Medicaid's Role in Health Care for American Indians and Alaska Natives

The Indian Health Service (IHS) is the agency within the U.S. Department of Health and Human Services (HHS) that is primarily responsible for providing health care services to American Indian and Alaska Native (AIAN) people (IHS 2020a). Medicaid is one of several programs that play a secondary but meaningful role in financing health services for this population: it provides health insurance coverage for AIAN people, covering more than one-third of AIAN adults in 2018 (KFF 2020). It is also an essential source of revenue for the facilities and programs that make up the IHS delivery system.

The IHS funds and delivers health services through a network of programs and facilities. Services are provided free of charge to eligible individuals. Eligibility is generally restricted to members of federally recognized tribes and their descendants who live within the geographic service area of an IHS or tribally operated facility, typically on or near a reservation or other trust land area. It does not provide insurance coverage or offer a defined benefit package. In general, it only provides the services available at its facilities. Because it is not an entitlement program, it does so to the extent permitted by its annual federal appropriation and a limited amount of revenue from other sources (such as reimbursement from insurers such as Medicaid).

Policymakers, advocates, researchers, and other stakeholders have noted that the IHS has been historically underfunded, causing it to prioritize and ration services (NIHB 2020a, Walker 2020, GAO 2018, USCCR 2018, Davidson 2017, Warne and Frizzell 2014). Unmet needs also reflect provider shortages and other access barriers in AIAN communities.

This brief provides an overview of the relationship between the federal government and AIAN people in the United States and provides a snapshot of the AIAN people in terms of demographics, economic and health disparities, and access to health coverage and care. It then describes the structure of the IHS, including eligibility criteria, delivery system, and financing sources. It goes on to detail the special Medicaid rules and protections that apply to AIAN beneficiaries and Indian health providers. Finally, it discusses some of the key policy issues affecting Medicaid's relationship with the IHS and in serving the AIAN population.

Background

The federal trust responsibility is the basis for the U.S. government's provision of health services to AIAN people. It is grounded in obligations under numerous treaties and other legal actions to provide such services to eligible AIANs (IHS 2015a).

The relationship between tribal nations and the federal government has been defined as a government-to-government relationship in numerous treaties, federal laws, regulations, executive orders, and court cases (IHS 2015a). While Indian tribes are sovereign political entities, the federal government is obligated to protect tribal self-governance, lands, assets, and resources; uphold treaty rights; and carry out federal law established through statute and court cases. This obligation is referred to as the federal trust responsibility (ANA 2014). This unique relationship also serves as the basis for federal policies and programs, including a number of federal Medicaid rules, that require separate consideration for AIAN people and tribes (see below) (Hobbs, Straus, Dean & Walker 2018).

Demographic information

There are no standard criteria for determining who meets the definition of an Indian, or AIAN, person.[1] Many federal programs and laws use a definition that includes only members of federally recognized tribes.[2] (Some individuals who identify as AIAN are members of one of the 574 federally recognized tribes, others are members of state-recognized tribes, and others are not enrolled in a tribe.)[3] For the purposes of Medicaid and the State Children's Health Insurance Program (CHIP), the definition generally includes individuals who are eligible to receive services from an Indian health provider, meaning an IHS or tribal provider or an urban Indian organization (UIO) (see below). These eligibility criteria are related but not strictly tied to tribal membership (CMS 2020a). Most demographic data on AIAN people come from the U.S. Census and American Community Survey (ACS), which rely on self-identification (Connolly et al. 2019, Liebler 2018).[4]

About 1.8 percent of the U.S. population (5.8 million people) identify as AIAN alone or in combination with another race. Of those individuals, 2.8 million identify as AIAN alone (MACPAC 2020a). Nearly half reside in 10 states (Alaska, Arizona, California, New Mexico, New York, North Carolina, Oklahoma, South Dakota, Texas, and Washington).[5] Increasingly, AIAN people live outside of tribal areas; in 2010, 78 percent lived outside tribal statistical areas compared to 38 percent in 1970 (OMH 2018, NUIFC 2008). Nearly 70 percent of AIAN individuals live in metropolitan areas (UIHI 2020a).

Economic and health disparities

AIAN people experience persistent economic and health disparities. Nearly one quarter (23 percent) of AIAN people live in poverty, almost double the national poverty rate (MACPAC 2020a). AIAN people also have significantly higher rates of unemployment, lower rates of home ownership, and are less likely to have a bachelor's degree (MACPAC 2020a).[6]

AIAN people report being in poor or fair health at nearly twice the rate of American adults overall (20.6 percent versus 12.1 percent) (Villarroel et al. 2020). The infant mortality rate is twice that of the white, non-Hispanic population (9.2 per 1,000 live births versus 4.7) (OMH 2019a). Moreover, they have higher rates of many chronic conditions, including obesity, heart disease, and diabetes, as well as behavioral health conditions such as alcohol and substance use disorders (SUD) and mental health disorders (SAMHSA 2020, IHS 2019, OMH 2019b, AHRQ 2018, Leavitt et al. 2018, IHS 2015b).

Although some of these metrics have improved over the past 30 years, disparities could be exacerbated by the COVID-19 pandemic, which has had a disproportionate impact on AIAN people and tribal communities (Muhammad et al. 2019, NCAI 2019a, HUD 2014, Artiga and Orgera 2020, Doshi et al. 2020, Mineo 2020). For example, in 23 states, cumulative incidence of confirmed COVID-19 cases among AIAN people was 3.5 times that of white, non-Hispanic people (CDC 2020a). COVID-19 hospitalization rates for AIAN people is 5.3 times higher than for white, non-Hispanic people and the death rate is 1.4 times higher (CDC 2020b).

Access to Health Coverage and Care

Although many AIAN people are eligible to receive services at IHS-funded facilities free of charge, its services are not available to those who are not members of a federally recognized tribe or live outside the geographic service areas of IHS-funded facilities and programs. Some are covered by Medicaid (see below). Others do not have another source of coverage, especially in states that have not adopted the Medicaid expansion under the Patient Protection and Affordable Care Act (ACA, P.L. 112-148, as amended) (Frerichs et al. 2019, Artiga et al. 2017). In 2019, the uninsured rate for AIAN people was nearly 20 percent in 2019, more than double the uninsured rate for Americans overall (9.2 percent) (MACPAC 2020a).[7]

Medicaid coverage

Medicaid provides health coverage to low-income AIAN individuals who meet Medicaid eligibility standards regardless of their eligibility to receive IHS services. In 2018, Medicaid covered 1.8 million AIAN people, including 36 percent of AIAN adults under age 65. This is higher than the portion of all U.S. adults who are covered by Medicaid (22 percent) (KFF 2020). AIAN people make up fewer than 1 percent of Medicaid beneficiaries nationally, but in some states, they are among the largest racial or ethnic groups. For example, in Alaska and South Dakota, over 30 percent of Medicaid beneficiaries are AIAN (KFF 2020).

