	4,958	100.0%	241	4.9%	0	0.0%	4,717	95.1%
IHS Area Counties	4,496	100.0%	229	5.1%	0	0.0%	4,267	94.9%
Aberdeen	381	100.0%	25	6.6%	0	0.0%	356	93.4%
Alaska	65	100.0%	5	7.7%	0	0.0%	60	92.3%
Albuquerque	416	100.0%	20	4.8%	0	0.0%	396	95.2%
Bemidji	308	100.0%	13	4.2%	0	0.0%	295	95.8%
Billings	184	100.0%	15	8.2%	0	0.0%	169	91.8%
California	203	100.0%	12	5.9%	0	0.0%	191	94.1%
Nashville	196	100.0%	14	7.1%	0	0.0%	182	92.9%
Navajo	816	100.0%	48	5.9%	0	0.0%	768	94.1%
Oklahoma	796	100.0%	22	2.8%	0	0.0%	774	97.2%
Phoenix	691	100.0%	31	4.5%	0	0.0%	660	95.5%
Portland	236	100.0%	13	5.5%	0	0.0%	223	94.5%
Tucson	204	100.0%	11	5.4%	0	0.0%	193	94.6%
Non-IHS Counties	462	100.0%	12	2.6%	0	0.0%	450	97.4%

Table B.13
Number and Percent of AIAN Medicare Enrollees with Hospital Coverage, Medical Coverage or Both
All Year long in each Service Area
Calendar Year 2006

IHS Area	Total		Hospital-only		Medical-only		Hospital and Medical	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All US Counties	141,344	100%	12,653	9.0%	115	0.1%	128,576	91.0%
IHS Area Counties	122,353	100%	11,481	9.4%	115	0.1%	110,757	90.5%
Aberdeen	7,153	100%	1,064	14.9%	7	0.1%	6,082	85.0%
Alaska	8,463	100%	953	11.3%	1	0.0%	7,509	88.7%
Albuquerque	5,294	100%	722	13.6%	4	0.1%	4,568	86.3%
Bemidji	9,104	100%	809	8.9%	0	0.0%	8,295	91.1%
Billings	4,691	100%	557	11.9%	0	0.0%	4,134	88.1%
California	8,640	100%	464	5.4%	4	0.0%	8,172	94.6%
Nashville	4,316	100%	359	8.3%	3	0.1%	3,954	91.6%
Navajo	17,483	100%	1,906	10.9%	33	0.2%	15,544	88.9%
Oklahoma	36,438	100%	2,653	7.3%	14	0.0%	33,771	92.7%
Phoenix	8,223	100%	878	10.7%	10	0.1%	7,335	89.2%
Portland	10,972	100%	930	8.5%	36	0.3%	10,006	91.2%
Tucson	1,576	100%	186	11.8%	3	0.2%	1,387	88.0%
Non-IHS Counties	18,991	100%	1,172	6.2%	0	0.0%	17,819	93.8%

Table B.14
Number and Percent of AIAN Medicare Enrollees with Fee-for-Service or Managed Care Coverage in each Service Area
Calendar Year 2006

	All		Fee-for-Service		Managed Care	
IHS Area	Number	Percent	Number	Percent	Number	Percent
All US Counties	160,963	100.0%	146,404	91.0%	14,559	9.0%
IHS Area Counties	139,363	100.0%	128,033	91.9%	11,330	8.1%
Aberdeen	8,202	100.0%	7,911	96.5%	291	3.5%
Alaska	9,581	100.0%	9,577	100.0%	4	0.0%
Albuquerque	6,039	100.0%	5,639	93.4%	400	6.6%
Bemidji	10,365	100.0%	9,528	91.9%	837	8.1%
Billings	5,371	100.0%	5,155	96.0%	216	4.0%
California	9,735	100.0%	8,367	85.9%	1,368	14.1%
Nashville	4,906	100.0%	4,689	95.6%	217	4.4%
Navajo	19,861	100.0%	19,506	98.2%	355	1.8%
Oklahoma	41,461	100.0%	36,805	88.8%	4,656	11.2%
Phoenix	9,502	100.0%	8,386	88.3%	1,116	11.7%
Portland	12,506	100.0%	10,999	87.9%	1,507	12.1%
Tucson	1,834	100.0%	1,471	80.2%	363	19.8%
Non-IHS Counties	21,600	100.0%	18,371	85.1%	3,229	14.9%

Table B.15
Number and Percent of AIAN Medicare Enrollees with Fee-for-Service or Managed Care Coverage in each Service Area by Eligibility Group
Calendar Year 2006

Aged

IHS Area	Fee-for-Service Number	Fee-for-Service Percent	Managed Care Number	Managed Care Percent
All US Counties	103,080	100.0%	12,008	100.0%
IHS Area Counties	91,653	88.9%	9,316	77.6%
Aberdeen	5,317	5.2%	223	1.9%
Alaska	7,489	7.3%	3	0.0%
Albuquerque	4,141	4.0%	353	2.9%
Bemidji	6,262	6.1%	732	6.1%
Billings	3,773	3.7%	191	1.6%
California	5,670	5.5%	1,210	10.1%
Nashville	3,157	3.1%	167	1.4%
Navajo	15,211	14.8%	285	2.4%
Oklahoma	26,555	25.8%	3,901	32.5%
Phoenix	5,580	5.4%	768	6.4%
Portland	7,569	7.3%	1,251	10.4%
Tucson	929	0.9%	232	1.9%
Non-IHS Counties	11,427	11.1%	2,692	22.4%

Disabled

IHS Area	Fee-for-Service Number	Fee-for-Service Percent	Managed Care Number	Managed Care Percent
All US Counties	42,705	100.0%	2,533	100.0%
IHS Area Counties	35,803	83.8%	1,998	78.9%
Aberdeen	2,536	5.9%	67	2.6%
Alaska	2,077	4.9%	1	0.0%
Albuquerque	1,437	3.4%	46	1.8%
Bemidji	3,240	7.6%	105	4.1%
Billings	1,358	3.2%	25	1.0%
California	2,670	6.3%	156	6.2%
Nashville	1,513	3.5%	50	2.0%
Navajo	4,180	9.8%	70	2.8%
Oklahoma	10,160	23.8%	755	29.8%
Phoenix	2,724	6.4%	340	13.4%
Portland	3,394	7.9%	256	10.1%
Tucson	514	1.2%	127	5.0%
Non-IHS Counties	6,902	16.2%	535	21.1%

Appendix B Enrollment Data for the IHS Service Areas

ESRD*

IHS Area	Fee-for-Service Number	Fee-for-Service Percent	Managed Care Number	Managed Care Percent
All US Counties	4,815	100.0%	143	100.0%
IHS Area Counties	4,375	90.9%	121	84.6%
Aberdeen	378	7.9%	3	2.1%
Alaska	65	1.3%	0	0.0%
Albuquerque	413	8.6%	3	2.1%
Bemidji	300	6.2%	8	5.6%
Billings	184	3.8%	0	0.0%
California	194	4.0%	9	6.3%
Nashville	194	4.0%	2	1.4%
Navajo	814	16.9%	2	1.4%
Oklahoma	762	15.8%	34	23.8%
Phoenix	662	13.7%	29	20.3%
Portland	228	4.7%	8	5.6%
Tucson	181	3.8%	23	16.1%
Non-IHS Counties	440	9.1%	22	15.4%

*Includes Aged and Disabled with ESRD and ESRD-only

Table B.16
Number of AIAN Medicare Enrollees with Managed Care Coverage for a Full year as a Percent of those covered one month or more in each Service Area
Calendar Year 2006

	Managed Care Coverage			
	One or more months		Full Year (12 months)	
IHS Area	Number	Percent	Number	Percent
All US Counties	14,559	100%	8,198	56.3%
IHS Area Counties	11,330	100%	6,069	53.6%
Aberdeen	291	100%	42	14.4%
Alaska	4	100%	3	75.0%
Albuquerque	400	100%	279	69.8%
Bemidji	837	100%	429	51.3%
Billings	216	100%	34	15.7%
California	1,368	100%	1,039	76.0%
Nashville	217	100%	121	55.8%
Navajo	355	100%	143	40.3%
Oklahoma	4,656	100%	1,799	38.6%
Phoenix	1,116	100%	836	74.9%
Portland	1,507	100%	1,067	70.8%
Tucson	363	100%	277	76.3%
Non-IHS Counties	3,229	100%	2,129	65.9%

Table B.17
Number and Percent of AIAN Medicare Enrollees with one or more months of Hospital or Medical or Both Coverage for whom their State Medicaid Programs paid any premiums (Buy-in) in each Service area
Calendar Year 2006

	Hospital-only			Medical-only			Hospital and Medical		
	Total Enrollees	State Buy-in		Total Enrollees	State Buy-in		Total Enrollees	State Buy-in	
IHS Area	Number	Number	Percent	Number	Number	Percent	Number	Number	Percent
All US Counties	14,694	39	0.00	177	160	90.4%	146,092	57,381	39.3%
IHS Area Counties	13,298	38	0.00	163	151	92.6%	125,902	50,701	40.3%
Aberdeen	1,205	1	0.00	13	10	76.9%	6,984	3,497	50.1%
Alaska	1,079	1	0.00	3	2	66.7%	8,499	4,058	47.7%
Albuquerque	817	3	0.00	4	4	100.0%	5,218	2,126	40.7%
Bemidji	957	3	0.00	7	6	85.7%	9,401	3,279	34.9%
Billings	629	0	0.00	5	5	100.0%	4,737	1,995	42.1%
California	544	1	0.00	6	6	100.0%	9,185	3,849	41.9%
Nashville	422	1	0.00	3	2	66.7%	4,481	1,536	34.3%
Navajo	2,168	22	0.01	43	39	90.7%	17,650	10,838	61.4%
Oklahoma	3,177	2	0.00	18	18	100.0%	38,266	10,899	28.5%
Phoenix	1,017	3	0.00	12	12	100.0%	8,473	3,840	45.3%
Portland	1,077	1	0.00	46	44	95.7%	11,383	3,886	34.1%
Tucson	206	0	0.00	3	3	100.0%	1,625	898	55.3%
Non-IHS Counties	1,396	1	0.00	14	9	64.3%	20,190	6,680	33.1%

Table B.18
Number and Percent of AIAN Medicare Enrollees with one or more months of Hospital or Medical or Both Coverage for whom their State Medicaid Program paid any premiums (Buy-in) in each Service Area by Eligibility Group
Calendar Year 2006

Aged

IHS Area	Hospital-only			Medical-only			Hospital and Medical		
	Total Enrollees	State Buy-in		Total Enrollees	State Buy-in		Total Enrollees	State Buy-in	
	Number	Number	Percent	Number	Number	Percent	Number	Number	Percent
All US Counties	10,488	30	0.3%	175	160	91.4%	104,425	32,624	31.2%
IHS Area Counties	9,771	30	0.3%	161	151	93.8%	91,037	29,891	32.8%
Aberdeen	921	1	0.1%	11	10	90.9%	4,608	1,926	41.8%
Alaska	911	1	0.1%	3	2	66.7%	6,578	2,690	40.9%
Albuquerque	675	1	0.1%	4	4	100.0%	3,815	1,299	34.0%
Bemidji	628	2	0.3%	7	6	85.7%	6,359	1,501	23.6%
Billings	499	0	0.0%	5	5	100.0%	3,460	1,200	34.7%
California	353	1	0.3%	6	6	100.0%	6,521	2,008	30.8%
Nashville	273	0	0.0%	3	2	66.7%	3,048	788	25.9%
Navajo	1,783	20	1.1%	43	39	90.7%	13,670	8,087	59.2%
Oklahoma	2,107	1	0.0%	18	18	100.0%	28,331	5,997	21.2%
Phoenix	691	3	0.4%	12	12	100.0%	5,645	2,060	36.5%
Portland	800	0	0.0%	46	44	95.7%	7,974	1,852	23.2%
Tucson	130	0	0.0%	3	3	100.0%	1,028	483	47.0%
Non-IHS Counties	717	0	0.0%	14	9	64.3%	13,388	2,733	20.4%

Disabled

IHS Area	Hospital-only			Medical-only			Hospital and Medical		
	Total Enrollees	State Buy-in		Total Enrollees	State Buy-in		Total Enrollees	State Buy-in	
	Number	Number	Percent	Number	Number	Percent	Number	Number	Percent
All US Counties	4,119	30	0.2%	2	160	0.0%	41,117	32,624	59.3%
IHS Area Counties	3,446	30	0.2%	2	151	0.0%	34,353	29,891	59.5%
Aberdeen	276	1	0.0%	2	10	0.0%	2,325	1,926	66.0%
Alaska	168	1	0.0%	0	2	0.0%	1,910	2,690	71.3%
Albuquerque	130	1	1.5%	0	4	0.0%	1,353	1,299	58.5%
Bemidji	326	2	0.3%	0	6	0.0%	3,019	1,501	58.4%
Billings	121	0	0.0%	0	5	0.0%	1,262	1,200	62.0%
California	185	1	0.0%	0	6	0.0%	2,641	2,008	69.0%
Nashville	147	0	0.7%	0	2	0.0%	1,416	788	52.3%
Navajo	371	20	0.3%	0	39	0.0%	3,879	8,087	69.0%
Oklahoma	1,059	1	0.1%	0	18	0.0%	9,856	5,997	49.2%
Phoenix	317	3	0.0%	0	12	0.0%	2,747	2,060	62.9%
Portland	274	0	0.4%	0	44	0.0%	3,376	1,852	59.6%
Tucson	72	0	0.0%	0	3	0.0%	569	483	69.1%
Non-IHS Counties	673	0	0.1%	0	9	0.0%	6,764	2,733	57.9%

Appendix B Enrollment Data for the IHS Service Areas

ESRD*

IHS Area	Hospital-only			Medical-only			Hospital and Medical		
	Total Enrollees	State Buy-in		Total Enrollees	State Buy-in		Total Enrollees	State Buy-in	
	Number	Number	Percent	Number	Number	Percent	Number	Number	Percent
All US Counties	4,119	1	0.0%	2	0	0.0%	41,117	2,732	6.6%
IHS Area Counties	3,446	1	0.0%	2	0	0.0%	34,353	2,485	7.2%
Aberdeen	276	0	0.0%	2	0	0.0%	2,325	201	8.6%
Alaska	168	0	0.0%	0	0	0.0%	1,910	40	2.1%
Albuquerque	130	0	0.0%	0	0	0.0%	1,353	228	16.9%
Bemidji	326	0	0.0%	0	0	0.0%	3,019	121	4.0%
Billings	121	0	0.0%	0	0	0.0%	1,262	99	7.8%
California	185	0	0.0%	0	0	0.0%	2,641	135	5.1%
Nashville	147	0	0.0%	0	0	0.0%	1,416	83	5.9%
Navajo	371	1	0.3%	0	0	0.0%	3,879	520	13.4%
Oklahoma	1,059	0	0.0%	0	0	0.0%	9,856	396	4.0%
Phoenix	317	0	0.0%	0	0	0.0%	2,747	397	14.5%
Portland	274	0	0.0%	0	0	0.0%	3,376	137	4.1%
Tucson	72	0	0.0%	0	0	0.0%	569	128	22.5%
Non-IHS Counties	673	0	0.0%	0	0	0.0%	6,764	247	3.7%

*Includes Aged and Disabled with ESRD and ESRD-only

Table B.19
Number and Percent of AIAN Medicare Enrollees with Full year Coverage for whom their State-Medicaid Programs paid any premiums (Buy-in) in each Service area
Calendar Year 2006

