THE CENTERS FOR MEDICARE AND MEDICAID SERVICES
INTRA-AGENCY AGREEMENT
Eliminating Barriers to American Indian and Alaska Native (AI/AN) Data in State Medicaid Systems.

Between the Indian Health Service (IHS)
and the
Centers for Medicare and Medicaid Services (CMS)
IA-02-161

I. Purpose

The purpose of this agreement is to provide the Indian Health Service with assistance and policy-based support in order to integrate their Resource Patient Management System (RPMS) with State Medicaid eligibility systems. IHS will work closely with CMS Central and Regional Office (RO) in order to accomplish this task.

Upon completion, this effort will benefit CMS in that Medicaid demographic data relative to the AI/AN population served by the IHS will be submitted by states and remain available within CMS systems further allowing for data analysis in the consideration of AI/AN policy.

II. Authority

The Economy Act of 1932, as amended (31 U.S. C. 1535), which authorizes transfer of funds from an agency to another under an intra-agency agreement.

III. Background

The IHS is an Agency in the Department of Health and Human Services (HHS). It is responsible for providing health care to more than 1.5 million eligible American Indians and Alaska Natives. The mission of IHS is to raise Indian health status to the highest possible level. IHS focuses its health programs on Indian tribes, which are diverse in terms of culture, history and size, as well as reservation size and geography. Health status also varies between tribes, but on the whole is considerably below that of the general population in the United States. With appropriations totaling approximately $1.6 billion in 2001, IHS administers its programs through 12 geographically defined IHS area offices, 47 IHS hospitals and 150 outpatient health centers, primarily located in rural and frontier settings.

The Indian Health Care Improvement Act, originally passed in 1974, amended Titles XVIII and XIX of the Social Security Act making it possible for CMS to pay the IHS, another Federal agency, for the Medicare and Medicaid services their providers provide to American Indian and Alaska Native Beneficiaries. Relative to the size of the IHS and its health care system, Medicaid income is significant and becoming increasingly more so due to the poor economic status of most reservations.

The Medicaid program began in 1965 with the passage of Title XIX of the Social Security Act. Thirty-five years later, Medicaid still provides low-income and disabled Americans with access to medical and health-related services. Since 1966, Medicaid provides health insurance to more than 36 million people and as each year passes the program strives to expand its coverage to assist the uninsured and underinsured. Medicaid provides three types of health protection: 1) health insurance for low-income families and people with disabilities; 2) long-term care for older Americans and people with disabilities, and 3) coverage that helps low-income elderly offset shortfalls in their Medicare benefit.

The Medicaid program is a joint Federal-State partnership. The Federal government partially funds the program and establishes mandatory and optional program characteristics. The HHS' Centers for Medicare and Medicaid Services (CMS) provides Federal Financial Participation (FFP) matching rates to encourage and assist States in developing systems that improve the management of their Medical Assistance Program. Systems such as the Medicaid Management Information System (MMIS) and Integrated Eligibility System (IES) represent two of the larger scale systems that States use in support of their programs. In FY97, CMS spent over $600 million on State MMIS. CMS and RO staffs certify the initial operation of the systems, as well as review and approve all major purchases and changes to the MMIS. The States provide their share of funding (varies from State to State), choose which program options they wish to implement, and directly administer the program in their State. Within broad national guidelines, which the Federal government provides each of the States: 1) establishes its own eligibility standards; 2) determines the type, amount, duration, and scope of services; 3) sets the rate of payment for services; 4) administers its own program. As a result, Medicaid coverage, eligibility, and reimbursement rules differ from State to State, and may vary dramatically.

In calendar year 2002, all States will operate a Medicaid Management Information System (MMIS) to handle claims processing and information needs. While the MMIS can be tailored to a specific State's needs, most are designed to serve six broad functions: beneficiary information, provider information, claims processing, surveillance and utilization review, management and administrative reporting, and maintaining a reference file. Many States shifting their Medicaid population from a fee-for-service model to a managed care model may use the MMIS to handle payment for capitated plans.