Medicaid coverage for AIAN people increased following the ACA Medicaid expansion. The share of AIAN people with Medicaid rose from 30 percent in 2013 to 36 percent in 2018; this increase primarily took place in expansion states (KFF 2020). Similarly, among AIAN people with IHS access, Medicaid enrollment increased by 45 percent in expansion states and 25 percent in non-expansion states from 2010 to 2018 (TSGAC 2019).[8] The number and proportion of AIAN adults covered by Medicaid has likely grown since 2018, as more states adopted the ACA Medicaid expansion. Oklahoma, a state with a large AIAN population, will begin enrolling Medicaid expansion beneficiaries in July 2021 (OKHCA 2020).

Access to care

Compared to Americans overall, AIAN people are less likely to report having a usual source of care or provider and are more likely to report avoiding or delaying medical care due to cost or other reasons (KFF 2020, Frerichs et al. 2019). Many AIAN people face barriers to care such as living in remote rural areas, lack of transportation, and cultural and language barriers. Such barriers affect both those with and without IHS eligibility or insurance coverage. For example, AIAN Medicaid beneficiaries, compared to white, non-Hispanic beneficiaries, are

- significantly less likely to report that it is always or usually easy to get needed medical care, tests, or treatments;
- significantly less likely to report that it is always or usually easy to get needed mental or behavioral health services; and
- significantly more likely to report that they are never able to see a specialist as soon as needed (MACPAC 2020b).

Structure of the Indian Health Service

The IHS was established in 1955 to meet federal treaty obligations to provide health services to members of federally recognized tribes on or near reservations.[9] Today, it serves 2.56 million people through a network of health care programs and facilities located in 37 states (IHS 2020a, b).

Eligibility and service delivery

The IHS funds and delivers health services through three primary mechanisms:

- directly providing services through IHS-operated facilities and programs;
- funding services provided through facilities and programs operated by Indian tribes or tribal organizations under self-determination contracts or self-governance compacts;[10]
- awarding contract and grant funding to UIOs, which provide services and run programs in urban areas.

Together, the IHS and tribes operate over 500 hospitals, health centers, clinics, and other facilities, which are generally located on or near reservations and other trust land areas. Most are operated by tribes (Table 1). As noted above, eligibility for services is generally restricted to members of federally recognized tribes, their descendants, and certain other individuals meeting specific criteria who live within the geographic service areas (IHS 2020a).[11]

The IHS also contracts with and provides grant funding to 41 UIOs, which operate 74 facilities in 22 states (IHS 2020b, NIHB 2020a). UIOs provide culturally competent health care and social services to urban AIAN communities but serve a broader range of individuals than IHS and tribally operated facilities (including members of state-recognized tribes and members of tribes whose federal recognition has been terminated).[12]

TABLE 1. Facilities Operated by the IHS and Tribes as of July 1, 2020, Excluding UIOs

Facility type	Operated by IHS	Operated by tribes
Hospital	24	22
Health center	51	279
Health station	24	79
Alaska village clinic	0	59
School health center	12	6
Youth regional treatment centers	6	6
Total facilities	117	451

Source. IHS 2020a.
Notes. IHS is the Indian Health Service. UIO is urban Indian organization. Excludes facilities operated by UIOs. Of the 46 hospitals, 5 IHS and 9 tribally-operated hospitals are critical access hospitals. One tribally-operated hospital is an inpatient rehabilitation facility.

Available services vary by facility, but consist largely of primary and emergency care services; few specialty or ancillary services are available (GAO 2019). [13,14] When patients need other services, they may be referred to receive services from private providers through the Purchased/Referred Care (PRC) program (IHS 2011). Funding for this program is limited, however, and it is often able only to serve the highest-priority cases, that is, emergency services needed for the preservation of life or limb (USCCR 2018).[15] Although unmet need for PRC services has declined in the last decade, PRC programs denied and deferred an estimated $616 million in care in FY 2019 (IHS 2020b).[16] UIOs cannot make PRC referrals. When PRC referrals are unavailable, patients must pay out of pocket unless they have another source of coverage.

Patients may also experience long wait times, due in part to persistent provider shortages at many Indian health facilities (GAO 2018, 2016).[17] IHS budget constraints also manifest in aging or inadequate facilities, medical equipment, and information technology: for example, the average age of IHS hospitals is 37.5 years, compared to 10 years for hospitals nationwide (NIHB 2020a, NCUIH 2020a, Cullen et al. 2020).[18]

Financing and spending

For fiscal year (FY) 2021, the federal appropriation for the IHS is $6.24 billion, with an additional $150,000 for the Special Diabetes Program for Indians (SDPI).[19,20] Appropriated funds are distributed to IHS regions and tribes. [21] A small portion is allocated to preventive health programs (e.g., community health representatives, public health nursing, health education) and other services. An even smaller portion is allocated to fund contract and grant funding to UIOs (IHS 2020b).[22]

The IHS and tribes may bill for services provided to patients enrolled in Medicaid and other insurance programs. Medicaid collections are a particularly important source of revenue: in FY 2019, Medicaid collections at IHS-run facilities amounted to $808 million, nearly 70 percent of total collections from third parties.[23] Facilities and programs operated by tribes are particularly dependent on third-party collections: for some, they make up half or more of their funding (NIHB 2020b).[24]

Medicaid revenue is particularly essential for Indian health providers when federal IHS funding is reduced or interrupted (i.e., during sequestration or government shutdowns). For example, during the 34-day government shutdown in 2019, the IHS was unable to provide funds for tribal health programs and UIOs, making Medicaid collections the primary (or in some cases the only) source of revenue for many Indian health providers (NIHB 2020b, Jackson 2019, Fears 2019, Schneider 2019).