	Hospital-only			Medical-only			Hospital and Medical		
	Total Enrollees	State Buy-in		Total Enrollees	State Buy-in		Total Enrollees	State Buy-in	
IHS Area	Number	Number	Percent	Number	Number	Percent	Number	Number	Percent
All US Counties	12,641	25	0.00	119	114	95.8%	121,964	44,208	36.2%
IHS Area Counties	11,469	24	0.00	112	109	97.3%	104,971	39,164	37.3%
Aberdeen	1,063	0	0.00	6	5	83.3%	5,706	2,709	47.5%
Alaska	953	0	0.00	1	1	100.0%	7,085	3,180	44.9%
Albuquerque	721	2	0.00	4	4	100.0%	4,346	1,715	39.5%
Bemidji	806	0	0.00	0	0	0.0%	7,873	2,438	31.0%
Billings	557	0	0.00	0	0	0.0%	3,896	1,517	38.9%
California	464	1	0.00	4	4	100.0%	7,746	2,974	38.4%
Nashville	359	1	0.00	2	1	50.0%	3,777	1,199	31.7%
Navajo	1,900	16	0.01	32	31	96.9%	14,432	8,746	60.6%
Oklahoma	2,652	0	0.00	14	14	100.0%	32,605	8,410	25.8%
Phoenix	878	3	0.00	10	10	100.0%	6,728	2,751	40.9%
Portland	930	1	0.00	36	36	100.0%	9,504	2,868	30.2%
Tucson	186	0	0.00	3	3	100.0%	1,273	657	51.6%
Non-IHS Counties	1,172	1	0.00	7	5	71.4%	16,993	5,044	29.7%

Appendix C
AIAN Health Care Utilization Data
Hospital Services and Payments by IHS Area

Source Data File:
Medical Provider for Analysis and Review (MedPAR) File for 2006

Hospital Stays	**Tables**								
Hospital Type	C.1	C.2	C.16	C.17					
Eligibility Group	C.2	C.3	C.4						
Coverage	C.6								
Hospital Days	**Tables**								
Hospital Type	C.7	C.8	C.9	C.10					
Eligibility Group	C.8	C.10							
Coverage	C.9	C.10							
Hospital Payments	**Tables**								
Hospital Type	C.11	C.12	C.13	C.15	C.18	C.19	C.20	C.21	C.22
Eligibility Group	C.12	C.13	C.19	C.20					
Payer	C.11	C.12	C.13	C.15	C.21	C.22			

Table C.1
Number and Percent of Hospital Stays (Discharges) of AIAN Medicare Enrollees
in each Service Area by Hospital type
Calendar Year 2006

IHS Area	Total		Short Stay Hospitals		Long Stay Hospitals	
	Number	Percent	Number	Percent	Number	Percent
All US Counties	64,198	100%	56,960	88.7%	7,238	11.3%
IHS Area Counties	55,866	100%	49,392	88.4%	6,474	11.6%
Aberdeen	4,288	100%	3,716	86.7%	572	13.3%
Alaska	3,372	100%	2,869	85.1%	503	14.9%
Albuquerque	1,865	100%	1,741	93.4%	124	6.6%
Bemidji	4,358	100%	3,586	82.3%	772	17.7%
Billings	2,839	100%	2,160	76.1%	679	23.9%
California	2,742	100%	2,508	91.5%	234	8.5%
Nashville	2,029	100%	1,834	90.4%	195	9.6%
Navajo	7,613	100%	6,942	91.2%	671	8.8%
Oklahoma	17,797	100%	16,164	90.8%	1,633	9.2%
Phoenix	4,184	100%	3,707	88.6%	477	11.4%
Portland	3,911	100%	3,341	85.4%	570	14.6%
Tucson	868	100%	824	94.9%	44	5.1%
Non-IHS Counties	8,332	100%	7,568	90.8%	764	9.2%

Table C.2
Number and Percent of Hospital Stays (Discharges) of AIAN Medicare Enrollees in each Service Area
by Hospital type and Disability Group
Calendar Year 2006

Aged

IHS Area	Total Number	Total Percent	Short-Stay Hospitals Number	Short-Stay Hospitals Percent	Long-Stay Hospitals Number	Long-Stay Hospitals Percent
All US Counties	43,337	100%	38,355	88.5%	4,982	11.5%
IHS Area Counties	38,352	100%	33,813	88.2%	4,539	11.8%
Aberdeen	2,789	100%	2,380	85.3%	409	14.7%
Alaska	2,642	100%	2,253	85.3%	389	14.7%
Albuquerque	1,187	100%	1,104	93.0%	83	7.0%
Bemidji	2,732	100%	2,202	80.6%	530	19.4%
Billings	2,049	100%	1,543	75.3%	506	24.7%
California	1,779	100%	1,635	91.9%	144	8.1%
Nashville	1,300	100%	1,185	91.2%	115	8.8%
Navajo	5,819	100%	5,270	90.6%	549	9.4%
Oklahoma	12,418	100%	11,388	91.7%	1,030	8.3%
Phoenix	2,484	100%	2,164	87.1%	320	12.9%
Portland	2,697	100%	2,257	83.7%	440	16.3%
Tucson	456	100%	432	94.7%	24	5.3%
Non-IHS Counties	4,985	100%	4,542	91.1%	443	8.9%

Disabled and ESRD-only

IHS Area	Total Number	Total Percent	Short-Stay Hospitals Number	Short-Stay Hospitals Percent	Long-Stay Hospitals Number	Long-Stay Hospitals Percent
All US Counties	20,861	100%	18,605	89.2%	2,256	10.8%
IHS Area Counties	17,514	100%	15,579	89.0%	1,935	11.0%
Aberdeen	1,499	100%	1,336	89.1%	163	10.9%
Alaska	730	100%	616	84.4%	114	15.6%
Albuquerque	678	100%	637	94.0%	41	6.0%
Bemidji	1,626	100%	1,384	85.1%	242	14.9%
Billings	790	100%	617	78.1%	173	21.9%
California	963	100%	873	90.7%	90	9.3%
Nashville	729	100%	649	89.0%	80	11.0%
Navajo	1,794	100%	1,672	93.2%	122	6.8%
Oklahoma	5,379	100%	4,776	88.8%	603	11.2%
Phoenix	1,700	100%	1,543	90.8%	157	9.2%
Portland	1,214	100%	1,084	89.3%	130	10.7%
Tucson	412	100%	392	95.1%	20	4.9%
Non-IHS Counties	3,347	100%	3,026	90.4%	321	9.6%

Table C.3
Number and Percent of Hospital Stays (Discharges) of AIAN Medicare Enrollees
in each Hospital type by Service Area
Calendar Year 2006

IHS Area	Short Stay Hospitals		Long Stay Hospitals	
	Number	Percent	Number	Percent
All US Counties	56,960	100%	7,238	100%
IHS Area Counties	49,392	86.7%	6,474	89.4%
Aberdeen	3,716	6.5%	572	7.9%
Alaska	2,869	5.0%	503	6.9%
Albuquerque	1,741	3.1%	124	1.7%
Bemidji	3,586	6.3%	772	10.7%
Billings	2,160	3.8%	679	9.4%
California	2,508	4.4%	234	3.2%
Nashville	1,834	3.2%	195	2.7%
Navajo	6,942	12.2%	671	9.3%
Oklahoma	16,164	28.4%	1,633	22.6%
Phoenix	3,707	6.5%	477	6.6%
Portland	3,341	5.9%	570	7.9%
Tucson	824	1.4%	44	0.6%
Non-IHS Counties	7,568	13.3%	764	10.6%

Table C.4
Number and Percent of Hospital Stays (Discharges) of AIAN Enrollees
in each Hospital type by Service Area and Eligibility Group
Calendar Year 2006

Aged

IHS Area	Short-Stay Hospitals Number	Short-Stay Hospitals Percent	Long-Stay Hospitals Number	Long-Stay Hospitals Percent
All US Counties	38,355	100%	4,982	100%
IHS Area Counties	33,813	88.2%	4,539	91.1%
Aberdeen	2,380	6.2%	409	8.2%
Alaska	2,253	5.9%	389	7.8%
Albuquerque	1,104	2.9%	83	1.7%
Bemidji	2,202	5.7%	530	10.6%
Billings	1,543	4.0%	506	10.2%
California	1,635	4.3%	144	2.9%
Nashville	1,185	3.1%	115	2.3%
Navajo	5,270	13.7%	549	11.0%
Oklahoma	11,388	29.7%	1,030	20.7%
Phoenix	2,164	5.6%	320	6.4%
Portland	2,257	5.9%	440	8.8%
Tucson	432	1.1%	24	0.5%
Non-IHS Counties	4,542	11.8%	443	8.9%

Disabled and ESRD-only

IHS Area	Short-Stay Hospitals Number	Short-Stay Hospitals Percent	Long-Stay Hospitals Number	Long-Stay Hospitals Percent
All US Counties	18,605	100%	2,256	100%
IHS Area Counties	15,579	83.7%	1,935	85.8%
Aberdeen	1,336	7.2%	163	7.2%
Alaska	616	3.3%	114	5.1%
Albuquerque	637	3.4%	41	1.8%
Bemidji	1,384	7.4%	242	10.7%
Billings	617	3.3%	173	7.7%
California	873	4.7%	90	4.0%
Nashville	649	3.5%	80	3.5%
Navajo	1,672	9.0%	122	5.4%
Oklahoma	4,776	25.7%	603	26.7%
Phoenix	1,543	8.3%	157	7.0%
Portland	1,084	5.8%	130	5.8%
Tucson	392	2.1%	20	0.9%
Non-IHS Counties	3,026	16.3%	321	14.2%

Table C.5
Hospitalization Rates per 1,000 AIAN Medicare Enrollees with Hospital Coverage (either alone or with Medical Coverage), and not in Managed Care, in each Service Area by Hospital Type
Calendar Year 2006

IHS Area	Enrollees With Hospital Coverage Number	Enrollees In Managed Care Number	Short Stay Hospitals Stays	Short Stay Hospitals Stays Per 1000 Enrollees	Long Stay Hospitals Stays	Long Stay Hospitals Stays Per 1000 Enrollees
All US Counties	160,786	14,559	56,960	390	7,238	49
IHS Area Counties	139,200	11,330	49,392	386	6,474	51
Aberdeen	8,189	291	3,716	470	572	72
Alaska	9,578	4	2,869	300	503	53
Albuquerque	6,035	400	1,741	309	124	22
Bemidji	10,358	837	3,586	377	772	81
Billings	5,366	216	2,160	419	679	132
California	9,729	1,368	2,508	300	234	28
Nashville	4,903	217	1,834	391	195	42
Navajo	19,818	355	6,942	357	671	34
Oklahoma	41,443	4,656	16,164	439	1,633	44
Phoenix	9,490	1,116	3,707	443	477	57
Portland	12,460	1,507	3,341	305	570	52
Tucson	1,831	363	824	561	44	30
Non-IHS Counties	21,586	3,229	7,568	412	764	42

Table C.6
Hospitalization rate per 1000 AIAN enrollees with Hospital Coverage (alone or with Medical Coverage), and not in Managed Care, in each Service Area by Hospital Type and Eligibility Group
Calendar Year 2006

Aged

IHS Area	Enrollees with Hospital Coverage Number	Enrollees in Managed Care Number	Short Stay Stays	Hospitals Stays per 1000 Enrollees	Long Stay Stays	Hospitals Stays per 1000 Enrollees
All US Counties	114,913	12,008	38,355	373	4,982	48
IHS Area Counties	100,808	9,316	33,813	370	4,539	50
Aberdeen	5,529	223	2,380	449	409	77
Alaska	7,489	3	2,253	301	389	52
Albuquerque	4,490	353	1,104	267	83	20
Bemidji	6,987	732	2,202	352	530	85
Billings	3,959	191	1,543	410	506	134
California	6,874	1,210	1,635	289	144	25
Nashville	3,321	167	1,185	376	115	36
Navajo	15,453	285	5,270	347	549	36
Oklahoma	30,438	3,901	11,388	429	1,030	39
Phoenix	6,336	768	2,164	389	320	57
Portland	8,774	1,251	2,257	300	440	58
Tucson	1,158	232	432	467	24	26
Non-IHS Counties	14,105	2,692	4,542	398	443	39

Disabled and ESRD-only

IHS Area	Enrollees with Hospital Coverage Number	Enrollees in Managed Care Number	Short Stay Stays	Hospitals Stays per 1000 Enrollees	Long Stay Stays	Hospitals Stays per 1000 Enrollees
All US Counties	45,873	2,551	18,605	429	2,256	52
IHS Area Counties	38,392	2,014	15,579	428	1,935	53
Aberdeen	2,660	68	1,336	515	163	63
Alaska	2,089	1	616	295	114	55
Albuquerque	1,545	47	637	425	41	27
Bemidji	3,371	105	1,384	424	242	74
Billings	1,407	25	617	446	173	125
California	2,855	158	873	324	90	33
Nashville	1,582	50	649	424	80	52
Navajo	4,365	70	1,672	389	122	28
Oklahoma	11,005	755	4,776	466	603	59
Phoenix	3,154	348	1,543	550	157	56
Portland	3,686	256	1,084	316	130	38
Tucson	673	131	392	723	20	37
Non-IHS Counties	7,481	537	3,026	436	321	46

Table C.7
Number and Percent of Hospital Days of Stay and Average Days per Stay of AIAN Medicare Enrollees in each Hospital Type by Service Area
Calendar Year 2006

	Short-Stay Hospital			Long-Stay Hospital		
IHS Area	Days	Percent	Days per Stay	Days	Percent	Days per Stay
All US Counties	304,974	100.0%	5.4	63,260	100.0%	8.7
IHS Area Counties	263,929	86.5%	5.3	54,426	86.0%	8.4
Aberdeen	19,051	6.2%	5.1	2,687	4.2%	4.7
Alaska	19,665	6.4%	6.9	2,581	4.1%	5.1
Albuquerque	9,140	3.0%	5.2	1,850	2.9%	14.9
Bemidji	17,305	5.7%	4.8	4,209	6.7%	5.5
Billings	11,013	3.6%	5.1	3,105	4.9%	4.6
California	13,489	4.4%	5.4	1,807	2.9%	7.7
Nashville	10,123	3.3%	5.5	1,557	2.5%	8.0
Navajo	37,370	12.3%	5.4	5,553	8.8%	8.3
Oklahoma	84,624	27.7%	5.2	20,534	32.5%	12.6
Phoenix	20,869	6.8%	5.6	5,198	8.2%	10.9
Portland	16,122	5.3%	4.8	4,433	7.0%	7.8
Tucson	5,158	1.7%	6.3	912	1.4%	20.7
Non-IHS Counties	41,045	13.5%	5.4	8,834	14.0%	11.6

Table C.8
Number and Percent of Hospital Days of Stay and Average Days per Stay of AIAN Medicare Enrollees in each Hospital Type by Service Area and Eligibility Group
Calendar Year 2006

Aged

	Short-Stay Hospital			Long-Stay Hospital		
IHS Area	Days	Percent	Days per Stay	Days	Percent	Days per Stay
All US Counties	202,947	100.0%	3.2	35,760	100.0%	0.6
IHS Area Counties	178,719	88.1%	3.2	31,116	87.0%	0.6
Aberdeen	12,103	6.0%	2.8	1,565	4.4%	0.4
Alaska	15,667	7.7%	4.6	1,640	4.6%	0.5
Albuquerque	5,623	2.8%	3.0	989	2.8%	0.5
Bemidji	10,252	5.1%	2.4	1,839	5.1%	0.4
Billings	7,738	3.8%	2.7	1,896	5.3%	0.7
California	8,179	4.0%	3.0	781	2.2%	0.3
Nashville	6,293	3.1%	3.1	889	2.5%	0.4
Navajo	28,020	13.8%	3.7	3,858	10.8%	0.5
Oklahoma	59,671	29.4%	3.4	11,957	33.4%	0.7
Phoenix	11,905	5.9%	2.8	2,906	8.1%	0.7
Portland	10,608	5.2%	2.7	2,288	6.4%	0.6
Tucson	2,660	1.3%	3.1	508	1.4%	0.6
Non-IHS Counties	24,228	11.9%	2.9	4,644	13.0%	0.6