MMIS' have numerous external interfaces with outside entities. One such interface is the data exchange MMIS has with the State's Integrated Eligibility System (IES). The IES is used to determine Medicaid eligibility and eligibility for other assistance programs. It is the primary source for populating the Medicaid eligibility files during claims processing and eligibility inquiries. The Food and Nutrition Services (FNS), the Administration for Children and Families (ACF), and CMS, jointly fund these IES'. In addition, State MMIS' exchange data with managed care plans, CMS' Medicare Buy-in System, and CMS's Medicaid Drug Rebate Initiative System.

The IHS is responsible for providing federal health services to AI/ANs. Health policy issues, such as: access to care, quality of care provider, performance measurements of AI/AN providers, and costs of service providers are as predominant in the AI/AN population as they are nationwide. There has been considerable concern amongst the Tribes that CMS does not have

quality data on their population. This is largely due to the fact that CMS reimburses IHS and Tribal programs for services rendered through an all-inclusive rate. This monetary amount is sent to providers on the basis of a "bundled" number of services provided to each member of the AI/AN population. In order for this method of payment to continue, which is the preference for IHS and Tribes, it is important to create a process whereby data related to the AI/AN beneficiary population could be transferred to State MMIS' to allow subsequent transfers to CMS.

IV. Scope of Work and Responsibilities

IHS will:

A. Work closely with staff at CMS Central Office to prepare a Workplan detailing the work to be performed and how it will be performed, who will be involved, timeframes for accomplishing specific tasks, including delivery dates.

B. Prepare and submit monthly progress reports to work agreed upon in the approved work plan. The reports must describe and establish key process areas that IHS systems are to address in creating a systemic change for the transmission of AI/AN data. Additionally, the report shall indicate the vulnerabilities associated with systems change in order that the collection and analysis of this data may occur so that both States and IHS may adequately address risk-planning activities; explain current technical and programmatic barriers to collecting AI/AN data for CMS and IHS use; provide proposed approaches, methodologies, processes; and provide recommendations to CMS in the development of operational policies and procedures to establish consistency in data collection.

C. Prepare and submit a final report detailing the changes and accomplishments made in developing the data interchange system, the training required to perform transfer tasks, the schedules for such transfers to occur and the degree to which patient encounter data is available in state MMIS'. The final report shall be a functional and procedural depiction of data collection between States, CMS and IHS that details the process and system in terms of its participants, functions and relationships for identifying and analyzing vulnerabilities to their systems. The report should assist States, CMS and IHS in prioritizing the actions they must take in order to collect comprehensive AI/AN data.

D. The reports must also take into consideration the current Medicaid and IHS business processes and supporting systems architecture, and enterprise infrastructure so as not to conflict with any other statutory requirements, State or Federal.

E. Select three states in which to conduct this initiative that include IHS hospitals and/or clinics serving a significant number of AI/ANs. CMS reserves the right to approve States selection.

F. Participate in project management and problem solving meetings with CMS and other participants, including designated contractor(s) and provide recommendations or resolutions to problem areas.

G. At CMS' request, the contractor shall meet with CMS and IHS contractors working on AI/AN data issues. This includes attendance at meetings and conferences as requested. Monthly meetings in Baltimore and quarterly conferences with CMS and IHS staff shall be considered for planning purposes.

CMS will:

A. Provide to IHS funding in the amount of $400,000 for the purpose of carrying out IA activities.
B. Meet with IHS to discuss, develop and agree upon Workplan.
C. Participate in monthly project conference calls.
D. Review and provide comments on progress reports within two weeks of receipt.
E. Make available technical staff to advise on an as needed basis throughout the course of the IA.

V. Schedule of Activities

A. IHS to submit Workplan no later than September 13, 2002.
B. Meeting with IHS and CMS to discuss Workplan by no later than September 20, 2002.
C. Submit and receive monthly progress reports.
D. Monthly project meetings to discuss project status, work plans and schedules, and other project related topics. These meetings will be held on-site at CMS, or by teleconference as necessary for the efficiency of the project.
E. Final report due one month following the completion of the development phase of the project.
F. The contractor(s) should be available to provide their expertise in the form of presentations and workgroup sessions at Regional and/or National meetings or conferences for CMS and, State Medicaid Agency staff, and others representing the AI/AN population or possibly Departments of Health and the National Medicaid Management Information System (MMIS) conference.