Medicaid's role as a source of revenue has grown substantially as a result of the Medicaid expansion. For example, the proportion of patients at 73 IHS-operated facilities who reported having Medicaid coverage grew from 41 percent in FY 2013 to 53 percent in FY 2018. Similarly, Medicaid collections at IHS-operated facilities grew from $496 million in FY 2013 to $729 million in FY 2018, a 47 percent increase (GAO 2019). These increases are also attributable to increased efforts by Indian health providers to help enroll patients in Medicaid and other sources of health insurance when possible (GAO 2019). Increased collections from

Medicaid and other third parties in recent years have allowed Indian health facilities to expand services, provide more PRC services, raise compensation for staff, continue or establish new health promotion activities, renovate facilities, and purchase or repair medical equipment (GAO 2019).[25]

Special Medicaid Rules and Protections

The Medicaid statute includes several special rules and protections that apply to AIAN beneficiaries, Indian health providers, and tribal governments. Several important examples are detailed below.

- **Medicaid federal medical assistance percentage (FMAP)**. The federal government fully reimburses states for amounts expended for Medicaid services that AIAN beneficiaries receive through an IHS or tribal facility.[26] These include any service that the IHS or tribal facility is authorized to provide under IHS rules, that is also covered under the Medicaid state plan. It can also include services provided by non-IHS or tribal providers under care coordination agreements.[27,28]
- **Tribal consultation requirements**. The Centers for Medicare & Medicaid Services (CMS), like other federal agencies, is required to engage in regular and meaningful consultation and collaboration with tribal officials (CMS 2020b). It must seek consultation and participation of tribes in the development of policies and program activities that affect them or the relationship between tribes and the federal government. States are also subject to tribal consultation requirements. Any state with one or more Indian health provider must seek advice and input prior to submitting a Medicaid or CHIP state plan amendment (SPA), waiver request, or demonstration project that is likely to have a direct effect on AIAN beneficiaries and Indian health providers.[29] States are also required to describe their processes for seeking advice from Indian health providers in their Medicaid and CHIP state plans (CMS 2015).
- **Financial eligibility.** Certain types of income are not taken into account when determining income-based Medicaid or CHIP eligibility for AIAN individuals. These include income from selling culturally significant jewelry or basketwork; per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties; and payments received from farming, fishing, and natural resources on Indian land trusts (CMS 2020c, CMS 2016b).
- **Premiums and cost sharing.** States cannot impose premiums, cost sharing, enrollment fees, or similar charges on AIAN Medicaid or CHIP beneficiaries (CMS 2020c, MACPAC 2017).
- **Estate recovery**. Medicaid estate recovery rules do not apply to trust property located on reservations, certain trust lands, and Alaska native regions; or income from treaty-protected natural resources, cultural religious or spiritually significant items, or items that support traditional or subsistence lifestyles (CMS 2016b).
- **Managed care**. States may not use an SPA to require AIAN individuals to enroll in managed care unless the entity is an Indian health entity (i.e., an entity operated by the IHS, a tribe, or a UIO (§ 1932(a)(2)(C) of the Social Security Act (the Act)). AIAN individuals may choose to enroll in a managed care plan. Managed care entities must demonstrate that the number of participating Indian health care providers is sufficient to ensure timely access to services for enrollees eligible to receive services from such providers (§ 1932(h)(2) of the Act).[30]

Policy Issues

The IHS and tribes, along with advocates, researchers, and others, have raised a number of issues regarding the relationship between Medicaid and the IHS and opportunities for improvement in Medicaid's role in providing health care to AIAN people. Several of these are detailed below.

Eligible but not enrolled

A large number of AIAN people are eligible but not enrolled in Medicaid, despite efforts by the IHS and CMS, states, Indian health providers, tribes, and other organizations to promote enrollment (TSGAC 2019, CMS 2016a, IHS 2016a). In expansion states, coverage gains have been uneven across geographic areas (Frerichs et al. 2020). As many as 70,000 or more uninsured AIAN people living in expansion states may be eligible for Medicaid but unenrolled (TSGAC 2019).[31]

There are several challenges to enrolling eligible AIAN people in Medicaid, including geographical remoteness, limited access to Internet or phone service, language barriers, cultural factors, distrust of government programs, or lack of knowledge of the benefits of coverage.

Some tribes and Indian health providers are particularly active in enrollment efforts, or have more resources to support enrollment.[32] For example, Indian health providers that have direct access to a state's Medicaid eligibility portal or onsite eligibility or outreach workers may be particularly well-positioned to enroll patients in Medicaid because they can conduct real-time eligibility determinations. However, not all providers have these capabilities (CMS 2016a).

Application of Section 1115 demonstration policies to AIAN beneficiaries

Under the Trump Administration, CMS expanded the scope of policies approved under Section 1115 demonstration authority. Most notably, it approved state requests to restrict retroactive eligibility and adopt work and community engagement requirements as a condition of eligibility. It also promoted state adoption of flexible benefit designs under aggregate or per-capita cap financing models without being required to comply with certain federal Medicaid rules (CMS 2020c).

Tribes, advocacy organizations, and some states have requested that AIAN beneficiaries be exempt from these policies, noting that the policies create barriers to enrollment and access, and are not-well suited for the AIAN population. Some have also argued that the policies undermine the trust responsibility (see above) (NIHB 2020c and 2017, Colt 2018, Navajo Nation 2018, Delrow 2017).

In response, CMS indicated that it did not have the authority to allow states to provide exemptions based on race. In a 2018 letter to tribal leaders, CMS expressed concern that exempting AIAN beneficiaries from work and community engagement requirements could raise civil rights issues. Tribes, advocates, and many legal experts disagreed with this interpretation, citing legal precedent allowing tribes to be singled out for special treatment due to their political status (Fonseca 2019, Hobbs, Straus, Dean & Walker 2018, Montiel 2018).

CMS and states have provided some exemptions to policies approved through Section 1115 demonstration authority but have done so inconsistently. For example, of nearly a dozen states that received approval to implement work and community engagement requirements, few provide exemptions for AIAN beneficiaries, and those that do exempt only members of federally recognized tribes. Tribes, their advocates, and other stakeholders have asked CMS and states to provide such exemptions consistently, and to all AIAN beneficiaries eligible to receive services from Indian health providers, not just members of federally recognized tribes (NIHB 2020c, Colt 2018). The National Indian Health Board and others have asked that Congress and HHS clarify that Medicaid waivers cannot be used to override Indian-specific provisions in federal Medicaid law (NIHB 2020c).