Disabled and ESRD-only

	Short-Stay Hospital			Long-Stay Hospital		
IHS Area	Days	Percent	Days per Stay	Days	Percent	Days per Stay
All US Counties	102,027	100.0%	1.6	27,500	100.0%	0.4
IHS Area Counties	85,210	83.5%	1.5	23,310	84.8%	0.4
Aberdeen	6,948	6.8%	1.6	1,122	4.1%	0.3
Alaska	3,998	3.9%	1.2	941	3.4%	0.3
Albuquerque	3,517	3.4%	1.9	861	3.1%	0.5
Bemidji	7,053	6.9%	1.6	2,370	8.6%	0.5
Billings	3,275	3.2%	1.2	1,209	4.4%	0.4
California	5,310	5.2%	1.9	1,026	3.7%	0.4
Nashville	3,830	3.8%	1.9	668	2.4%	0.3
Navajo	9,350	9.2%	1.2	1,695	6.2%	0.2
Oklahoma	24,953	24.5%	1.4	8,577	31.2%	0.5
Phoenix	8,964	8.8%	2.1	2,292	8.3%	0.5
Portland	5,514	5.4%	1.4	2,145	7.8%	0.5
Tucson	2,498	2.4%	2.9	404	1.5%	0.5
Non-IHS Counties	16,817	16.5%	2.0	4,190	15.2%	0.5

Table C.9
Days of Hospital Stay for AIAN Enrollees with Hospital Coverage (alone or with Medical Coverage), and not in Managed Care, and Days of Stay per 1,000 Enrollees in each Service Area by Hospital Type
Calendar Year 2006

IHS Area	Enrollees with Hospital Coverage Number	Enrollees in Managed Care Number	Short Stay Hospitals Days	Short Stay Hospitals Days Per 1000 Enrollees	Long Stay Hospitals Days	Long Stay Hospitals Days Per 1000 Enrollees
All US Counties	160,786	14,559	304,974	2,086	63,260	433
IHS Area Counties	139,200	11,330	263,929	2,064	54,426	426
Aberdeen	8,189	291	19,051	2,412	2,687	340
Alaska	9,578	4	19,665	2,054	2,581	270
Albuquerque	6,035	400	9,140	1,622	1,850	328
Bemidji	10,358	837	17,305	1,818	4,209	442
Billings	5,366	216	11,013	2,138	3,105	603
California	9,729	1,368	13,489	1,613	1,807	216
Nashville	4,903	217	10,123	2,160	1,557	332
Navajo	19,818	355	37,370	1,920	5,553	285
Oklahoma	41,443	4,656	84,624	2,300	20,534	558
Phoenix	9,490	1,116	20,869	2,492	5,198	621
Portland	12,460	1,507	16,122	1,472	4,433	405
Tucson	1,831	363	5,158	3,514	912	621
Non-IHS Counties	21,586	3,229	41,045	2,236	8,834	481

Table C.10
Days of Hospital Stay for AIAN Enrollees with Hospital Coverage (alone or with Medical Coverage), and not in Managed Care, and Days of Stay per 1,000 Enrollees in each Service Area by Hospital Type and Eligibility Group
Calendar Year 2006

Aged

IHS Area	Enrollees with Hospital Coverage Numbers	Enrollees in Managed Care Numbers	Short-Stay Hospitals Days	Short-Stay Hospitals Days per 1000 Enrollees	Long-Stay Hospitals Days	Long-Stay Hospitals Days per 1000 Enrollees
All US Counties	114,913	12,008	202,947	1,972	35,760	348
IHS Area Counties	100,808	9,316	178,719	1,953	31,116	340
Aberdeen	5,529	223	12,103	2,281	1,565	295
Alaska	7,489	3	15,667	2,093	1,640	219
Albuquerque	4,490	353	5,623	1,359	989	239
Bemidji	6,987	732	10,252	1,639	1,839	294
Billings	3,959	191	7,738	2,054	1,896	503
California	6,874	1,210	8,179	1,444	781	138
Nashville	3,321	167	6,293	1,995	889	282
Navajo	15,453	285	28,020	1,847	3,858	254
Oklahoma	30,438	3,901	59,671	2,249	11,957	451
Phoenix	6,336	768	11,905	2,138	2,906	522
Portland	8,774	1,251	10,608	1,410	2,288	304
Tucson	1,158	232	2,660	2,873	508	549
Non-IHS Counties	14,105	2,692	24,228	2,123	4,644	407

Disabled and ESRD-only

IHS Area	Enrollees with Hospital Coverage Numbers	Enrollees in Managed Care Numbers	Short-Stay Hospitals Days	Short-Stay Hospitals Days per 1000 Enrollees	Long-Stay Hospitals Days	Long-Stay Hospitals Days per 1000 Enrollees
All US Counties	45,236	2,533	102,027	991	27,500	267
IHS Area Counties	37,799	1,998	85,210	931	23,310	255
Aberdeen	2,601	67	6,948	1,309	1,122	211
Alaska	2,078	1	3,998	534	941	126
Albuquerque	1,483	46	3,517	850	861	208
Bemidji	3,345	105	7,053	1,128	2,370	379
Billings	1,383	25	3,275	869	1,209	321
California	2,826	156	5,310	938	1,026	181
Nashville	1,563	50	3,830	1,214	668	212
Navajo	4,250	70	9,350	616	1,695	112
Oklahoma	10,915	755	24,953	940	8,577	323
Phoenix	3,064	340	8,964	1,610	2,292	412
Portland	3,650	256	5,514	733	2,145	285
Tucson	641	127	2,498	2,698	404	436
Non-IHS Counties	7,437	535	16,817	1,473	4,190	367

Table C.11
Amounts and Percent of Medicare, Enrollee and Other Payer Payments (in thousands of dollars)
in each Service Area by Payer and Hospital Type
Calendar Year 2006

Short-Stay Hospitals

IHS Area	Total Payments Amount in 1000's	Total Payments Percent	Medicare Payments Amount in 1000's	Medicare Payments Percent	Enrollee Payments Amount in 1000's	Enrollee Payments Percent	Other Payer Amount in 1000's	Other Payer Percent
All US Counties	539,719	100.0%	482,368	89.4%	37,947	7.0%	19,404	3.6%
IHS Area Counties	470,208	100.0%	420,880	89.5%	32,866	7.0%	16,462	3.5%
Aberdeen	33,492	100.0%	28,606	85.4%	2,272	6.8%	2,614	7.8%
Alaska	41,818	100.0%	38,983	93.2%	2,124	5.1%	712	1.7%
Albuquerque	15,802	100.0%	14,267	90.3%	1,192	7.5%	343	2.2%
Bemidji	34,909	100.0%	29,794	85.3%	2,344	6.7%	2,771	7.9%
Billings	18,769	100.0%	16,865	89.9%	1,406	7.5%	498	2.7%
California	28,830	100.0%	25,834	89.6%	1,776	6.2%	1,220	4.2%
Nashville	16,232	100.0%	14,661	90.3%	1,258	7.8%	313	1.9%
Navajo	65,696	100.0%	60,122	91.5%	4,684	7.1%	890	1.4%
Oklahoma	134,375	100.0%	119,238	88.7%	10,502	7.8%	4,635	3.4%
Phoenix	36,463	100.0%	33,158	90.9%	2,435	6.7%	869	2.4%
Portland	35,170	100.0%	31,324	89.1%	2,284	6.5%	1,562	4.4%
Tucson	8,652	100.0%	8,027	92.8%	590	6.8%	35	0.4%
Non-IHS Counties	69,511	100.0%	61,489	88.5%	5,081	7.3%	2,942	4.2%

Long-Stay Hospitals

IHS Area	Total Payments Amount in 1000's	Total Payments Percent	Medicare Payments Amount in 1000's	Medicare Payments Percent	Enrollee Payments Amount in 1000's	Enrollee Payments Percent	Other Payer Amount in 1000's	Other Payer Percent
All US Counties	73,756	100.0%	66,740	90.5%	6,093	8.3%	922	1.3%
IHS Area Counties	65,175	100.0%	58,926	90.4%	5,396	8.3%	854	1.3%
Aberdeen	2,695	100.0%	2,296	85.2%	357	13.3%	42	1.5%
Alaska	6,561	100.0%	6,207	94.6%	337	5.1%	17	0.3%
Albuquerque	2,038	100.0%	1,883	92.4%	155	7.6%	0	0.0%
Bemidji	4,400	100.0%	3,705	84.2%	546	12.4%	149	3.4%
Billings	3,800	100.0%	3,407	89.7%	391	10.3%	2	0.0%
California	2,646	100.0%	2,381	90.0%	226	8.5%	40	1.5%
Nashville	1,706	100.0%	1,519	89.0%	131	7.7%	56	3.3%
Navajo	8,184	100.0%	7,279	88.9%	589	7.2%	316	3.9%
Oklahoma	20,241	100.0%	18,492	91.4%	1,608	7.9%	142	0.7%
Phoenix	7,276	100.0%	6,710	92.2%	507	7.0%	59	0.8%
Portland	4,603	100.0%	4,139	89.9%	432	9.4%	31	0.7%
Tucson	1,025	100.0%	907	88.5%	117	11.5%	0	0.0%
Non-IHS Counties	8,580	100.0%	7,815	91.1%	698	8.1%	68	0.8%

Table C.12
For Short-Stay Hospitals: Amounts and Percent of Medicare, Enrollee and Other Payer Payments (in thousands of dollars) in each Service Area by Eligibility Group
Calendar Year 2006

Aged

IHS Area	Total Payments Amount in 1000's	Total Payments Percent	Medicare Payments Amount in 1000's	Medicare Payments Percent	Enrollee Payments Amount in 1000's	Enrollee Payments Percent	Other Payer Amount in 1000's	Other Payer Percent
All US Counties	362,035	100.0%	325,501	89.9%	25,697	7.1%	10,837	3.0%
IHS Area Counties	318,939	100.0%	286,741	89.9%	22,628	7.1%	9,571	3.0%
Aberdeen	22,185	100.0%	18,327	82.6%	1,481	6.7%	2,378	10.7%
Alaska	32,938	100.0%	30,903	93.8%	1,668	5.1%	367	1.1%
Albuquerque	9,393	100.0%	8,539	90.9%	757	8.1%	97	1.0%
Bemidji	20,890	100.0%	17,901	85.7%	1,467	7.0%	1,522	7.3%
Billings	13,344	100.0%	12,112	90.8%	997	7.5%	235	1.8%
California	17,951	100.0%	16,264	90.6%	1,141	6.4%	546	3.0%
Nashville	9,943	100.0%	8,972	90.2%	795	8.0%	176	1.8%
Navajo	48,540	100.0%	44,652	92.0%	3,571	7.4%	317	0.7%
Oklahoma	94,049	100.0%	84,322	89.7%	7,465	7.9%	2,263	2.4%
Phoenix	21,659	100.0%	19,583	90.4%	1,405	6.5%	671	3.1%
Portland	23,314	100.0%	20,770	89.1%	1,562	6.7%	982	4.2%
Tucson	4,734	100.0%	4,397	92.9%	320	6.8%	17	0.4%

Disabled and ESRD-only

IHS Area	Total Payments Amount in 1000's	Total Payments Percent	Medicare Payments Amount in 1000's	Medicare Payments Percent	Enrollee Payments Amount in 1000's	Enrollee Payments Percent	Other Payer Amount in 1000's	Other Payer Percent
All US Counties	177,684	100.0%	156,867	88.3%	12,250	6.9%	8,567	4.8%
IHS Area Counties	151,269	100.0%	134,139	88.7%	10,238	6.8%	6,891	4.6%
Aberdeen	11,307	100.0%	10,279	90.9%	791	7.0%	236	2.1%
Alaska	8,881	100.0%	8,080	91.0%	456	5.1%	345	3.9%
Albuquerque	6,409	100.0%	5,729	89.4%	434	6.8%	246	3.8%
Bemidji	14,019	100.0%	11,894	84.8%	877	6.3%	1,249	8.9%
Billings	5,425	100.0%	4,754	87.6%	409	7.5%	263	4.8%
California	10,879	100.0%	9,570	88.0%	635	5.8%	674	6.2%
Nashville	6,289	100.0%	5,689	90.5%	464	7.4%	136	2.2%
Navajo	17,156	100.0%	15,470	90.2%	1,113	6.5%	573	3.3%
Oklahoma	40,326	100.0%	34,916	86.6%	3,038	7.5%	2,372	5.9%
Phoenix	14,803	100.0%	13,575	91.7%	1,030	7.0%	198	1.3%
Portland	11,856	100.0%	10,554	89.0%	722	6.1%	580	4.9%
Tucson	3,918	100.0%	3,630	92.6%	270	6.9%	18	0.5%
Non-IHS Counties	26,415	100.0%	22,728	86.0%	2,012	7.6%	1,676	6.3%

Table C.13
For Long-Stay Hospitals: Amounts and Percent of Medicare, Enrollee and Other Payer Payments (in thousands of dollars) in each Service Area by Eligibility Group
Calendar Year 2006

Aged

IHS Area	Total Payments Amount in 1000's	Total Payments Percent	Medicare Payments Amount in 1000's	Medicare Payments Percent	Enrollee Payments Amount in 1000's	Enrollee Payments Percent	Other Payer Amount in 1000's	Other Payer Percent
All US Counties	49,537	100.0%	45,247	91.3%	3,923	7.9%	367	0.7%
IHS Area Counties	44,087	100.0%	40,279	91.4%	3,494	7.9%	314	0.7%
Aberdeen	1,782	100.0%	1,502	84.3%	250	14.0%	30	1.7%
Alaska	5,410	100.0%	5,134	94.9%	259	4.8%	17	0.3%
Albuquerque	1,195	100.0%	1,146	95.8%	50	4.2%	0	0.0%
Bemidji	2,972	100.0%	2,533	85.2%	329	11.1%	110	3.7%
Billings	2,828	100.0%	2,532	89.5%	294	10.4%	2	0.1%
California	1,546	100.0%	1,409	91.1%	107	6.9%	30	1.9%
Nashville	1,110	100.0%	1,009	90.9%	75	6.8%	26	2.3%
Navajo	6,271	100.0%	5,857	93.4%	409	6.5%	5	0.1%
Oklahoma	12,818	100.0%	11,727	91.5%	1,026	8.0%	64	0.5%
Phoenix	4,362	100.0%	4,060	93.1%	302	6.9%	0	0.0%
Portland	3,199	100.0%	2,859	89.4%	309	9.7%	31	1.0%
Tucson	594	100.0%	512	86.1%	83	13.9%	0	0.0%
Non-IHS Counties	5,450	100.0%	4,967	91.2%	429	7.9%	53	1.0%

Disabled and ESRD-only

IHS Area	Total Payments Amount in 1000's	Total Payments Percent	Medicare Payments Amount in 1000's	Medicare Payments Percent	Enrollee Payments Amount in 1000's	Enrollee Payments Percent	Other Payer Amount in 1000's	Other Payer Percent
All US Counties	24,219	100.0%	21,494	88.7%	2,170	9.0%	555	2.3%
IHS Area Counties	21,088	100.0%	18,646	88.4%	1,902	9.0%	540	2.6%
Aberdeen	913	100.0%	795	87.0%	107	11.7%	12	1.3%
Alaska	1,151	100.0%	1,073	93.3%	77	6.7%	0	0.0%
Albuquerque	843	100.0%	737	87.5%	106	12.5%	0	0.0%
Bemidji	1,428	100.0%	1,171	82.0%	217	15.2%	39	2.8%
Billings	972	100.0%	875	90.0%	97	10.0%	0	0.0%
California	1,101	100.0%	972	88.3%	119	10.8%	10	0.9%
Nashville	596	100.0%	510	85.5%	55	9.3%	31	5.2%
Navajo	1,913	100.0%	1,422	74.3%	180	9.4%	311	16.3%
Oklahoma	7,424	100.0%	6,764	91.1%	582	7.8%	77	1.0%
Phoenix	2,914	100.0%	2,651	91.0%	205	7.0%	59	2.0%
Portland	1,404	100.0%	1,280	91.2%	123	8.7%	1	0.1%
Tucson	430	100.0%	396	91.9%	35	8.1%	0	0.0%
Non-IHS Counties	3,131	100.0%	2,847	91.0%	268	8.6%	15	0.5%

Table C.14
Amounts and Percent of Enrollee Deductible and Coinsurance Payments as a Percent of the Enrollee Payment in each Service Area by Hospital Type
Calendar Year 2006