VI. Duration of Agreement

This agreement provides for FY 2002 funding. It is effective upon signature of both parties through August 12, 2003, the expected contract completion date of the overall project. Any modifications or amendments to this agreement must be agreed to by both parties in writing. This agreement may be continued upon the approval of both agencies.

VII. Project Officers

IHS:
Dr. Richard Church
Indian Health Service
Reyes Building
801 Thomas Avenue
Rockville, MD 20852
301/443-0750
301/443-7279 (FAX)

CMS:
Dorothy A. Dupree, MBA
Senior Policy Advisor, AI/AN Programs
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail stop: S3-16-16
Baltimore, MD 21244
410/786-1942
410/786-8001 (FAX)

VIII. Funds

Transfer of Funds

FROM:	**CMS**	**TO:**	**IHS**
Agency Symbol:	75050080	Agency Symbol:	75030030
Appropriation:	7520511	Appropriation:	7520390
CAN:	15997235	CAN:	2J942090
Object Class:	2539	Object Class:	25.39
Allotment:	50	Allotment:	2-39000
Allowance:	752	Allowance:	2-39194
EIN:	52-0883104	EIN:	52-0821668
Control Number:	**IA-02-161**		
FMIB Number:	9351		
Amount:	NTE $400,000	Amount:	NTE $400,000
Billing Contact:		Billing Contact:	
Jean Katzen		Laurie Kitto	
(410) 786-5423		(301) 443-2529	
(410) 786-7259 (Fax)		(301) 443-9157 (FAX)	
Other:		Indian Health Service	
Linda Mansfield		Reyes Building	
CMS IA Officer		801 Thompson Avenue	
410-786-4193		Rockville, MD 20852	

The IHS will bill CMS through the Intra-governmental payment and collection system (IPAC) after receipt of the signed IA by all parties. CMS will transfer FY 2002 funds not to exceed $400,000 to the IHS. Prior to the IPAC submission to CMS, the IHS shall submit payment documentation to justify the IPAC billing that will be submitted to CMS. Send this documentation to:

Jean Katzen
P.O. Box 7520
Baltimore, MD 21207-0520

Agencies submitting IPAC bills to CMS without funds documentation will be charged back if documentation is not received within five working days of IPAC submission. Please include the following CMS control number on the OPAC submission: **IA-02-161**

MAILING ADDRESS:
Centers for Medicare and Medicaid Services
Office of Financial Management
Division of Accounting
POB 7520
Baltimore, MD 21207-0520

IX. Duplication

Full implementation of this agreement will not duplicate existing agreements.

X. Privacy Act/Systems Security

This Agreement has been reviewed for Privacy Act implications. All data containing individual-specific records fall under the Privacy Act of 1975, as amended 5 U.S. C. 552a. It is anticipated that HIS, States and CMS will maintain AI/AN data resulting from the efforts of this initiative. The CMS Information Systems Security policy is based on the Privacy Act of 1974; Office of Management and Budget Circular A-130, revised, "Management of Federal Information Resources"; the Computer Security Act of 1987; General Accounting Services Administration Issuances; and Department of Health and Human Services Information Manual Circular # 10, "Automated Information Systems Security Program". This policy applies to all existing systems and any that shall be developed under this agreement. For further information, reference CMS' Information Systems Security Policy, Standards, and Guidelines Handbook.

XI. Disclaimer

CMS will not accept responsibility for reimbursement of late fees or other costs incurred due to the negligence of the serving Agency in complying with its obligations to third party contractors.

XII. Signatures

CMS:

_____ _____
Dallas "Rob" Sweezy DATE
Director
Public Affairs Office &
Intergovernmental and Tribal Affairs

_____ _____
Derrick A. Wilson DATE
Management Analyst
Funds Certifier

IHS:

_____ _____
Duane Jeanotte DATE
Acting Director of Headquarters Operations
Indian Health Service