Availability of 100 percent FMAP

There are a number of restrictions on when the 100 percent FMAP may apply for Medicaid services that AIAN beneficiaries receive. These restrictions are designed to ensure that the 100 percent FMAP is only provided for services furnished to AIAN individuals by or under the care of Indian health providers. However, some states, tribes, and advocates have suggested that access could be improved if restrictions on enhanced Medicaid FMAP were changed as follows:

- **Allow Medicaid payment for services provided by Indian health providers outside a clinic facility.** Under CMS's current interpretation of federal law, clinics may not bill Medicaid for services provided outside the four walls of the facility.[33] This restriction means that Indian health providers, which often set up mobile units, triage centers, and other mechanisms to deliver services offsite cannot be paid for such services at their facility rate. Instead, these services may only be billed and paid as an assigned claim from the off-site provider (CMS 2017). These off-site services are particularly important for Indian health providers working to address the COVID-19 pandemic in remote, rural communities (NIHB 2020d).[34] CMS is not currently reviewing Medicaid claims for compliance with this requirement, but may begin to do so in 2021 (CMS 2021). Enforcement of this restriction may cause significant financial strain on IHS and tribal clinics (NIHB 2020d, TSGAC 2020).
- **Provide the 100 percent FMAP for services received through UIOs.** Services provided to AIAN beneficiaries at UIOs are subject to the state's regular FMAP unless provided at the request of an IHS or tribal provider under a care coordination agreement (CMS 2016c). Proponents of extending the 100 percent FMAP to services received through a UIO argue that the federal government should be fully responsible for the cost of such services, as it is for the cost of services provided through other Indian health providers. Enhanced federal financing could help chronically underfunded UIOs to receive higher Medicaid payments and payments for additional services (NCUIH 2020b).
- **Authorize Indian health providers to receive Medicaid payment for certain services authorized by the IHCIA when provided to AIAN beneficiaries.** Under current law, Indian health providers can only receive Medicaid payment for services that are authorized by the Medicaid state plan. Some advocates have proposed expanding this to allow Medicaid payment for certain services that are authorized by the IHCIA but are not otherwise covered under the state plan (referred to as qualified Indian provider services) (NIHB 2020d). Examples include services provided as part of the community health representative and community health aide programs, as well as certain health promotion and disease prevention services, diabetes prevention and treatment services, and mental health services (NIHB 2020d, 25 USC § 1601).

Opportunities to expand access to culturally competent care

Researchers, advocates, and state and federal officials have also called for Medicaid to improve its ability to provide culturally competent services to AIAN beneficiaries, for example by covering traditional healing services. Many tribes have incorporated such practices into their health care delivery, and the IHS and Congress have long noted their acceptance and respect for such services. For example, the Indian Health Care Improvement Act (IHCIA, P.L. 94-437) contains sections noting acceptance of, and promoting, traditional healing services. It specifically incorporates traditional healing practices into preventive and behavioral service categories (AHCCCS 2016). Even so, traditional healing services are not a Medicaid covered service. The state of Arizona, in consultation with tribes, is seeking Section 1115 demonstration authority to cover traditional healing services furnished by Indian health providers to AIAN Medicaid beneficiaries (AHCCCS 2020a, b).

Others have called for an expansion of Medicaid's ability to provide services to AIAN beneficiaries through Indian health providers. For example, the National Tribal Budget Formulation Workgroup recommended an additional $129.6 million in the FY 2022 IHS budget to develop long-term care programs and develop staffing programs to carry out home and community-based services in the Portland area. Such programs could address unmet need for these services, which, while costly to set up, could largely be self-sustaining through collections from Medicaid and other payers once established (NIHB 2020a).

Endnotes

[1] The terms Indian and AIAN are sometimes used interchangeably. The term Indian is used frequently in federal and state law, and more informally, to refer to American Indian and Alaska Native people, entities, and spaces (NCAI 2019b, ACF 2013). The term AIAN is frequently used to describe the population, including for the purpose of the U.S. Census. It is also used by CMS to describe the population for the purposes of Medicaid and CHIP.

[2] Tribes set their own criteria for membership. These may be related to lineal descent (i.e., ancestry), or amount of Indian blood (referred to as blood quantum). Some federal laws also use definitions that rely on lineal descent or blood quantum (Schmidt 2012, Spruhan 2018).

[3] Federally recognized tribes are legally defined as tribal nations with a formal government-to-government relationship with the U.S. government; as of January 2020, there are 574 such tribes (DOI 2020). These entities are variously called tribes, nations, bands, pueblos, communities, and Native villages. Of the 574 federally recognized tribes, 229 are located in Alaska, and the remaining tribes are located in 35 other states (NCAI 2020). There are also approximately 100 state-recognized tribes (OMH 2018).

[4]Many organizations and researchers have raised concerns about the accuracy and quality of available data on the AIAN population. For example, the Census has historically undercounted AIAN individuals, and American Community Survey estimates may be unreliable (DeWeaver 2010, NCAI n.d.). Since 2010, the Census Bureau has increased consultations with AIAN people, tribes, and organizations about improving data collection (Liebler 2018). However, concerns remain that standard data collection practices effectively omit or misclassify AIAN individuals (UIHI 2020b).

[5] These figures are for individuals who reported AIAN as their only race.

[6] There is substantial variation in these measures across geographic regions, and AIAN individuals living on reservations or in Alaska Native villages tend to fare worse on these indicators than AIAN individuals in general (NCAI 2019a, HUD 2014).

[7] The rate of AIAN people with private health insurance coverage (45.7 percent) is lower than the rate for Americans overall (67.4 percent) (MACPAC 2020a).

[8] For the purpose of these data, individuals with IHS access are defined as individuals who responded "Yes" to part g of the following question in the 2016 American Community Survey questionnaire: "16. Is this person CURRENTLY covered by any of the following types of health insurance or health coverage plans? ... g. Indian Health Service."

[9] The Snyder Act of 1921 (P.L. 67-85) and the Indian Health Care Improvement Act of 1976 (IHCIA, P.L. 94-437) comprise the cornerstone legislative authority to appropriate funds specifically for health care for AIAN people (IHS 2015a). The IHCIA also established a direct relationship between the IHS and the Medicare and Medicaid programs by expressly allowing Medicare and Medicaid to pay for services provided to eligible AIAN individuals at Indian health facilities.