Short-Stay Hospitals

IHS Area	Total Enrollee Payments Amount in 1000's	Percent	Deductible Payment Amount in 1000's	Percent	Coinsurance Payments Amount in 1000's	Percent
All US Counties	37,947	100.0%	35,480	93.5%	2,467	6.5%
IHS Area Counties	32,866	100.0%	30,783	93.7%	2,083	6.3%
Aberdeen	2,272	100.0%	2,192	96.5%	80	3.5%
Alaska	2,124	100.0%	1,985	93.5%	138	6.5%
Albuquerque	1,192	100.0%	1,118	93.8%	74	6.2%
Bemidji	2,344	100.0%	2,227	95.0%	117	5.0%
Billings	1,406	100.0%	1,311	93.3%	95	6.7%
California	1,776	100.0%	1,660	93.5%	116	6.5%
Nashville	1,258	100.0%	1,161	92.3%	97	7.7%
Navajo	4,684	100.0%	4,448	95.0%	236	5.0%
Oklahoma	10,502	100.0%	9,777	93.1%	726	6.9%
Phoenix	2,435	100.0%	2,167	89.0%	269	11.0%
Portland	2,284	100.0%	2,243	98.2%	40	1.8%
Tucson	590	100.0%	495	83.9%	95	16.1%
Non-IHS Counties	5,081	100.0%	4,696	92.4%	384	7.6%

Long-Stay Hospitals

IHS Area	Total Enrollee Payments Amount in 1000's	Percent	Deductible Payment Amount in 1000's	Percent	Coinsurance Payments Amount in 1000's	Percent
All US Counties	6,093	100.0%	3,845	63.1%	2,248	36.9%
IHS Area Counties	5,396	100.0%	3,463	64.2%	1,933	35.8%
Aberdeen	357	100.0%	326	91.1%	32	8.9%
Alaska	337	100.0%	326	96.8%	11	3.2%
Albuquerque	155	100.0%	45	29.1%	110	70.9%
Bemidji	546	100.0%	457	83.6%	90	16.4%
Billings	391	100.0%	384	98.2%	7	1.8%
California	226	100.0%	138	61.4%	87	38.6%
Nashville	131	100.0%	103	78.9%	28	21.1%
Navajo	589	100.0%	352	59.7%	237	40.3%
Oklahoma	1,608	100.0%	748	46.5%	860	53.5%
Phoenix	507	100.0%	220	43.4%	287	56.6%
Portland	432	100.0%	356	82.5%	76	17.5%
Tucson	117	100.0%	8	7.2%	109	92.8%
Non-IHS Counties	698	100.0%	383	54.8%	315	45.2%

Table C.15
Amount of Payment by Medicare, Enrollee and Other Payer per Hospital Stay (Discharge)
in each Service Area by Hospital Type
Calendar Year 2006

Short-Stay Hospitals

	Total		Medicare		Enrollee		Other	
IHS Area	Amount in 1000's	Amount per Stay	Amount in 1000's	Amount per Stay	Amount in 1000's	Amount per Stay	Amount in 1000's	Amount per Stay
All US Counties	539,719	9,475	482,368	8,469	37,947	666	19,404	341
IHS Area Counties	470,208	9,520	420,880	8,521	32,866	665	16,462	333
Aberdeen	33,492	9,013	28,606	7,698	2,272	611	2,614	703
Alaska	41,818	14,576	38,983	13,588	2,124	740	712	248
Albuquerque	15,802	9,076	14,267	8,195	1,192	684	343	197
Bemidji	34,909	9,735	29,794	8,308	2,344	654	2,771	773
Billings	18,769	8,689	16,865	7,808	1,406	651	498	231
California	28,830	11,495	25,834	10,301	1,776	708	1,220	487
Nashville	16,232	8,850	14,661	7,994	1,258	686	313	170
Navajo	65,696	9,464	60,122	8,661	4,684	675	890	128
Oklahoma	134,375	8,313	119,238	7,377	10,502	650	4,635	287
Phoenix	36,463	9,836	33,158	8,945	2,435	657	869	235
Portland	35,170	10,527	31,324	9,376	2,284	684	1,562	468
Tucson	8,652	10,501	8,027	9,742	590	716	35	43
Non-IHS Counties	69,511	9,185	61,489	8,125	5,081	671	2,942	389

Long-Stay Hospitals

	Total		Medicare		Enrollee		Other	
IHS Area	Amount in 1000's	Amount per Stay	Amount in 1000's	Amount per Stay	Amount in 1000's	Amount per Stay	Amount in 1000's	Amount per Stay
All US Counties	73,756	10,190	66,740	9,221	6,093	842	922	127
IHS Area Counties	65,175	10,067	58,926	9,102	5,396	833	854	132
Aberdeen	2,695	4,711	2,296	4,014	357	625	42	73
Alaska	6,561	13,044	6,207	12,340	337	669	17	34
Albuquerque	2,038	16,439	1,883	15,187	155	1,253	0	0
Bemidji	4,400	5,700	3,705	4,799	546	708	149	193
Billings	3,800	5,596	3,407	5,018	391	576	2	2
California	2,646	11,310	2,381	10,175	226	964	40	170
Nashville	1,706	8,750	1,519	7,790	131	670	56	289
Navajo	8,184	12,196	7,279	10,848	589	877	316	471
Oklahoma	20,241	12,395	18,492	11,324	1,608	985	142	87
Phoenix	7,276	15,253	6,710	14,068	507	1,062	59	123
Portland	4,603	8,075	4,139	7,262	432	758	31	55
Tucson	1,025	23,292	907	20,622	117	2,670	0	0
Non-IHS Counties	8,580	11,231	7,815	10,229	698	913	68	89

Table C.16
For Short-Stay Hospitals: Amount of Payment by Medicare, Enrollees and Other Payers Per Hospital Stay (Discharge) in each Service Area by Eligibility Group
Calendar Year 2006

Aged

IHS Area	Total Payments Amount in 1000's	Total Payments Amount per Stay	Medicare Payments Amount in 1000's	Medicare Payments Amount per Stay	Enrollee Payments Amount in 1000's	Enrollee Payments Amount per Stay	Other Payer Amount in 1000's	Other Payer Amount per Stay
All US Counties	362,035	9,439	325,501	8,487	25,697	670	10,837	283
IHS Area Counties	318,939	9,432	286,741	8,480	22,628	669	9,571	283
Aberdeen	22,185	9,322	18,327	7,700	1,481	622	2,378	999
Alaska	32,938	14,619	30,903	13,716	1,668	740	367	163
Albuquerque	9,393	8,508	8,539	7,734	757	686	97	88
Bemidji	20,890	9,487	17,901	8,129	1,467	666	1,522	691
Billings	13,344	8,648	12,112	7,849	997	646	235	153
California	17,951	10,979	16,264	9,947	1,141	698	546	334
Nashville	9,943	8,391	8,972	7,571	795	671	176	149
Navajo	48,540	9,211	44,652	8,473	3,571	678	317	60
Oklahoma	94,049	8,259	84,322	7,404	7,465	655	2,263	199
Phoenix	21,659	10,009	19,583	9,049	1,405	649	671	310
Portland	23,314	10,330	20,770	9,203	1,562	692	982	435
Tucson	4,734	10,958	4,397	10,179	320	740	17	39
Non-IHS Counties	43,096	9,488	38,761	8,534	3,069	676	1,266	279

Disabled and ESRD-only

IHS Area	Total Payments Amount in 1000's	Total Payments Amount per Stay	Medicare Payments Amount in 1000's	Medicare Payments Amount per Stay	Enrollee Payments Amount in 1000's	Enrollee Payments Amount per Stay	Other Payer Amount in 1000's	Other Payer Amount per Stay
All US Counties	177,684	9,550	156,867	8,431	12,250	658	8,567	460
IHS Area Counties	151,269	9,710	134,139	8,610	10,238	657	6,891	442
Aberdeen	11,307	8,463	10,279	7,694	791	592	236	177
Alaska	8,881	14,417	8,080	13,117	456	740	345	560
Albuquerque	6,409	10,061	5,729	8,993	434	682	246	386
Bemidji	14,019	10,129	11,894	8,594	877	634	1,249	902
Billings	5,425	8,793	4,754	7,704	409	663	263	426
California	10,879	12,462	9,570	10,962	635	727	674	772
Nashville	6,289	9,690	5,689	8,766	464	714	136	210
Navajo	17,156	10,261	15,470	9,252	1,113	666	573	343
Oklahoma	40,326	8,443	34,916	7,311	3,038	636	2,372	497
Phoenix	14,803	9,594	13,575	8,798	1,030	668	198	128
Portland	11,856	10,937	10,554	9,736	722	666	580	535
Tucson	3,918	9,996	3,630	9,260	270	689	18	47
Non-IHS Counties	26,415	8,729	22,728	7,511	2,012	665	1,676	554

Table C.17
For Long-Stay Hospitals: Amount of Payment by Medicare, Enrollees and Other Payers Per Hospital Stay (Discharge) in each Service Area by Eligibility Group
Calendar Year 2006

Aged

IHS Area	Total Payments Amount in 1000's	Total Payments Amount per Stay	Medicare Payments Amount in 1000's	Medicare Payments Amount per Stay	Enrollee Payments Amount in 1000's	Enrollee Payments Amount per Stay	Other Payer Amount in 1000's	Other Payer Amount per Stay
All US Counties	49,537	9,943	45,247	9,082	3,923	787	367	74
IHS Area Counties	44,087	9,713	40,279	8,874	3,494	770	314	69
Aberdeen	1,782	4,356	1,502	3,671	250	611	30	73
Alaska	5,410	13,908	5,134	13,197	259	666	17	44
Albuquerque	1,195	14,403	1,146	13,804	50	599	0	0
Bemidji	2,972	5,608	2,533	4,780	329	621	110	207
Billings	2,828	5,589	2,532	5,005	294	582	2	3
California	1,546	10,735	1,409	9,784	107	744	30	207
Nashville	1,110	9,651	1,009	8,775	75	654	26	222
Navajo	6,271	11,422	5,857	10,668	409	745	5	9
Oklahoma	12,818	12,444	11,727	11,386	1,026	996	64	63
Phoenix	4,362	13,630	4,060	12,687	302	944	0	0
Portland	3,199	7,270	2,859	6,498	309	703	31	69
Tucson	594	24,766	512	21,317	83	3,449	0	0
Non-IHS Counties	5,450	12,302	4,967	11,213	429	969	53	119

Disabled and ESRD-only

IHS Area	Total Payments Amount in 1000's	Total Payments Amount per Stay	Medicare Payments Amount in 1000's	Medicare Payments Amount per Stay	Enrollee Payments Amount in 1000's	Enrollee Payments Amount per Stay	Other Payer Amount in 1000's	Other Payer Amount per Stay
All US Counties	24,219	10,735	21,494	9,527	2,170	962	555	246
IHS Area Counties	21,088	10,898	18,646	9,636	1,902	983	540	279
Aberdeen	913	5,603	795	4,874	107	658	12	71
Alaska	1,151	10,095	1,073	9,416	77	679	0	0
Albuquerque	843	20,561	737	17,986	106	2,576	0	0
Bemidji	1,428	5,901	1,171	4,840	217	898	39	163
Billings	972	5,617	875	5,056	97	561	0	0
California	1,101	12,230	972	10,802	119	1,317	10	111
Nashville	596	7,454	510	6,375	55	693	31	386
Navajo	1,913	15,678	1,422	11,654	180	1,473	311	2,550
Oklahoma	7,424	12,311	6,764	11,218	582	965	77	128
Phoenix	2,914	18,561	2,651	16,883	205	1,304	59	375
Portland	1,404	10,797	1,280	9,847	123	943	1	7
Tucson	430	21,524	396	19,789	35	1,735	0	0
Non-IHS Counties	3,131	9,753	2,847	8,870	268	835	15	47

Table C.18
Total and Medicare Hospital Payments and the Payment per Day of Stay
for AIAN Medicare Enrollees in each Service Area by Hospital Type
Calendar Year 2006

Short-Stay Hospitals

IHS Area	Total Payments Amount in 1000's	Total Payments Amount per Day	Medicare Payments Amount in 1000's	Medicare Payments Amount per Day
All US Counties	539,719	1,770	482,368	1,582
IHS Area Counties	470,208	1,782	420,880	1,595
Aberdeen	33,492	1,758	28,606	1,502
Alaska	41,818	2,127	38,983	1,982
Albuquerque	15,802	1,729	14,267	1,561
Bemidji	34,909	2,017	29,794	1,722
Billings	18,769	1,704	16,865	1,531
California	28,830	2,137	25,834	1,915
Nashville	16,232	1,603	14,661	1,448
Navajo	65,696	1,758	60,122	1,609
Oklahoma	134,375	1,588	119,238	1,409
Phoenix	36,463	1,747	33,158	1,589
Portland	35,170	2,181	31,324	1,943
Tucson	8,652	1,677	8,027	1,556
Non-IHS Counties	69,511	1,694	61,489	1,498

Long-Stay Hospitals

IHS Area	Total Payments Amount in 1000's	Total Payments Amount per Day	Medicare Payments Amount in 1000's	Medicare Payments Amount per Day
All US Counties	73,756	1,166	66,740	1,055
IHS Area Counties	65,175	1,198	58,926	1,083
Aberdeen	2,695	1,003	2,296	855
Alaska	6,561	2,542	6,207	2,405
Albuquerque	2,038	1,102	1,883	1,018
Bemidji	4,400	1,045	3,705	880
Billings	3,800	1,224	3,407	1,097
California	2,646	1,465	2,381	1,318
Nashville	1,706	1,096	1,519	976
Navajo	8,184	1,474	7,279	1,311
Oklahoma	20,241	986	18,492	901
Phoenix	7,276	1,400	6,710	1,291
Portland	4,603	1,038	4,139	934
Tucson	1,025	1,124	907	995
Non-IHS Counties	8,580	971	7,815	885

Table C.19
For Short Stay Hospitals: Total Payments and the Payment per Day of Stay
for AIAN Medicare Enrollees in each Service Area
by Eligibility Group
Calendar Year 2006

Aged

IHS Area	Total Payments Amount in 1000's	Total Payments Amount per Day	Medicare Payments Amount in 1000's	Medicare Payments Amount per Day
All US Counties	362,035	1,784	325,501	1,604
IHS Area Counties	318,939	1,785	286,741	1,604
Aberdeen	22,185	1,833	18,327	1,514
Alaska	32,938	2,102	30,903	1,972
Albuquerque	9,393	1,670	8,539	1,519
Bemidji	20,890	2,038	17,901	1,746
Billings	13,344	1,724	12,112	1,565
California	17,951	2,195	16,264	1,988
Nashville	9,943	1,580	8,972	1,426
Navajo	48,540	1,732	44,652	1,594
Oklahoma	94,049	1,576	84,322	1,413
Phoenix	21,659	1,819	19,583	1,645
Portland	23,314	2,198	20,770	1,958
Tucson	4,734	1,780	4,397	1,653
Non-IHS Counties	43,096	1,779	38,761	1,600

Disabled and ESRD-only

IHS Area	Total Payments Amount in 1000's	Total Payments Amount per Day	Medicare Payments Amount in 1000's	Medicare Payments Amount per Day
All US Counties	177,684	1,742	156,867	1,538
IHS Area Counties	151,269	1,775	134,139	1,574
Aberdeen	11,307	1,627	10,279	1,479
Alaska	8,881	2,221	8,080	2,021
Albuquerque	6,409	1,822	5,729	1,629
Bemidji	14,019	1,988	11,894	1,686
Billings	5,425	1,657	4,754	1,451
California	10,879	2,049	9,570	1,802
Nashville	6,289	1,642	5,689	1,485
Navajo	17,156	1,835	15,470	1,655
Oklahoma	40,326	1,616	34,916	1,399
Phoenix	14,803	1,651	13,575	1,514
Portland	11,856	2,150	10,554	1,914
Tucson	3,918	1,569	3,630	1,453
Non-IHS Counties	26,415	1,571	22,728	1,351

Table C.20
For Long Stay Hospitals: Total Payments and the Payment per Day of Stay
for AIAN Medicare Enrollees in each Service Area
by Eligibility Group
Calendar Year 2006