[10] As authorized by the Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638), federally recognized tribes can enter into self-determination contracts or self-governance compacts with the director of the IHS to take over administration of IHS facilities. This allows tribes more flexibility to tailor health programs to the needs of their communities, and provides more control over use of federal funds (IHS 2016b). Tribally run health systems can apply for other grants (e.g., from the Health Resources and Services Administration) and reinvest any profits they generate, a practice that is increasing (Bylander 2017). In FY 2019, the IHS transferred over 60 percent of its appropriations to tribes to operate their own health care programs under self-determination contracts or self-governance compacts (GAO 2019).

[11] Certain non-Indians can also be eligible, including adopted children, stepchildren, legal wards, or spouses of eligible Indians (IHS 2020c).

[12] Some UIOs also provide services to individuals who are not AIAN using non-IHS funds. This is particularly true of UIOs that receive HRSA funding, which requires that they serve a diverse clientele. Approximately half of UIOs receive Medicaid payment as federally qualified health centers (FQHCs) (IHS 2017).

[13] IHS and tribally operated hospitals range in size from 4 to over 100 beds, and are open 24 hours a day (GAO 2019). Nearly all have emergency departments, and eight are designated trauma centers (CRS 2016). Health centers primarily offer primary care services, along with ancillary services such as pharmacy, laboratory, and X-ray (CRS 2016, GAO 2019). Youth regional treatment centers are inpatient facilities that provide substance use disorder (SUD) and other behavioral health services to AIAN youth (CRS 2016). Alaska village clinics are unique to Alaska. Other facilities, like health stations and school health centers, provide limited primary care services and are typically open less than 40 hours per week (GAO 2019).

[14] Approximately half of UIOs provide comprehensive services, including pharmacy, laboratory, radiology, and dental services. Others provide a more limited set of services. Some UIOs provide full or limited ambulatory care, others provide only residential and outpatient substance abuse treatment programs, and others provide outreach and referral services rather than direct medical care (IHS 2020b, IHS 2017).

[15] The IHS has established five PRC medical priority levels: (1) emergent and acutely urgent care services, (2) preventive care services including prenatal care and mammograms, (3) primary and secondary care services, including scheduled ambulatory services for nonemergent conditions and specialty consultations, (4) chronic tertiary and extended care services, including rehabilitation care, skilled nursing facility care, and organ transplants, and (5) excluded services, including cosmetic and experimental procedures. Federally administered PRC programs must pay for all highest priority services before paying for lower priority services. Tribally administered PRC programs can establish their own prioritization mechanisms (GAO 2019).

[16]In some years, available funding has covered less than half of the cost of needed services. For example, in 2011, the PRC budget was $779 million. To cover the cost of all needed referrals made by IHS providers, the PRC program needed an additional $861 million (IHS 2011).

[17] These challenges are due in part to budget constraints and the inability to provide competitive salaries, but also due to the rural, geographically isolated nature of many IHS-funded facilities and the lack of nearby available housing and other resources for staff (GAO 2018, USCCR 2018).

[18] Many state and federal lawmakers, tribes, advocacy organizations, and others have called for substantial increases to the IHS annual appropriation. For example, the National Indian Health Board (NIHB) asked Congress to provide $12.76 billion in FY 2022, nearly double the President's FY 2021 budget request of $6.4 billion. Some have also called for changes to the way the IHS is funded: examples include providing advance appropriations for IHS to allow for better long-term planning, reclassifying certain IHS line items from annual discretionary appropriations to mandatory ones, and permanently exempting the IHS from sequestration and recissions (GAO 2019, USCCR 2018, NIHB 2020a).

[19]This figure does not include additional funds appropriated to respond to the COVID-19 pandemic (IHS 2020e, NIHB 2020e).

[20] The annual IHS appropriation is discretionary and the SDPI appropriation is mandatory.

[21] The IHS has 12 regions: Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Nashville, Navajo, Oklahoma, Phoenix, Portland, and Tucson (IHS 2020d). Each regional office distributes funding to IHS-run facilities in its jurisdiction. Tribes that operate health systems under self-determination contracts or self-governance compacts negotiate with the IHS each year to determine the amount of funding they receive from the IHS appropriation (NIHB 2020b).

[22] IHS contract and grant funding to UIOs are categorized as "other services." The amount of IHS contract and grant funding to UIOs has not kept pace with the shift of the AIAN population to urban areas (USCCR 2018). Like the IHS overall, UIOs have been chronically underfunded: in recent years, approximately 1 percent of the IHS budget has been dedicated to UIOs (NIHB 2020a, 2015; USCCR 2018). UIOs also have other funding sources; for example, some receive funds from other federal agencies such as HRSA and the Substance Abuse and Mental Health Services Administration). They may also receive state, private, and other non-IHS federal grants, and collect revenue from patient fees. Like other IHS and tribal facilities, UIOs can bill third-party payers such as Medicare and Medicaid (IHS 2017).

[23] This does not include third-party collections at facilities operated by tribes.

[24] Tribes are not required to report these data to the IHS or other federal agencies.

[25] These improvements have not occurred uniformly across all IHS or tribally operated programs and facilities (GAO 2019).

[26] In the case of AIAN individuals enrolled in managed care, states receive a 100 percent FMAP for portion of the capitation payment attributable to the cost of services received through an IHS or tribal facility (CMS 2016c).

[27] An IHS or tribal facility practitioner can request a service for his or her patient from a non-IHS or tribal Medicaid provider. Such services are considered received through an IHS or tribal facility for the purposes of the 100 percent FMAP, as long as the patient remains in the care of the IHS or tribal provider in accordance with a written care coordination agreement meeting certain requirements (CMS 2016c). Prior to CMS guidance issued in 2016, the definition of received through an IHS or tribal facility generally did not extend to services provided outside these facilities. CMS made this change in order to help states increase access to care, strengthen continuity of care, and improve population health (CMS 2016c).

[28] IHS-eligible Medicaid enrollees can choose to receive care from an Indian health provider or any other provider they have access to through Medicaid. For services that are not considered received through an IHS or tribal facility, states receive their normal FMAP.

[29] The quality and effectiveness of state and federal tribal consultation practices has been subject to debate. CMS and states have multiple mechanisms to consult with tribes or gather their input (GAO 2008). The extent to which states consult with tribes and incorporate feedback before making changes to their Medicaid programs varies (NIHB 2020b).

[30] Some advocates argue that managed care is ill-suited for AIAN populations, even when states and managed care plans technically meet these requirements. For example, managed care plans may automatically assign AIAN beneficiaries to non-Indian health providers, or lack a sufficient number of Indian health providers in their networks (NIHB 2020b). AIAN Medicaid

beneficiaries are more likely to give their health plan lower ratings and less likely to give their health plans high ratings than white, non-Hispanic beneficiaries (MACPAC 2020b).

[31] Estimates shown in this paragraph are for the number of AIAN individuals with access to IHS services who could be eligible for Medicaid; they do not include individuals who identify as AIAN but do not have access to IHS services.

[32] Some anecdotal reports suggest that tribally run health systems and UIOs are particularly active in enrolling eligible patients in Medicaid, perhaps because they have more control over federal funds than those administered directly by the IHS. They also have more flexibility to reinvest resources freed up when Medicaid revenues grow (Bylander 2017, IHS n.d.)

[33] This restriction does not apply for services provided to individuals experiencing homelessness outside the four walls of a clinic facility.

[34] CMS suggests that Indian health providers affected by this policy re-designate as federally qualified health centers as a means of continuing to bill Medicaid for such services, as FQHCs are not subject to the four walls restrictions. However, re-designating as FQHCs may present other disadvantages or restrictions depending on the state (TSGAC 2020).

References

Administration for Children and Families (ACF), U.S. Department of Health and Human Services. 2013. Indian and American Indian tribe. May 6, 2013. Washington, DC: ACF. https://www.acf.hhs.gov/sites/default/files/assets/aian_defs_of_indian_and_indian_tribe.pdf.

Administration for Native Americans (ANA), Administration for Children & Families, U.S. Department of Health and Human Services. 2014. American Indians and Alaska Natives – The trust responsibility. March 19, 2014. Washington, DC: ANA. https://www.acf.hhs.gov/ana/resource/american-indians-and-alaska-natives-the-trust-responsibility.

Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. 2013. Program brief: AHRQ research and other activities relevant to American Indians and Alaska Natives. Washington, DC: AHRQ. https://www.ahrq.gov/sites/default/files/publications/files/amindbrf_0.pdf.

Arizona Health Care Cost Containment System (AHCCCS), State of Arizona. 2020a. Draft Arizona demonstration renewal proposal, 2021–2026. Phoenix, AZ: AHCCCS. https://azahcccs.gov/Resources/Downloads/1115Waiver/1115WaiverRenewalPacket_DRAFT.pdf.

Arizona Health Care Cost Containment System (AHCCCS), State of Arizona. 2020b. 1115 waiver public forum. Phoenix, AZ: AHCCCS. https://azahcccs.gov/Resources/Downloads/1115Waiver/1115WaiverPublicForumPresentation.pdf.

Arizona Health Care Cost Containment System (AHCCCS), State of Arizona. 2016. Proposed AZ 1115 waiver language: AHCCCS reimbursement for traditional healing services. Phoenix, AZ: AHCCCS. https://www.azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2016/TraditionalHealingWaiverLanguage.pdf.

Artiga, S., and K. Orgera. 2020. *COVID-19 presents significant risks for American Indian and Alaska Native people.* May 14, 2020. Washington, DC: Kaiser Family Foundation. https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-presents-significant-risks-for-american-indian-and-alaska-native-people/.

Artiga, S., P. Ubri, and J. Foutz. 2017. *Medicaid and American Indians and Alaska Natives.* September 7, 2017. Washington, DC: Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/medicaid-and-american-indians-and-alaska-natives/.

Bylander, J. 2017. Propping up Indian health care through Medicaid. *Health Affairs* 36: 8: 1360 – 1364. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0849.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2020a. CDC data show disproportionate COVID-19 impact in American Indian/Alaska Native populations. August 19, 2020, press release. Atlanta, GA. https://www.cdc.gov/media/releases/2020/p0819-covid-19-impact-american-indian-alaska-native.html.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2020b. COVID-19 hospitalization and death by race/ethnicity. August 18, 2020. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Center for Medicaid and CHIP Services informational bulletin regarding "Extension of grace period related to the "four walls" requirement under 42 C.F.R. § 440.90 for Indian Health Service and tribal facilities." January 15, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/cib11421.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. *Information for American Indians and Alaska Natives applying for coverage.* March 2020. Baltimore, MD: CMS. https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Information-for-AIANs-Applying-for-Coverage2017.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. Tribal consultation. February 4, 2020. Baltimore, MD: CMS. https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Consultation.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020c. Trump Administration announces transformative Medicaid healthy adult opportunity. January 30, 2020, press release. Baltimore, MD. https://www.cms.gov/newsroom/press-releases/trump-administration-announces-transformative-medicaid-healthy-adult-opportunity.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. *Frequently asked questions (FAQs): Federal funding for services "Received Through" an IHS/tribal facility and furnished to Medicaid eligible American Indians and Alaska Natives.* January 18, 2017. Baltimore, MD: CMS. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/faq11817_12.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016a. Center for Medicaid and CHIP Services informational bulletin regarding "Strategies to enroll American Indian and Alaska Native families and children in Medicaid and CHIP." November 28, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/cib112816.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016b. *10 important facts about IHS and health insurance.* August 2016. Baltimore, MD: CMS. https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/10-Important-Facts-About-IHS-and-Health-Care-.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016c. Letter from Vikki Wachino to state health officials regarding "Federal funding for services "received through" an IHS/tribal facility and furnished to Medicaid-eligible American Indians and Alaska Natives." February 26, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. *Tribal consultation policy*. December 10, 2015. Baltimore, MD: CMS. https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf.

Coalition of Large Tribes (COLT). 2018. The coalition of large tribes hereby supports tribes stance on treaty obligations of the united states government in continuing its government to government relationship and directing health human service to waive mandatory community engagement and work requirements. Resolution no. ABQ – 11. http://largetribes.org/wp-content/uploads/2018/05/COLT-Resolution-Treaty-Obligations-HHS.pdf.