Aged

IHS Area	Total Payments Amount in 1000's	Total Payments Amount per Day	Medicare Payments Amount in 1000's	Medicare Payments Amount per Day
All US Counties	49,537	1,385	45,247	1,265
IHS Area Counties	44,087	1,417	40,279	1,294
Aberdeen	1,782	1,138	1,502	959
Alaska	5,410	3,299	5,134	3,130
Albuquerque	1,195	1,209	1,146	1,158
Bemidji	2,972	1,616	2,533	1,378
Billings	2,828	1,492	2,532	1,336
California	1,546	1,979	1,409	1,804
Nashville	1,110	1,248	1,009	1,135
Navajo	6,271	1,625	5,857	1,518
Oklahoma	12,818	1,072	11,727	981
Phoenix	4,362	1,501	4,060	1,397
Portland	3,199	1,398	2,859	1,250
Tucson	594	1,170	512	1,007
Non-IHS Counties	5,450	1,173	4,967	1,070

Disabled and ESRD-only

IHS Area	Total Payments Amount in 1000's	Total Payments Amount per Day	Medicare Payments Amount in 1000's	Medicare Payments Amount per Day
All US Counties	24,219	881	21,494	782
IHS Area Counties	21,088	905	18,646	800
Aberdeen	913	814	795	708
Alaska	1,151	1,223	1,073	1,141
Albuquerque	843	979	737	856
Bemidji	1,428	603	1,171	494
Billings	972	804	875	724
California	1,101	1,073	972	948
Nashville	596	893	510	763
Navajo	1,913	1,128	1,422	839
Oklahoma	7,424	866	6,764	789
Phoenix	2,914	1,271	2,651	1,156
Portland	1,404	654	1,280	597
Tucson	430	1,066	396	980
Non-IHS Counties	3,131	747	2,847	680

Table C.21
Medicare Payment Rate per AIAN Enrollee with Hospital Coverage (either alone or with Medical coverage), and not in Managed Care, in each Service Area by Hospital Type
Calendar Year 2006

IHS Area	Enrollees with Hospital Coverage Number	Enrollees with Managed Care Number	Short-Stay Hospital Payment in 1000's	Short-Stay Hospital Payment Per Enrollee	Long-Stay Hospital Payment in 1000's	Long-Stay Hospital Payment Per Enrollee
All US Counties	160,786	14,559	482,368	3,299	66,740	456
IHS Area Counties	139,200	11,330	420,880	3,291	58,926	461
Aberdeen	8,189	291	28,606	3,622	2,296	291
Alaska	9,578	4	38,983	4,072	6,207	648
Albuquerque	6,035	400	14,267	2,532	1,883	334
Bemidji	10,358	837	29,794	3,129	3,705	389
Billings	5,366	216	16,865	3,275	3,407	662
California	9,729	1,368	25,834	3,090	2,381	285
Nashville	4,903	217	14,661	3,129	1,519	324
Navajo	19,818	355	60,122	3,089	7,279	374
Oklahoma	41,443	4,656	119,238	3,241	18,492	503
Phoenix	9,490	1,116	33,158	3,960	6,710	801
Portland	12,460	1,507	31,324	2,860	4,139	378
Tucson	1,831	363	8,027	5,468	907	618
Non-IHS Counties	21,586	3,229	61,489	3,350	7,815	426

Table C.22
Medicare Payment per AIAN Enrollee with Hospital Coverage (either alone or with Medical coverage), and not in Managed Care, in each Service Area by Hospital Type and Eligibility Group
Calendar Year 2006

Aged

IHS Area	Enrollees with Hospital Coverage Number	Enrollees with Managed Care Number	Short Stay Hospital Payment in 1000's	Short Stay Hospital Payment Per Enrollee	Long Stay Hospital Payment in 1000's	Long Stay Hospital Payment Per Enrollee
All US Counties	114,913	12,008	325,501	3,163	45,247	440
IHS Area Counties	100,808	9,316	286,741	3,134	40,279	440
Aberdeen	5,529	223	18,327	3,454	1,502	283
Alaska	7,489	3	30,903	4,128	5,134	686
Albuquerque	4,490	353	8,539	2,064	1,146	277
Bemidji	6,987	732	17,901	2,862	2,533	405
Billings	3,959	191	12,112	3,214	2,532	672
California	6,874	1,210	16,264	2,871	1,409	249
Nashville	3,321	167	8,972	2,845	1,009	320
Navajo	15,453	285	44,652	2,944	5,857	386
Oklahoma	30,438	3,901	84,322	3,178	11,727	442
Phoenix	6,336	768	19,583	3,517	4,060	729
Portland	8,774	1,251	20,770	2,761	2,859	380
Tucson	1,158	232	4,397	4,749	512	552
Non-IHS Counties	14,105	2,692	38,761	3,396	4,967	435

Disabled

IHS Area	Enrollees with Hospital Coverage Number	Enrollees with Managed Care Number	Short Stay Hospital Payment in 1000's	Short Stay Hospital Payment Per Enrollee	Long Stay Hospital Payment in 1000's	Long Stay Hospital Payment Per Enrollee
All US Counties	45,873	2,551	156,867	3,621	21,494	496
IHS Area Counties	38,392	2,014	134,139	3,687	18,646	513
Aberdeen	2,660	68	10,279	3,966	795	307
Alaska	2,089	1	8,080	3,870	1,073	514
Albuquerque	1,545	47	5,729	3,824	737	492
Bemidji	3,371	105	11,894	3,642	1,171	359
Billings	1,407	25	4,754	3,440	875	633
California	2,855	158	9,570	3,548	972	360
Nashville	1,582	50	5,689	3,713	510	333
Navajo	4,365	70	15,470	3,602	1,422	331
Oklahoma	11,005	755	34,916	3,406	6,764	660
Phoenix	3,154	348	13,575	4,838	2,651	945
Portland	3,686	256	10,554	3,077	1,280	373
Tucson	673	131	3,630	6,697	396	730
Non-IHS Counties	7,481	537	22,728	3,273	2,847	410

Appendix D
AIAN Enrollment & Utilization Data
For the Urban Service Area

Source Data Files:
Denominator File for 2006
Medical Provider for Analysis and Review (MedPAR) File for 2006

Table D.1
Number and Percent of AIAN Medicare enrollees in each Eligibility group in the Urban and IHS Service Areas

	Urban Area		IHS Areas*	
Eligibility Group	Number	Percent	Number	Percent
Total Enrollees	30,097	100.0%	139,363	100.0%
Aged	20,399	67.3%	100,969	72.5%
Disabled	9,545	28.6%	37,801	27.1%
ESRD-only	153	4.1%	639	0.5%

*IHS Area Counties, all CHSDA combined, from Appendix Table B.1; Some CHSDA counties (such as San Diego) are also included in the 98 Urban Service Area counties.

Table D.2
Number and Percent of Aged AIAN Medicare Enrollees in each Gender and Age Group in the Urban and IHS Service Areas

	Men				Women			
	Urban Area		IHS Areas		Urban Area		IHS Areas	
Aged	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All Ages	7,871	100.0%	42,032	100.0%	12,528	100.0%	58,937	100.0%
65 to 74	5,296	67.3%	28,259	67.2%	7,790	62.2%	36,672	62.2%
75 to 84	2,103	26.7%	11,314	26.9%	3,588	28.6%	16,790	28.5%
85 & Over	472	6.0%	2,459	5.9%	1,150	9.2%	5,475	9.3%

Table D.3
Number and Percent of AIAN Medicare enrollees with ESRD in each Eligibility group in the Urban and IHS Service Areas

	Urban Area		IHS Areas*	
Eligibility Group	Number	Percent	Number	Percent
All ESRD	1,093	100.0%	4,496	100.0%
Aged with ESRD	353	32.3%	1,630	36.3%
Disabled with ESRD	587	53.7%	2273	50.6%
ESRD-only	153	14.0%	593	13.2%

*IHS Area Counties, all CHSDA combined, from Appendix Table B.1; Some CHSDA counties (such as San Diego) are also included in the 98 Urban Service Area counties.

Table D.4
Number and Percent of Disabled and ESRD-only AIAN Medicare Enrollees in each Gender and Age Group in the Urban and IHS Service Areas

	Men				Women			
	Urban Area		IHS Areas		Urban Area		IHS Areas	
Disabled/ESRD-only	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All Ages	4,943	100.0%	20,374	100.0%	4,755	100.0%	17,427	100.0%
Under 45	1,915	38.7%	6,971	34.2%	1,584	33.3%	5,384	30.9%
45 to 54	1,534	31.0%	6,283	30.8%	1549	32.6%	5413	31.1%
55 to 64	1,494	30.2%	7,120	34.9%	1,622	34.1%	6,630	38.0%

Table D.5
AIAN Medicare Enrollees with Hospital and Medical Coverage in the Urban and IHS Service Areas

	Urban Area		IHS Areas	
Coverage Type	Number	Percent	Number	Percent
Total Enrollees	30,097	100.0%	139,363	100.0%
Both Hospital & Medical*	27,519	91.4%	125,902	90.3%
Hospital-only	2,542	8.4%	13,298	9.5%
Medical*-only	36	0.1%	163	0.1%

Table D.6
AIAN Medicare Enrollees with Hospital and Medical Coverage by Eligibility Group in the Urban and IHS Service Areas

	Aged				Disabled/ESRD-only			
	Urban Area		IHS Areas		Urban Area		IHS Areas	
Coverage Type	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total Enrollees	20,399	100.0%	115,182	100.0%	9,698	100.0%	45,905	100.0%
Both Hospital & Medical*	18,699	91.7%	104,511	90.7%	8,820	90.9%	41,691	90.8%
Hospital-only	1,665	8.2%	10,496	9.1%	877	9.0%	4,212	9.2%
Medical*-only	35	0.2%	175	0.2%	1	0.0%	2	0.0%

Table D.7
AIAN Medicare Enrollees with Fee-For-Service and Managed Care Coverage
in the Urban and IHS Service Areas

	Urban Area		IHS Areas	
Coverage Type	Number	Percent	Number	Percent
Total Enrollees	30,097	100.0%	139,363	100.0%
Fee-For-Service	24,359	80.9%	128,033	91.9%
Managed Care	5,738	19.1%	11,330	8.1%

Table D.8
AIAN Medicare Enrollees with Fee-For-Service and Managed Care Coverage
by Eligibility Group in the Urban and IHS Service Areas

	Aged				Disabled/ESRD-only			
	Urban Area		IHS Areas		Urban Area		IHS Areas	
Coverage Type	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total Enrollees	20,399	100.0%	115,182	100.0%	9,698	100.0%	45,905	100.0%
Fee-For-Service	15,736	77.1%	103,170	89.6%	8,623	88.9%	43,354	94.4%
Managed Care	4,663	22.9%	12,012	10.4%	1,075	11.1%	2,551	5.6%

Table D.9
AIAN Medicare Enrollees with a Premium Paid in any Month and whether their State Medicaid
Program Paid the Premium by Type of Coverage in the Urban and IHS Service Areas

	Urban Area				IHS Areas			
	Any Premium Paid		State Paid Premium		Any Premium Paid		State Paid Premium	
Coverage Type	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Both Hospital & Medical*	27,519	100.0%	10,599	38.5%	126,012	100.0%	50,751	40.3%
Hospital-only	3,288	100.0%	9	0.3%	16,598	100.0%	286	1.7%
Medical*-only	70	100.0%	67	95.7%	311	100.0%	61	19.6%

Table D.10
Number and Percent of Hospital Stays (discharges) by Type of Hospital for AIAN Medicare enrollees by Eligibility group in the Urban and IHS Service Areas

Eligibility of Hospitalized Enrollees	Short Stay Hospitals				Long Stay Hospitals			
	Urban Area		IHS Areas		Urban Area		IHS Areas	
	Stays	Percent	Stays	Percent	Stays	Percent	Stays	Percent
Both Groups	10,193	100.0%	49,392	100.0%	743	100.0%	6,474	100.0%
Aged	5,985	58.7%	33,813	68.5%	357	48.0%	4,539	70.1%
Disabled/ESRD-only	4,208	41.3%	15,579	31.5%	386	52.0%	1,935	29.9%

Table D.11
Number and Percent of Total Days of Stay, and the Average Days per Hospital Stay (Discharge) of AIAN Medicare beneficiaries by Type of Hospital in each Eligibility Group in the Urban Service Area

Eligibility of Hospitalized Enrollees	Total Days of Stay					
	Short Stay Hospitals			Long Stay Hospitals		
	Days	Percent	Per Discharge	Days	Percent	Per Discharge
Both Groups	57,439	100.0%	5.6	12,613	100.0%	17.0
Aged	33,278	57.9%	5.6	5,364	42.5%	15.0
Disabled/ESRD-only	24,161	42.1%	5.7	7,249	57.5%	18.8

Table D.12
Hospitalization Rates per 1,000 AIAN Enrollees with Hospital Coverage (either alone or with Medical Coverage) and not in Managed Care by Type of Hospital in each Eligibility Group in the Urban Service Area

Eligibility of Hospitalized Enrollees	Enrollees		Hospital Stays			
	With Hospital Coverage	In Managed Care	Short Stay Hospitals		Long Stay Hospitals	
	Number	Number	Stays	Rate per 1000 Enrollees**	Stays	Rate per 1000 Enrollees**
All Groups	30,061	5,738	10,193	419	743	31
Aged	20,364	4,663	5,985	381	357	23
Disabled/ESRD-only	9,697	1,075	4,208	488	386	45

Table D.13

Amounts of Medicare, Enrollee and Other Payer Payments (in thousands of dollars) and the Percent of the Medicare Payment paid by Enrollees (or their state of residence), and any other Payer by Type of Hospital in each Eligibility Group in the Urban Service Area

Eligibility of Hospitalized Enrollees	Medicare Payments				Enrollee Payments				Other Payer Payments			
	Short Stay		Long Stay		Short Stay		Long Stay		Short Stay		Long Stay	
	Amount in 1000's	Percent	Amount in 1000's	Percent	Amount in 1000's	Percent	Amount in 1000's	Percent	Amount in 1000's	Percent	Amount in 1000's	Percent
All Groups	$ 88,233	100.0%	$ 11,393	100.0%	$ 6,974	7.9%	$ 914	8.0%	$ 3,105	3.5%	$ 79	0.7%
Aged	$ 52,576	100.0%	$ 5,964	100.0%	$ 4,149	7.9%	$ 465	7.8%	$ 1,542	2.9%	$ 8	0.1%
Disabled/ESRD-only	$ 35,657	100.0%	$ 5,430	100.0%	$ 2,826	7.9%	$ 449	8.3%	$ 1,562	4.4%	$ 71	1.3%

Table D.14
Amount and Percent of Total Payment, and the Average Payment per Hospital Stay (Table 28) of AIAN Medicare beneficiaries by Type of Hospital in each Eligibility Group in the Urban Service Area

Eligibility of Hospitalized Enrollees	Total Payments*					
	Short Stay Hospitals			Long Stay Hospitals		
	Amount	Percent	Per Discharge	Amount	Percent	Per Discharge
Both Groups	$ 98,312	100.0%	$ 9,645	$ 12,386	100.0%	$ 16,670
Aged	$ 58,267	59.3%	$ 9,735	$ 6,436	52.0%	$ 18,029
Disabled/ESRD-only	$ 40,045	40.7%	$ 9,516	$ 5,950	48.0%	$ 15,413

*Medicare, Enrollee and Other Payer payments combined.

Table D.15
Payment Rates per 1,000 AIAN Enrollees with Hospital Coverage (either alone or with Medical Coverage) and not in Managed Care by Type of Hospital in each Eligibility Group in the Urban Service Area

Eligibility of Hospitalized Enrollees	Enrollees		Total Payments*			
	With Hospital Coverage	In Managed Care	Short Stay Hospitals		Long Stay Hospitals	
	Number	Number	Amount in 1000's	Rate per 1000 Enrollees	Amount in 1000's	Rate per 1000 Enrollees
All Groups	30,061	5,738	$ 98,312	$ 4,042	$ 12,386	$ 509
Aged	20,364	4,663	$ 58,267	$ 3,711	$ 6,436	$ 410
Disabled/ESRD-only	9,697	1,075	$ 40,045	$ 4,645	$ 5,950	$ 690

*Medicare, Enrollee and Other Payer payments from Table 31 combined.

Appendix E
CMS Supplementary Materials

Medicare Hospital Providers E.1

Medicare Payments by Service Type E.2

Medicare/Medicaid Glossary of Terms

Table E.1
Medicare Hospital and Nursing Facility Provider Types

Total participating hospitals	6,163
Short-term hospitals	3,669
Psychiatric units	1,265
Rehabilitation units	972
Swing bed units	556
Critical access hospitals	1,294
Psychiatric hospitals	488
Long-term hospitals	394
Rehabilitation hospitals	221
Childrens' Hosptials	78
Religious non-medical	19
Non-participating Hospitals	757
Emergency	407
Federal	350
All SNFs/SNF-NFs/NFs only	15,796
All SNFs/SNF-NFs/NFs	15,038
Title 18 Only SNF	824
Hospital-based	349
Free-standing	475
Title 18/19 SNF/NF	14,214
Hospital-based	758
Free-standing	13,456
Title 19 Only NFs	758
Hospital-based	139
Free-standing	619
All ICF-MR facilities	6,429

**2008 CMS Statistics*, Table II.3. Available at www.cms.hhs.gov/ResearchGenInfo/02_CMSStatistics.asp

Table E.2
Medicare Service Payment Amounts

Fiscal year 2007

	Benefit payments[1] in millions	Percent distribution
Total HI[2]	$202,545	100.0
Inpatient hospital	125,510	62.0
Skilled nursing facility	20,965	10.4
Home health agency[3]	6,442	3.2
Hospice	9,694	4.8
Managed care	39,934	19.7
Total SMI[2]	173,895	100.0
Physician/other suppliers	59,503	34.2
DME	8,563	4.9
Other carrier	16,809	9.7
Outpatient hospital	23,626	13.6
Home health agency[3]	7,709	4.4
Other intermediary	14,141	8.1
Laboratory	7,135	4.1
Managed care	36,409	20.9
Total Part D	49,174	100.0

[1]Includes the effects of regulatory items and recent legislation but not proposed law.

[2]Excludes QIO expenditures.

[3]Distribution of home health benefits between the trust funds reflects the actual outlays as reported by the Treasury.

NOTES: Based on FY 2008 President's Budget. Benefits by type of service are estimated and are subject to change. Totals do not necessarily equal the sum of rounded components.

SOURCE: CMS, OACT and OFM

GLOSSARY

Administration Costs—The costs incurred for marketing, enrollment, customer services, overhead, claims processing, and profits of for-profit entities.

Adults—Under Medicaid, parents or caretaker relatives of dependent children are eligible as adults based on one of several criteria: (1) they qualify as parents or caretaker relatives under section 1931 provisions, which relate to prior AFDC cash assistance standards (including unemployed parents), (2) they are medically needy, (3) they qualify under poverty-related eligibility criteria (including pregnant women), (4) they are eligible under a section 1115 demonstration, or (5) they qualify under other adult eligibility provisions. Adults who have been granted Medicaid eligibility under disability provisions are usually identified as disabled beneficiaries. Some persons under age 21, who are parents, or caretaker relatives of dependent children or who are pregnant, may be identified as adults. In some States, childless adults (non-disabled adults who are not parents or caretaker relatives of dependent children or pregnant women) may qualify for Medicaid as adults under section 1115 rules. By Federal law, all States have to extend Medicaid to pregnant women with income less than 133 percent of the FPL.

Aged—One of the categories used for classifying Medicare enrollees and Medicaid eligibles. Under Medicare, persons age 65 or over are included in this category if they are: entitled to monthly SSA benefits or payments from the RRB, uninsured for SSA or RRB benefits, but transitionally insured for Medicare, or not included in the previously mentioned groups, but based on meeting certain criteria, elect to purchase HI and/or SMI coverage by paying the appropriate monthly premium. Persons age 65 or over identified as having ESRD are included. Under Medicaid, persons age 65 or over are included if, in addition to initially being age 65 or over met certain means (income and resources) criteria or incur medical expenses for health care that when deducted from income qualifies the individual for Medicaid. Not all persons age 65 or over are included in this group. For example, persons initially enrolled and classified as disabled may remain so classified even when they reach age 65.

Aid to Families with Dependent Children (AFDC)—Cash assistance program which covered single-parent and two-parent families with an unemployed principal earner. All recipients of AFDC received Medicaid automatically. Each State set its own income limits for AFDC. The Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA) ended Federal entitlement for cash welfare benefits under AFDC. Thus, PRWORA severed the link between cash welfare benefits under AFDC and eligibility for Medicaid. Subject to specific limitations, States must continue to offer Medicaid eligibility to former AFDC cash recipients under provisions outlined in section 1931. PRWORA established a new block grant program to States, called TANF. Under TANF, States may impose time limits on the receipt of welfare benefits and work requirements. There is no direct link between eligibility for TANF benefits and Medicaid (refer to PRWORA and TANF).

Allowed Charge—An individual charge determination (approved amount) made by a carrier on a covered Part B medical service or supply.

Ambulatory Surgical Center (ASC)—A facility that provides surgical services that do not require a hospital stay. Medicare pays an institutional fee for use of an ASC for certain approved surgical procedures. Medicare will also pay for physician and anesthesia services that are provided for these procedures.

Amount, Duration, and Scope—Criteria used to determine the Medicaid benefits and limitations in a State's Medicaid plan. Each State defines these parameters; therefore, State Medicaid plans vary in

what is actually covered.

- Amount—The number of visits, prescriptions, treatments, etc. allowed for Medicaid reimbursement.
- Duration—The number of days in a hospital, nursing facility, or ICF covered for reimbursement.
- Scope—The package of mandatory and optional health care services covered by Medicaid for specific subgroups of Medicaid beneficiaries.

Assigned Claim—A claim for which the physician or supplier agrees to accept the amount approved by Medicare as the total payment. Medicare pays the physician or supplier 80 percent of the Medicare approved fee schedule (less any unmet deductible). The doctor or supplier can charge the beneficiary only for the coinsurance, which is the remaining 20 percent of the approved amount. A participating physician or supplier agrees to accept assignment on all claims.

Average Annual Rate of Change (AARC)—The constant annual percent of change which, when compounded over a period of years, gives the same result as a given set of annual percent changes over the same period. Also referred to as average annual rate of growth.

Balance Billing—A type of cost sharing under Medicare in which a beneficiary is responsible for the difference between the physician's submitted charge and the Medicare allowed charge on unassigned claims. Currently, a non-participating physician cannot charge a Medicare beneficiary more than 115 percent of the amount listed in the Medicare fee schedule for unassigned physician claims.

Basis of Eligibility—The programmatic authority under which a person receives Medicaid eligibility (e.g., adults, aged, blind, children, disabled, etc.).

Beneficiary—As used in this Supplement, a Medicare beneficiary is an enrollee who used a covered medical service during a specified period of time (e.g., CY), whether or not the service was reimbursable. The term is often used generically, however, to refer to a person who is enrolled in one or both parts of the Medicare program, whether actual services are used or not. Under Medicaid, a beneficiary is an enrollee who receives a Medicaid-covered service or (beginning 1998) has a managed care or private health insurance premium paid on his/her behalf (an alternate reference to recipient).

Beneficiary Identification Code (BIC)—The code that identifies the relationship between an individual and a primary Social Security or RRB beneficiary.

Benefit Package—Services an insurer, government agency, or health plan offers to a group or individuals, subject to premiums, cost sharing, and other requirements or limitations.

Benefit Payments—Benefit payments under Medicare comprise all withdrawals from the HI and SMI trust funds to directly pay providers for services rendered for covered services to
Medicare enrollees under the FFS payment system and monthly premiums to managed care and other M+C organizations under capitated payment systems. Under FFS, payments recorded on bills (referred to as program payments) and payments made independently of the billing system (e.g., lump-sum adjustments to interim rates and end-of-year adjustments from cost settlements) are included. Estimates of benefit payments by Federal FY or CY are prepared by the CMS' Office of the Actuary both on a paid and on an incurred basis.

Benefit Period—The unit of time for measuring the use of Part A benefits (spell of illness). A benefit period begins the first day an enrollee is furnished inpatient hospital or extended care services by a qualified provider, and it ends when the enrollee has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. There is no limit to the number of benefit periods an enrollee can have. The enrollee must pay the hospital insurance deductible for each new benefit period.

Buy-In—A Medicare beneficiary who is also eligible for Medicaid, and for whom Medicare Part B premiums and/or Part A premiums are paid by a State Medicaid program (refer to dual eligible, dual entitlement, MN, QMB, QDWI, and SLMB).

Calendar Year (CY)—The 12-month period running from January 1-December 31 that is used for establishing the payment of the voluntary Part A and the Part B premiums, deductibles, and coinsurance requirements. It is used as the basis for tabulating the Medicare program utilization and cost sharing, program payments, and PHCE.

Capitation—A prospective payment method that pays the provider of service a uniform amount for each person served, usually on a monthly basis; rather than on a per service basis. Capitation is used in managed care alternatives such as comprehensive plans (e.g., HMOs) or partial plans (e.g., PHPs).

Carrier—An organization that has contracted with DHHS to process and pay approved physician and supplier claims, and perform other services under Medicare Part B (SMI) program.

Case Management—A process whereby covered persons with specific health care needs are identified and a plan that efficiently utilizes health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner (refer to PCCM).

Center for Beneficiary Choices (CBC)—This CMS component serves as the focal point for all Agency interactions with beneficiaries, their families, caregivers, health care providers, and others operating on their behalf concerning improving beneficiary ability to make informed decisions about their health and program benefits. These activities include strategic and implementation planning, execution, assessment, and communications. CBC is also responsible for Medicare contractor management, including leading the development of a long-term contractor strategy to ensure that future Medicare program contracts align with the mission and needs of the agency.

Centers for Medicare & Medicaid Services (CMS)—The Federal Agency within DHHS that runs Medicare. In addition, CMS works with the States to run the Medicaid and SCHIP programs. CMS works to make sure that the beneficiaries in these programs are able to get highquality health care.

Center for Medicaid and State Operations (CMSO)—This CMS component focuses on programs administered by States. This includes Medicaid and SCHIP, insurance regulation functions, survey and certification, and the Clinical Laboratory Improvements Act (CLIA) program.

Center for Medicare Management (CMM)—This CMS component is responsible for management of the traditional Medicare FFS program. This includes development of payment policy and management of the Medicare FFS contractors.

Children—Under Medicaid, children are eligible based on one of several criteria: (1) they are dependent children who qualify under section 1931 provisions, which relate to prior AFDC cash assistance standards

(including children of unemployed parents), (2) they are medically needy, (3) they qualify under poverty-related eligibility criteria, (4) they are foster care or adoptive children, (5) they are eligible under a section 1115 demonstration, or (6) they qualify under other child eligibility provisions. States may elect to define the age cutoff for children at 19, 20, or 21 years. Children who have been granted Medicaid eligibility under disability provisions are usually identified as disabled beneficiaries. Some persons under age 21, who are pregnant, or who are parents or caretaker relatives of dependent children, may be identified as adults. By Federal law, all States have to extend Medicaid to children under age 6 with family income less than 133 percent of the FPL and to children under age 19 with family income less than 100 percent of the FPL.

Claim—A request to a carrier, intermediary, a State by a beneficiary, or by a provider acting on behalf of a beneficiary for payment of benefits under Medicare or Medicaid.

CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program; formerly the HCFA-64)—A quarterly report of each state's Medicaid expenditures for which states are entitled to Federal matching payments. It includes categories of expenditures not reported in the Medicaid Statistical Information System (the source of personlevel eligibility and utilization information), such as disproportionate share hospital payments, drug rebates, and (prior to 1998) managed care and certain other premiums.

Coinsurance—The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, that Medicare does not cover and for which the beneficiary is responsible; or, for which Medicaid may pay in the case of certain dually entitled beneficiaries. Under Part A HI, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st-90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of SNF care; from the 21st-100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under Part B SMI, after the annual deductible has been met, Medicare pays 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges are the coinsurance payable by the enrollee. However, there is no coinsurance for home health services or for clinical laboratory services under SMI.

Comparability—Under the Medicaid program, the State must ensure that the same Medicaid

benefits are available to all people who are eligible. Exceptions include benefits approved under Medicaid waiver or demonstration programs for special subpopulations of Medicaid eligibles.

Competitive Medical Plan (CMP)—Legislation in the 1982 TEFRA created this type of MCO to facilitate the enrollment of Medicare beneficiaries into MCPs. CMPs are organized and financed similar to HMOs. The difference is that CMPs are not tied by all the regulatory
requirements of HMOs.

Coordinated Care Plan (CCP)—A plan that includes a CMS-approved network of providers that are under contract or arrangement with the M+C organization to deliver the benefit package approved by CMS. CCPs include plans offered by HMOs, PSOs, PPOs, as well as other types of network plans (except network MSA plans).

Cost-Based HMO—A MCO paid by Medicare for the actual cost of providing care to Medicare enrollees. The term includes cost HMOs, cost CMPs, and HCPPs.

Cost Sharing—The generic term that includes copayments, coinsurance, deductibles, and outof-pocket payments for balanced billing on unassigned claims. Excludes monthly premiums for SMI coverage, voluntary HI coverage, and supplemental insurance.

Copayments—A specified dollar amount, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a prescription.

Coinsurance—A percentage share of medical bills which a beneficiary must pay.

Deductibles—Specified amounts of spending which an individual or a family must incur before insurance begins to make payments.

Covered Charges—Services or benefits for which a health plan makes either partial or full payment (refer to total charges).

Covered Day of Care—A day of care which was covered in full or in part by HI Medicare benefits. This excludes Days of Stay prior to the start of the program on July 1, 1966, Days of Stay prior to the person's entitlement to HI benefits, and Days of Stay after exhaustion of benefits (refer to total Days of Stay).

Covered Services—Services and supplies for which Medicare, Medicaid, or SCHIP will reimburse. (Examples of covered services are given in this glossary under specific headings, such as SNF.)

Current Procedural Terminology (CPT) Codes—A medical code set used for reporting medical services and procedures performed by physicians or other qualified providers. CPT codes, descriptions, and other data only are copyright 2001 American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).

Deductible—The amounts paid by enrollees or by a third party for covered services before Medicare or Medicaid makes reimbursements. The Medicare HI deductible applies to each new benefit period, is determined each year by a formula specified by law, and approximates the current cost of a 1-day inpatient hospital stay. The Medicare SMI deductible is, by law, the first $100 of covered charges per CY, effective January 1, 1991.

Deficit Reduction Act of 1984 (DEFRA)—Required States to provide Medicaid coverage to the following groups meeting AFDC income and resources requirements: (1) first-time pregnant women who would be eligible for AFDC if the child were born; (2) pregnant women in two-parent families with an unemployed principal breadwinner; and (3) children born after September 30, 1983, up to age 5, in two-parent families. Extends one year of automatic Medicaid eligibility (e.g., without separate application) to infants born to women who were eligible for and receiving Medicaid at the time of the child's birth. Child remains eligible so long as the mother remains eligible.

Department of Health and Human Services (DHHS)—Administers many of the social programs of the Federal Government dealing with the health and welfare of the citizens of the U.S.

Diagnosis Related Groups (DRGs)—A patient classification system that categorizes patients into groups that are clinically coherent and homogeneous with respect to inpatient SSH resource use. The Medicare PPS uses approximately 500 DRGs as the basis for paying participating SSHs under Medicare.

Disabled—One of the categories used for classifying Medicare enrollees and Medicaid eligibles. Under Medicare, disabled under age 65 receiving Social Security or RRB disability insurance benefits for 24 months are eligible for coverage. Individuals under age 65 who are diagnosed with ESRD are also eligible to receive Medicare benefits and are included with the disabled unless otherwise noted. Under Medicaid, refers to low-income individuals of any age who are eligible as persons meeting SSA's programmatic definition of disability. This includes individuals receiving SSI as well as those whose incomes are too high for SSI, but qualify under separate Medicaid income standards.