Congressional Research Service (CRS). 2016. *The Indian Health Service (IHS): An overview.* January 12, 2016. Washington, DC: 2016. https://www.everycrsreport.com/files/20160112_R43330_e219d8fe6e3eac73b12c48180f9b78e87842aca7.pdf.

Connolly, M., M. Gallagher, Hodge, F., et al. 2019. Identification in a time of invisibility for American Indians and Alaska Natives in the United States. *Statistical Journal of the International Association for Official Statistics* 35, no. 1: 71-89. https://content.iospress.com/articles/statistical-journal-of-the-iaos/sji190495.

Cullen, T., M.A. Demaree, and S. Effler. Closing the health disparity gap for American Indians And Alaska Natives through health IT modernization. *Health Affairs Blog,* January 27, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200122.299286/full/.

Davidson, J. 2017. Staffing, budget shortages put Indian Health Service at 'high risk.' *The Washington Post,* February 20. https://www.washingtonpost.com/news/powerpost/wp/2017/02/20/staffing-budget-shortages-put-indian-health-service-at-high-risk/.

Delrow, D., National Indian Health Board. 2018. Medicaid work requirements for American Indians and Alaska Natives. November 2, 2018. Washington, DC: National Indian Health Board. https://www.fedbar.org/wp-content/uploads/2019/12/PANEL-1-Delrow-PPT-Medicaid-Work-Requirements-pdf-1.pdf.

DeWeaver, N. *The American Community Survey: Serious implications for Indian Country*. October 11, 2020. Washington, DC: National Congress of American Indians Policy Research Center. https://www.ncai.org/policy-research-center/initiatives/ACS_Serious_Implications.PDF.

Doshi, S., A. Jordan, K. Kelly, and D. Solomon. 2020. *The COVID-19 response in Indian country: A federal failure.* June 18, 2020. Washington, DC: Center for American Progress. https://www.americanprogress.org/issues/green/reports/2020/06/18/486480/covid-19-response-indian-country/.

Fears, D. 2019. Tribes face food and medicine crisis as shutdown continues, lawmakers are told. *The Washington Post,* January 15. https://www.washingtonpost.com/climate-environment/2019/01/15/tribes-face-food-medicine-crisis-shutdown-continues-lawmakers-are-told/.

Fonseca, F. 2019. Arizona is only state where tribes avoid Medicaid work rules. *Associated Press,* January 18. https://abcnews.go.com/Health/wireStory/arizona-state-tribes-avoid-medicaid-work-rules-60482818.

Frerichs, L., R. Bell, K.H. Lich, et al. 2019. Regional differences in coverage among American Indians and Alaska Natives before and after the ACA. *Health Affairs* 38, no, 9: 1542-1549. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.00076.

Hobbs Straus Dean & Walker. 2018. Memo from Hobbs Straus Dean & Walker to the Centers for Medicare & Medicaid Services regarding "Constitutionality of Indian Health Care System." February 12, 2018. https://www.politico.com/f/?id=00000162-e50f-d230-a36b-e7ff36de0000.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2020a. *IHS profile.* Rockville, MD: IHS. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/IHSProfile.pdf.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2020b. *Fiscal year 2021: Justification of estimates for appropriations committees.* February 5, 2020. Rockville, MD: IHS. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2020c. Chapter 1 – Eligibility for Services: Part 2 – Services to Indians and others. In *Indian Health Manuel.* Rockville, MD: IHS. https://www.ihs.gov/ihm/pc/part-2/p2c1/#:~:text=Any%20individual%20who%20has%20not,the%20same%20basis%20and%20subject.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2020d. Locations. Rockville, MD: IHS. https://www.ihs.gov/locations/.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2020e. IHS receives more than $1 billion for coronavirus response. April 3, 2020, press release. Rockville, MD.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2019. *Indian health disparities.* Rockville, MD: IHS. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2017. *Indian Health Service: Office of Urban Indian Health Programs strategic plan, 2017 – 2020.* September 2017. Rockville, MD: IHS. https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/IndianHealthServiceOfficeofUrbanIndianHealthProgramsStrategicPlan.pdf.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2016a. IHS launches Medicaid and Medicare enrollment pilot at six facilities. July 20, 2016, press release. Rockville, MD. https://www.ihs.gov/newsroom/pressreleases/2016pressreleases/ihs-launches-medicaid-and-medicare-enrollment-pilot-at-six-facilities/#:~:text=The%20pilot%20targets%20American%20Indian,because%20they%20are%20not%20enrolled.&text=The%20project%20is%20expected%20to,to%20spend%20on%20patient%20care.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2016b. *Tribal self-governance.* Rockville, MD: IHS. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/TribalSelfGovernance.pdf.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2015a. *Basis for health services*. Rockville, MD: IHS. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/BasisforHealthServices.pdf.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2015b. *Behavioral health.* Rockville, MD: IHS. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/BehavioralHealth.pdf.

Indian Health Service (IHS), U.S. Department of Health and Human Services. n.d. *Fiscal year 2014: Report to Congress on Administration of the tribal Self-Governance Program.* Rockville, MD: IHS. https://www.ihs.gov/sites/selfgovernance/themes/responsive2017/display_objects/documents/resources/2014SGReportToCongress.pdf.

Indian Health Service (IHS), U.S. Department of Health and Human Services. 2011. Understanding the Purchased/Referred Care program: Part 1. *Indian Health Service Director's blog.* September 19, 2011. https://www.ihs.gov/newsroom/directorsblog/september2011/understanding-the-purchased-referred-care-program-part-1/.

Jackson, D.Z. 2019. How the government shutdown shredded Indian Health services. *Union of Concerned Scientists Blog,* February 8. https://blog.ucsusa.org/derrick-jackson/how-the-government-shutdown-shredded-indian-health-services.

Kaiser Family Foundation (KFF). 2020. State health facts: Medicaid coverage rates for the nonelderly by race/ethnicity. Washington, DC: KFF. https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Leavitt, R.A., A. Ertl, K. Sheats, et al. 2018. Suicides among American Indians/Alaska Natives – National Violent Death Reporting System, 18 states, 2003-2014. *Morbidity and Mortality Weekly Report* 67, no. 8: 237-242. https://www.cdc.gov/mmwr/volumes/67/wr/mm6708a1.htm#:~:text=American%20Indian%2FAlaska%20Natives%20(AI,have%20been%20increasing%20since%202003.