Discharge—A formal release from a hospital (under Medicare or Medicaid), a SNF (under Medicare), or a NF (under Medicaid). Discharges include persons who died during their stay or were transferred to another facility.

Disproportionate Share Hospitals (DSHs)—Hospitals that serve a disproportionately large volume of low-income persons. Hospitals that meet DSH criteria may receive supplemental payments from Medicare and Medicaid.

Dual Eligible—A person having entitlement to more than one program or plan. The term is sometimes limited to an individual who is eligible both for Medicare and Medicaid coverage, depending on the services and limitations placed by the State, as well as payment of Medicare monthly premium, deductibles, and coinsurance. More broadly used to include Medicare beneficiaries eligible for some or all of the Medicare cost sharing, but not full Medicaid benefits (refer to buy-in, dual entitlement, MN, QMB, QDWI, and SLMB).

Dual Entitlement—Indicates that an individual is entitled to both Medicare and some or all Medicaid coverage (refer to buy-in, dual eligible, MN, QMB, QDWI, and SLMB).

Durable Medical Equipment (DME)—Under Medicare, Medicaid, and SCHIP DME includes certain medical supplies and such items as hospital beds, wheelchairs, assistive devices, and oxygen, etc., used in a patient's home.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)—A screening and diagnostic and treatment program under Medicaid with the specific focus toward recipients under age 21, which reviews any physical or mental problems and the associated medical requirements to address these problems.

Eligibility—Meeting the requirements for coverage under Medicare, Medicaid, or SCHIP. In Medicaid data, the term eligible is often used to refer to individuals who qualify and have actually enrolled in the program.

End Stage Renal Disease (ESRD)—Irreversible kidney failure. To survive, the patient must either receive a kidney transplant or periodic kidney dialysis. Individuals with ESRD are eligible for Medicare benefits under a special entitlement.

Enrollee—A person who is eligible for coverage and is enrolled in the Medicare, Medicaid, or SCHIP programs.

ESRD Enrollees—Individuals who have chronic kidney disease requiring renal dialysis or a kidney transplant are considered to have ESRD. To qualify for Medicare coverage, such individuals must be fully or currently insured under Social Security or the Railroad Retirement System or be the dependent of an insured person. Eligibility for Medicare coverage begins the third month after the month in which a course of renal dialysis begins; coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility. Also, coverage may begin on admittance to a hospital to receive a kidney transplant or to receive dialysis before the transplant.

Federal HI Trust Fund—A trust fund of the U.S. Treasury in which monies collected from taxes on annual earnings of employees, employers, and self-employed persons covered by Social Security are deposited. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the HI program.

Federal Medical Assistance Percentage (FMAP)—The percentage of Medicaid benefit payments reimbursed by the Federal Government. FMAP is calculated annually based on a formula designed to provide a higher Federal matching rate to States with lower per capita income and by law may range from a minimum of 50 percent and to a maximum of 83 percent.

Federal SMI Trust Fund—A trust fund of the Treasury of the United States consisting of amounts deposited in or appropriated to the fund as provided by Title XVIII of the Social Security Act, including premiums paid by enrollees under SMI and contributions by the Federal Government from general revenues. Disbursements from the fund are made for benefit payments and administrative expenses incurred by the SMI program.

Federally Qualified Health Center (FQHC)—Health centers that have been approved by the Federal Government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless. Typically, Medicaid provides higher payment rates for outpatient facilities designated as FQHCs compared to facilities not so designated.

Federally-Qualified HMO—An HMO which meets Federal requirements for certification as a prepaid health plan that is able to offer a comprehensive range of services through a specified network of providers.

Federal Poverty Level (FPL)—Low-income guidelines established annually by the Federal Government. Public assistance programs, including Medicaid and SCHIP, often define income limits in relation to FPL.

Fee-for-Service (FFS) Reimbursement—The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide.

Fiscal Year (FY)—The 12-month period under which the Federal Government operates. Until 1976, the FY extended from July 1 of each year-June 30 of the following year. Beginning in 1976, the FY was changed to October 1-September 30. (The 3-month period July-September 1976—the so-called transition quarter—does not belong to any FY.) FY's are labeled by the year in which they end, e.g., October 1, 2000-September 30, 2001 is called FY 2001.

Freedom of Choice—Under Medicaid, the principle that a State must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.

General Hospital—A hospital maintained primarily for short-term inpatient care of acute illness or injury and for obstetrics.

Geographic Classifications:

- All Areas—The United States, Guam, Puerto Rico, Virgin Islands, other outlying areas, and foreign countries are included.

- All Other Areas—American Samoa, Canton Island, Caroline Islands, Guam, Puerto Rico,

- Mariana Islands, Marshall Islands, Midway Islands, Virgin Islands, and Wake Islands comprise this category.

- Place of Residence—The beneficiary's place of residence classification is a mailing address, not necessarily an actual place of residence. Some beneficiaries have their checks mailed to a post office or to a representative payee in a State or county that may differ from their own residence.

- Metropolitan Areas (MAs)—The general concept of a MA is one of a core area containing a large population nucleus, together with adjacent communities that have a high degree of social and economic integration with that core. Metropolitan Statistical Areas (MSAs), Consolidated Metropolitan Statistical Areas (CMSAs), and Primary Metropolitan Statistical Areas (PMSAs) are defined by the Office of Management and Budget (OMB) as a standard for Federal agencies in the preparation and publication of statistics relating to metropolitan areas. The entire territory of the United States is classified as metropolitan (inside MSAs or CMSAs) (PMSAs are components of CMSAs) or non-metropolitan (outside MSAs or CMSAs). MSAs, CMSAs, and PMSAs are defined in terms of entire counties except in New England, where the definitions are in terms of cities and towns. OMB also defines New England County Metropolitan Areas (NECMAs) which are county-based alternatives to the MSAs and CMSAs in the six New England States. Over time, new MAs are created and the boundaries of others change. The analysis of historical trends, therefore, must be made cautiously (refer to urban and rural).

- Urban and Rural—The urban population comprises all persons living in (a) places of 2,500 or more inhabitants incorporated as cities, villages, boroughs (except in Alaska and New York), and towns (except in the New England States, New York, and Wisconsin), but excluding those persons living in the rural portions of extended cities (places with low population density in one or more large parts of their area); (b) census designated places (previously termed unincorporated) of 2,500 or more inhabitants; and (c) other territory, incorporated or unincorporated, included in urbanized areas. An urbanized area comprises one or more places
  and the adjacent densely settled surrounding territory that together have a minimum population of 50,000 persons. In all definitions, the population not classified as urban constitutes the rural population.

HCFA-2082 (Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services)—An annual statistical report designed to collect State-reported data on Medicaid eligibles, beneficiaries, and expenditures by basis of eligibility, maintenance assistance status, type of service and characteristics of the beneficiary. The reporting system continued through FY 1998 and was replaced in 1999 by tables produced from the Medicaid Statistical Information System (MSIS). The HCFA-2082 differed from the HCFA-64 (now the CMS-64) in that not all actual expenditures are reported, the biggest differences being the absence of disproportionate share hospital payments, drug rebates, and prior to 1998 managed care and certain other premiums. Internal to the report itself, certain lump-sum, aggregate payments could not be associated with individual Medicaid beneficiaries, and their characteristics, which is the basis of reporting in the HCFA-2082 and from MSIS.

Healthcare Common Procedure Coding System (HCPCS)—A Medicare coding system for all services performed by a physician or supplier. It is based on the American Medical Association physicians' CPT codes and is augmented with codes for physician and non-physician services and supplies (such as ambulance and DME) which are not included in CPTs. State Medicaid agencies, with local modifications, use this system as a basis for reimbursement for ambulatory services.

Health Care Financing Review (HCFR)—The Health Care Financing Review is published quarterly by CMS' Office of Research, Development, and Information. The Review seeks to contribute to an improved understanding of the Medicare and Medicaid Programs and the U.S. health care system by presenting information and analyses on a broad range of health care financing and delivery issues. The Review highlights the results of policy-relevant research and provides a forum for a broad range of diverse viewpoints to stimulate discussions among a diverse audience that includes policymakers, planners, administrators, insurers, researchers, and health care providers.

Health Care Prepayment Plan (HCPP)—A MCO that contracts with CMS to enroll Medicare beneficiaries for coverage of some or all Medicare-covered physician and supplier services (Part B). HCPPs are paid on a reasonable-cost basis.

Health Insurance Claim Number (HICN)—A unique identifier of each Medicare beneficiary. It consists of a Social Security or RRB account numberplus a BIC.

Health Insurance Flexibility and Accountability (HIFA)—Demonstration initiative which encourages new comprehensive State approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. Emphasis is on broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the FPL.

Health Maintenance Organization (HMO)—An organization that manages and delivers a comprehensive package of health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each enrollee. The dollar amount is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO may suffer loses. If the enrollees cost less, the HMO profits, thus providing incentive for cost control (refer to managed care).

Home and Community-Based Services (HCBS) Waiver—An enabling Section, 1915(c), in the Social Security Act that authorizes the Secretary of HHS to alter a State Medicaid program. This waiver offers special services to beneficiaries who are at risk of being placed in a nursing facility or facility for the mentally retarded. HCBS include case management, homemaker/home health aide services, personal case services, adult day health services, rehabilitation services, and respite care.

Home and Community Care for the Functionally Disabled Elderly—An optional Medicaid State plan benefit which allows States to provide home and community-based services to functionally disabled elderly individuals.

Home Health Agency (HHA)—A public or private organization that provides skilled nursing services and other therapeutic services in the patient's home and that meets certain conditions to ensure the health and safety of the individual.

Home Health Services—Services furnished in a patient's home under the care of physicians.

These services are furnished under an established plan and periodically reviewed by a physician. They include part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services; medical supplies and appliances (other than drugs and biological); home health aide services; and services of interns and residents.

Hospice—A public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to patients that are certified to be terminally ill. Medicare beneficiaries may elect to receive hospice care instead of standard Medicare benefits for terminal illnesses. Under Medicaid, beneficiaries electing hospice no longer receive Medicaid covered therapeutic services.

Hospital Insurance (HI)—Medicare HI (also known as Medicare Part A) is an insurance program providing basic protection against the costs of hospital and related post-hospital services for individuals who are age 65 or over and are eligible for retirement benefits under the Social Security or the RRB system, for individuals under age 65 who have been entitled for at least 24 months to disability benefits under the Social Security or RRB system, and for certain other individuals who are medically determined to have ESRD and are covered by the Social Security or RRB system.

Hospital Insurance (Part A)—The part of Medicare that pays for inpatient hospital stays, care in a SNF, hospice care, and some home health care.

Independence Plus—An initiative which expedites the ability of States to offer many Medicaid program participants greater opportunities to take charge of their own health and direct their own services through a self-directed option. Families and individuals exercise greater choice, control, and responsibility for their services within cost neutral standards. Statutory authority for this initiative is found at §1115 and §1915(c) of the Social Security Act. Independence Plus allows eligible families and individuals to use a cash allowance or individual budget to obtain personal assistant services and related supports. In the 1115 demonstration, the participant may or may not manage the cash directly. In the 1915(c) waiver, the participant uses fiscal/employer agent and does not manage cash directly.

Inpatient Hospital Services—Items and services furnished to an inpatient of a hospital by the hospital, including room and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Institutional Services—For Medicare, includes those services provided by hospitals (outpatient and inpatient), HHAs, hospices, comprehensive outpatient rehabilitation facilities, ESRD facilities, local health clinics, and SNFs. For Medicaid, also includes NFs and ICFs/MR.

Intermediary—An organization selected by providers of health care that has an agreement with DHHS to process and pay institutional claims and perform other functions under Medicare's health insurance program.

Intermediate Care Facilities for the Mentally Retarded (ICF/MR)—Optional Medicaid service that provides residential care and services for individuals with mental retardation.

International Classification of Diseases - 9th Revision, Clinical Modification (ICD-9-CM)—A diagnosis and procedure classification system. ICD-9-CM codes are the basis for grouping patients into DRGs.

Laboratory and Radiological Services—Professional and technical laboratory and radiological services which may be ordered and provided by or under the direction of a physician or other licensed practitioner, or ordered by a physician and provided by a referral laboratory. These services must meet requirements of the Clinical Laboratory Improvement Amendment of 1988.

Lifetime Reserve—A Medicare HI enrollee has a non-renewable lifetime reserve of 60 days of inpatient hospital

care to draw on if the 90 covered days per benefit period are exhausted. Patients are required to pay a daily coinsurance amount equal to one-half of the inpatient hospital deductible for each lifetime reserve day.

Managed Care—A system in which the overall care of a patient is overseen by a single provider or organization. Many State Medicaid programs include managed care components as a method of ensuring quality in a cost-efficient manner.

Managed Care Organization (MCO)—Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. These include entities such as HMOs, PPOs, and point of service plans. In the Medicaid world, other organizations may set up programs to provide Medicaid managed care. These organizations include FQHCs, integrated delivery systems, and public health clinics.

Managed Care Plan (MCP)—A general term applied to a wide range of insurance plans,

including HMOs, where choice of providers is limited and administrative measures control

utilization of services. The types of Medicare and Medicaid MCPs include HMOs, CMPs, and HCPPs.

Mandatory versus Optional Services—Mandatory services are a specific set of services that must be covered by any State participating in the Medicaid Program (unless waived under section 1115 of the Social Security Act) as opposed to those which a State may elect to include under its Medicaid plan or waivers.

Medicaid—The joint Federal/State entitlement program, enacted in 1965 as Title XIX of the Social Security Act, that pays for medical care on behalf of certain groups of low-income persons.

Medicaid Drug Rebate Program—Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA1990), the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive Federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by the CMS' CMSO.

Medicaid Statistical Information System (MSIS)—As a result of legislation enacted from the Balanced Budget Act of 1997, States are required to submit all their eligibility and claims data on a quarterly basis, beginning in FY 1999, through the MSIS. MSIS is the basic source of State-reported eligibility and claims data on the Medicaid population, their characteristics, utilization, and payments. This system replaced the HCFA-2082.

Medical Savings Account (MSA)—A plan for the purpose of paying the qualified expenses of the account holder from a custodial account or trust.

Medically Needy (MN) Eligibles—An optional Medicaid eligibility group consisting of individuals who qualify under an income standard—the MN income level—that is separate from the standards used for categorically needy coverage. MN enrollees must meet Medicaid's categorical requirements (aged, disabled, adults with children, children) and may meet the MN income level by incurring high medical expenses—usually from hospital or nursing home care— which are deducted from their incomes in the process known as "spend-down".

Medicare Advantage (MA)—The Medicare health plan program established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which replaced the Medicare+Choice program (refer to M+C). MA options for beneficiaries can include CCPs (local HMOs, PPO plans, private FFS plans, and MSA plans, as well as regional PPO plans). In addition to introducing the regional PPO option, the MMA also introduced special needs plans (SNPs). While other MA plans are required to permit enrollment by any eligible beneficiary residing in the plan's service area, SNPs may limit their enrollment to certain categories of individuals, such as dual-eligible beneficiaries (those eligible for Medicare and Medicaid) or people with special health care needs (such as those with chronic illnesses, or those with ESRD). The MMA continued the M+C requirement that in order to enroll, a beneficiary must be entitled to Part A and enrolled in Part B. The prohibition on enrollment for beneficiaries with ESRD continues in MA except in the case of ESRD special needs plans. The MMA also made changes to the payment rules for plans by introducing a bidding system and a requirement that plans return to the government 25 percent of the savings that they can achieve in providing Medicare A and B services (in relation to a benchmark payment level).

Medicare Catastrophic Coverage Act (MCCA)—An amendment to Title XVIII of the Social Security Act designed to provide protection against catastrophic medical expenses and for other purposes. Many of its provisions were rescinded after being in effect for only CY 1989.

Medicare Current Beneficiary Survey (MCBS)—Survey in which a sample of Medicare

beneficiaries is interviewed to collect information on demographic characteristics, health status and functioning, insurance coverage, financial resources, and family supports. The beneficiaries are interviewed again periodically to form a continuous profile of their health care experience.

Medicare+Choice (M+C)—A Medicare Program established by the Balanced Budget Act of 1997 that is designed to provide Medicare enrollees more choices among health plans. Beneficiaries entitled to Part A and enrolled in Part B are eligible to enroll in an M+C plan (except those beneficiaries who already have ESRD). M+C also modified the methodology used to determine capitation payments to covered plans (refer to AAPCC).

Medicare Supplemental Insurance (MSI) or Medigap—Private insurance which supplements Medicare by paying Medicare deductibles and coinsurance. There are 10 nationally standardized policies. Some policies offer coverage not provided by Medicare, such as coverage for outpatient prescription drugs and care outside the U.S.

Midpoint Enrollment—Enrollment as of July 1 has been chosen as the denominator for Medicare utilization rates. The choice was based on the similarity of the July 1 enrollment to a 12-month average enrollment.
National Center for Health Statistics (NCHS)—The component of the U.S. Public Health Service which collects and maintains national and subpopulation statistics on various aspects of public health.

Non-Institutionalized—Individuals not living in facilities such as nursing homes.

Nursing Facility (NF)—A facility licensed by the State and certified by Federal statute and regulations that a NF meets applicable requirements, services are provided to beneficiaries age 21 or over.

Office of Clinical Standards and Quality (OCSQ)—This CMS component serves as the focal point for all quality, clinical, and medical science issues and policies for the Agency's programs. OCSQ has overall responsibility for the End Stage Renal Disease (ESRD) Network, and for the quality improvement organizations, formerly the peer review organization program.

Office of Financial Management (OFM)—This CMS component has overall responsibility for the fiscal integrity of CMS' programs.

Office of Information Services (OIS)—This CMS component is the organizational home to the CMS Chief Information Officer and the maintainer of the CMS data infrastructure. OIS provides connectivity, data maintenance, data dissemination, and technical assistance to the internal and external CMS.

Office of Research, Development, and Information (ORDI)—This CMS component provides the Agency with analytic support and information. ORDI is responsible for environmental scanning activities, designing and conducting research and evaluations of health care programs, designing and assessing potential improvements, and developing new measurement tools. ORDI coordinates all Agency demonstration activities, and develops research, demonstration, and other publications and papers related to health care issues.

Office of the Actuary (OACT)—This CMS component provides actuarial, economic and statistical services to various CMS components, other Federal agencies, the Medicare Board of Trustees, Congress, national advisory commissions, health research groups, and outside organizations.

Omnibus Budget Reconciliation Act (OBRA)—Federal law of a given year which directs how Federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts. Legislative changes may also be enacted directly (refer to TEFRA, DEFRA, MCCA).

Optional versus Mandatory Services—Optional services are those services which a State elects to include under its plan or managed care waivers as opposed to those which are required.

Outpatient Hospital Services—Services furnished to outpatients by a participating hospital for diagnosis or treatment of an illness or injury.

Outpatient Services—Medical and other services provided by a hospital or other qualified facility or supplier, such as mental health clinic, rural health clinic, X-ray mobile unit, or freestanding dialysis unit. Such services include: outpatient physical therapy, diagnostic X-ray and laboratory tests, and X-ray and other radiation therapy.

Participating Physician or Supplier—A physician/supplier that agrees to accept assignment on all Medicare claims under the Medicare SMI program. In Medicaid, participating providers agree to accept Medicaid reimbursement as payment in full.

Personal Health Care Expenditures (PHCE)—Health care goods and services purchased directly by or for individuals. They exclude: public program administration costs, the net cost of private health insurance, research by non-profit groups and government entities, and the value of new construction put in place for hospitals and nursing homes.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996— Created the TANF program to replace the earlier AFDC program (refer to AFDC and TANF).

Persons Served—A concept used for measuring utilization of covered services and program payments for these services. In general, under Medicare, a person served is considered to be a Medicare enrollee who used a covered health care or medical service under fee-for-service and incurred expenses greater than the deductible amount, resulting in the program making a payment on the enrollee's behalf. (When the term person served is used to describe a person who used a covered service regardless of having met the deductible, it will be indicated

by the footnotes.) Under Medicaid, a person served is considered to be a person for whom some sort of payment has been made for selected categories of service or coverage within the categories reported in the applicable Medicaid statistical reporting systems. Under the HCFA-2082 reporting system, person served generally referred to persons for whom Medicaid made a payment to a provider under fee-for-service. The concept was expanded in the Medicaid Statistical Information System to include persons for whom managed care capitated premiums and certain private health insurance premiums were made. Under Medicaid a person served is variously referred to as a Medicaid recipient or beneficiary. (Note: For utilization reporting, the payment of the Medicare Part B premium alone for a Medicare/Medicaid dual eligible beneficiary has never been construed as qualifying the person to be considered a person served.) For both programs, persons are counted once for each type of covered service used, regardless of the number of services used. That is, a person receiving the same service two or more times in a year is counted as one person served. For example, persons having two or more hospitalizations during a year are counted as one person served for inpatient hospital services. In addition persons are counted once in aggregate or overall categories, regardless of the different categories of services used. Thus a person who receives inpatient hospital services and nursing home care (skilled nursing facility under Medicare, nursing facility under Medicaid) services in a year is counted separately as receiving each of these services, but is counted only once in calculating all persons served.

Physician Payment Reform (PPR)—Was implemented by OBRA 1989. Under OBRA 1989, a Medicare fee schedule payment system for physician services replaced the previous reasonable charge payment system.

Physician Services—Under Medicare, physicians' services are services provided by an individual licensed under State law to practice medicine or osteopathy. Services covered by hospital bills are not included.

Poverty-Related Eligibles—These individuals are eligible for Medicaid without regard to cash assistance or MN standards. They are eligible for Medicaid based on income below a stated percentage of the FPL. They include pregnant women, newborns up to age 1, children up to age 18, aged, blind, and disabled individuals. At State option, certain aged, blind, and disabled poverty-related eligibles may receive the full scope of Medicaid benefits.

Preferred Provider Organization (PPO)—An arrangement between a provider network and a health insurance or a self-insured employer. Providers generally accept payments less than traditional FFS payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care.

Premium—A monthly fee that may be paid by Medicare, Medicaid, and SCHIP enrollees. Medicare HI enrollees who are Social Security or RRB beneficiaries and who qualify for coverage through age or disability are not required to pay premiums. Aged persons who are not eligible for automatic HI enrollment may pay a monthly premium to obtain HI coverage. SMI enrollees pay a monthly premium that is updated annually to reflect changes in program costs.

Prepaid Health Plan (PHP)—A partially capitated managed care arrangement in which a managed care company is at risk for certain outpatient services.

Primary Care—Basic or general health care, traditionally provided by family practice, pediatrics, and internal medicine.

Primary Care Case Management (PCCM)—Managed care option allowed under Section 1915(b) of the Social

Security Act in which each participant is assigned to a single primary care provider who must authorize most other services, such as care by specialty physicians, before the other providers can be reimbursed by Medicaid. Usually, services for care other than the case management fee are reimbursed on a FFS basis.

Principal Diagnosis—Under Medicare, the medical condition that is chiefly responsible for the admission of a patient to a hospital or for services provided by a physician or other provider. Under Medicaid, the diagnosis reported as the principal diagnosis on the last dated claim for a hospital stay.

Program Payments—The Medicare program payment amount includes only the amount shown in bills received and processed (as of a specific cutoff date) by the Medicare program in the CMS central office files. Not included in program payments are interim payments to institutional providers, payments to institutional providers resulting from adjustments to the end of FY cost reports, capitation payments for prepaid group health plans, beneficiary cost-sharing amounts, and administrative costs.

Programs of All-inclusive Care for the Elderly (PACE)—An optional Medicaid benefit that combines medical, social, and long-term care services for frail people. To be eligible, a person must:

- • Be age 55 or over.
- • Live in the service area of the PACE program.
- • Be certified as eligible for nursing home care by the appropriate State agency.
- • Be able to live safely in the community.

The goal of PACE is to help people stay independent and live in their community as long as possible, while getting high quality care they need.

Prospective Payment System (PPS)—A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

Provider—A Medicare provider is a facility, supplier, physician, or other individual or organization that furnishes health care services. Under Medicaid, a provider is an individual, group, or agency that provides a covered Medicaid service to a Medicaid enrollee.

Provider-Sponsored Organization (PSO)—Public or private entities established by or organized by health care providers or a group of affiliated providers that provide a substantial proportion of health care items and services directly through providers or affiliated groups of providers and share substantial financial risk.

Qualified Disabled and Working Individuals (QDWI)—Medicaid is required to pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These are individuals whose income is below 200 percent of the FPL and whose resources are not more than twice the value allowed under SSI (refer to buy-in, dual eligible, dual entitlement, MN, QMB, and SLMB).

Qualified Medicare Beneficiary (QMB)—A low-income Medicare beneficiary who qualifies for certain assistance under Medicaid. The beneficiary must have Medicare Part A and income less than or equal to 100 percent of the FPL and resources below twice the value allowed under SSI. For those who qualify, the Medicaid

program must pay Medicare Part A premiums (if applicable), Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare covered services depending on the State's fee schedule. Some of these individuals may qualify for full Medicaid benefits and are sometimes referred to as "QMB pluses" (refer to buy-in, dual eligible, dual entitlement, MN, QDWI, and SLMB).

Qualifying Individual (QI)—A low-income Medicare beneficiary for whom Medicaid pays all or part of the Medicare Part B premium, depending on beneficiary income and resources. States receive 100 percent matching from the Federal Government for this program. Congress provided funding for the QI program through FY 2002.

Railroad Retirement Board (RRB)—Independent agency of the Federal Government charged with administering the retirement-survivor and unemployment-sickness benefit program for railroad workers and their families.

Railroad Retirement System—Was legislated by the Railroad Retirement and Railroad

Unemployment Insurance Acts as a comprehensive retirement-survivors and unemploymentsickness benefits programs for railroad workers and their families.

Reasonable Cost—In processing claims for HI benefits, intermediaries use CMS guidelines to determine the reasonable cost incurred by individual providers in furnishing covered services to enrollees. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the HI program.

Recipient—A Medicaid enrollee who receives a Medicaid-covered service (an alternate reference to beneficiary).

Reduction Amount—The difference between the physician's submitted charge and the Medicare allowed charge.

Revenue Center—A facility cost center for which a separate charge is billed on an institutional claim.

Risk Contract—An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense, or degree.

Risk HMO—An organization that is paid a predetermined per-member payment by Medicare or Medicaid to provide all necessary covered services to its enrollees.

Resource Utilization Group Version III (RUG-III)—A patient classification system used to classify nursing home residents into homogeneous patient groups according to common health characteristics and the amount and type of resources they use.

Secondary Diagnosis—A medical condition other than the principal diagnosis that affected the treatment received, or length of stay in a hospital, or services rendered by a physician or other provider.

Short-Stay Hospital (SSH)—A hospital in which the average length of a stay is less than 30 days. General and special hospitals are included in this category.

Single State Agency—The Social Security Act requires that the State designate a single agency to administer or supervise administration of the State's Medicaid plan.

Skilled Nursing Facility (SNF)—In Medicare, an institution that has a transfer agreement with one or more participating hospitals, is primarily engaged in providing skilled nursing care and rehabilitative services to inpatients, and meets specific regulatory certification requirements.

SNF Services—In Medicare, services furnished to inpatients of a certified SNF that meets standards required by the Secretary of the DHHS and billed by the facility.

Social Security Act—The Titles of the 1965 Social Security Act include: Title II—Old Age, Survivors, and Disability Insurance Benefits (OASDI); also, Social Security; Title IV-A AFDC; Title IV-B—Child Welfare; Title IV-D—Child Support; Title IV-E—Foster Care and Adoption; Title IV-F—Job Opportunities and Basic Skills Training; Title V—Maternal and Child Health Services; Title XVI—SSI; Title XVIII—Medicare; Title XIX—Medicaid; Title XX—Social Services; and Title XXI—SCHIP.

Social Security Administration (SSA)—The Federal agency responsible for administering the Old Age, Survivors, and Disability Insurance (OASDI) program as well as the Supplemental Security Income (SSI) program of the Social Security Act.

Specified Low Income Medicare Beneficiary (SLMB)—A low-income Medicare beneficiary who qualifies for certain assistance under Medicaid. The beneficiary must have income above 100 percent, but not in excess of 120 percent of the FPL and limited resources. For those who qualify, the Medicaid program pays the Medicare Part B premium. Some of these individuals may qualify for full Medicaid benefits and are sometimes referred to as "SLMB pluses" (refer to buy-in, dual eligible, dual entitlement, MN, QMB, and QDWI).

State Children's Health Insurance Program (SCHIP)—A program designed to provide health coverage to uninsured children with incomes too high to qualify for Medicaid, but too low to afford private health insurance. SCHIP is funded through a Federal/State partnership and was enacted as part of the Balanced Budget Act of 1997.

Statewideness—A State Medicaid program must offer the same benefits to everyone throughout the State, exceptions being possible through Medicaid waivers and special contracting options (refer to waivers).

Supplemental Security Income (SSI)—A program of income support for low-income, aged, blind, and disabled persons established in Title XVI of the Social Security Act.

Supplementary Medical Insurance (SMI)—Also known as Medicare Part B, this is a voluntary insurance program that provides insurance benefits for physicians, outpatient hospital services, ambulatory services, and other medical supplies and services to aged and disabled individuals who elect to enroll under the program in accordance with the provisions of Title XVIII of the Social Security Act. The SMI program is financed by enrollee premium payments and contributions from funds appropriated by the Federal Government.

Supplier—An organization that has been issued a Medicare supplier number, and which provides DME (such as wheelchair, walker, and oxygen equipment), medical devices (such as artificial limbs and braces), or medical supplies (such as surgical dressings).

Supplier Services—The SMI program pays for covered supplier services. As defined in the CMS Part B Medicare annual data users' manual, these services include those provided by medical supply companies (for example, supplies and DME), ambulance suppliers, independent laboratories (billing independently), pharmacies, portable X-ray suppliers (billing ndependently), and voluntary health or charitable agencies.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)—Permits States to cover under Medicaid disabled children under age 19 who live at home who would have been eligible if in an institution. States must determine that institutional care would have been required, that home care is appropriate, and that the estimated cost of home care is no more than institutional care.

Temporary Assistance for Needy Families (TANF)—Created by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, TANF provides assistance and work opportunities to needy families. This program replaced the earlier AFDC program (refer to AFDC and PRWORA).

Total Charges—The hospital's charges for room, board, and ancillary services as recorded on the billing form (refer to covered charges).

Total Days of Stay—Any day during which inpatient hospital services were furnished to a person eligible for HI benefits under Medicare including covered and non-covered Days of Stay.

Total Personal Health Care Expenditures (PHCE)—The sum of all expenditures for health care by Medicare, Medicaid, private insurance, out-of-pocket, and all other public and private sources.

Uniform Bill 82 (UB82)—A Medicare claim form used by institutional providers from 1984 to 1993. In October 1993, the UB82 was replaced by the UB92.

Unique Physician Identification Number (UPIN)—A number which uniquely identifies an individual physician.

Utilization—A measure of the extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per number of persons eligible for the services.

Waiver—An exception to the usual requirements of Medicare or the usual requirements of Medicaid granted to a State by CMS, authorized through the following sections of the Social Security Act or Social Security Amendments:

402 of the Social Security Amendments of 1967—Provides Medicare demonstration authority to test alternative methods of Medicare payment and changes to the Medicare benefit package.

1115 of the Social Security Act—Allows States to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid Program. Radical, systemwide changes are possible under this provision.

1915 (b) of the Social Security Act—Allows States to waive freedom of choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager.

1915(c) of the Social Security Act—Allows States to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify for services in an ICF/MR, nursing facility, institution for mental disease, or inpatient hospital.

1929 of the Social Security Act—Allows States to provide a broad range of home and community-based services

to functionally disabled individuals as an optional State plan benefit. In all States except Texas, the option can serve only people age 65 or over.