Liebler, C.A. 2018. Counting America's first peoples. *The Annals of the American Academy of Political and Social Science* 677, no. 1: 180-190. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5967841/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. MACPAC analysis of 2019 American Community Survey data.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. MACPAC analysis of the 2014-2015 Nationwide Adult Medicaid Consumer Assessment of Healthcare Providers and Systems (NAM-CAHPS) Survey.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. *Federal requirements and state options: Premiums and cost sharing.* November 2017. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2017/11/Federal-Requirements-and-State-Options-Premiums-and-Cost-Sharing.pdf.

Mineo, L. 2020. For Native Americans, COVID-19 is 'the worst of both worlds at the same time.' *The Harvard Gazette* May 8. https://news.harvard.edu/gazette/story/2020/05/the-impact-of-covid-19-on-native-american-communities/#:~:text=According%20to%20Indian%20Health%20Services,is%20home%20to%20250%2C000%20people.

Montiel, A., Inter Tribal Association of Arizona. 2018. Medicaid Work Requirements: An Update and Path Forward. Presentation before the National Indian Health Board National Tribal Health Conference. September 19, 2018. https://www.nihb.org/docs/nthc18/Presentations/Wednesday%20Presentations/Medicaid%20Work%20Requirements_%20An%20Update%20and%20Path%20Forward%202.pdf.

Muhammad, D.A., R. Tec, and K. Ramirez. 2019. Racial wealth snapshot: American Indians/Native Americans. November 18, 2019. Washington, DC: National Community Reinvestment Coalition. https://ncrc.org/racial-wealth-snapshot-american-indians-native-americans/#_ednref2.

National Congress of American Indians (NCAI). 2020. Policy issues: Tribal governance. Washington, DC: NCAI. https://www.ncai.org/policy-issues/tribal-governance.

National Congress of American Indians (NCAI). 2019a. *Tribal nations of the United States: An introduction.* Washington, DC: NCAI. https://www.ncai.org/tribalnations/introduction/Indian_Country_101_Updated_February_2019.pdf.

National Congress of American Indians (NCAI). 2019b. NCAI response to usage of the term "Indian Country." December 27, 2019. Washington, DC: NCAI. https://www.ncai.org/news/articles/2019/12/27/ncai-response-to-usage-of-the-term-indian-country.

National Congress of American Indians (NCAI). n.d. Federal data collection in American Indian/Alaska Native communities. Washington, DC: NCAI. https://www.fws.gov/nativeamerican/pdf/tek-federal-data.pdf.

National Council of Urban Indian Health (NCUIH). 2020a. Letter from the National Congress of American Indians, National Indian Health Board, National Council of Urban Indian Health et al. to the Honorable Mitch McConnell and the Honorable Chuck Schumer regarding "*COVID-19 recovery legislation."* April 15, 2020. https://www.ncuih.org/COVID_News?article_id=410.

National Council of Urban Indian Health (NCUIH). 2020b. Addressing the urgent needs of our tribal communities. Testimony submitted to the U.S. House of Representatives Committee on Energy and Commerce, July 8, 2020. Washington, DC. https://www.ncuih.org/policy_blog?article_id=461.

National Indian Health Board (NIHB). 2020a. *Reclaiming tribal health: A national budget plan to rise above failed policies and fulfill trust obligations to tribal nations.* The National Tribal Budget Formulation Workgroup's recommendations on the Indian Health Service fiscal year 2022 budget. April 2020. Washington, DC: NIHB. https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf.

National Indian Health Board (NIHB). 2020b. Phone call with MACPAC, September 11.

National Indian Health Board (NIHB). 2020c. *2020 legislative and policy agenda for Indian health.* February 4, 2020. Washington, DC: NIHB. https://www.nihb.org/docs/04022020/FINAL_LEG_AND_POLICY_AGENDA_2020.pdf.

National Indian Health Board (NIHB). 2020d. Letter from the NIHB, National Congress of American Indians, Self-Governance Communication and Education Tribal Consortium, et al. to the Honorable Nancy Pelosi and the Honorable Kevin McCarthy regarding "COVID-19 recovery legislative proposal (phase #4). April 8, 2020. https://www.nihb.org/covid-19/wp-content/uploads/2020/04/FINAL_HOUSE_ATTACHMENT-2_NIHB_-Phase-4-Tribal-Healthcare_Public-Health-Priorities.pdf.

National Indian Health Board (NIHB). 2020e. Legislative action alert: Congress seals massive spending/stimulus deal. December 21, 2020. Washington, DC: NIHB. https://myemail.constantcontact.com/Congress-Seals--2-5-trillion-Spending---Stimulus-Package.html?soid=1110714960954&aid=XRwVIiUEUpA.

National Indian Health Board (NIHB). 2017. Letter from Stacy A. Bohlen to Seema Verma regarding "*Nebraska Medicaid Section 1115 Heritage Health Adult expansion demonstration."* January 17, 2020. Washington, DC: NIHB. https://www.nihb.org/tribalhealthreform/wp-content/uploads/2020/01/NIHB-Nebraska-Medicaid-Comment.pdf.

National Urban Indian Family Coalition (NUIFC). 2008. *The status of American Indian and Alaska Native children & families today.* Report to the Annie E. Casey Foundation. Seattle, WA: NUIFC. https://www.aecf.org/resources/urban-indian-america/.

Navajo Nation. 2018. President Begaye advocates for tribal exemption from Medicaid work requirement. September 3, 2018, press release. Window Rock, AZ. https://mailchi.mp/0e362609ee10/press-releasepresident-begaye-advocates-for-tribal-exemption-from-medicaid-work-requirement?e=5770ab07ba.

Office of Minority Health (OMH), U.S. Department of Health and Human Services. 2019a. Infant mortality and American Indians/Alaska Natives. Rockville, MD: OMH. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=38#:~:text=American%20Indian%2FAlaska%20Natives%20have,rate%20as%20non%2DHispanic%20whites.&text=American%20Indian%2FAlaska%20Native%20infants%20are%202.7%20times%20more%20likely,the%20age%20of%20one%20year.

Office of Minority Health (OMH), U.S. Department of Health and Human Services. 2019b. Mental and behavioral health – American Indians/Alaska Natives. Rockville, MD: OMH. https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39.

Office of Minority Health (OMH), U.S. Department of Health and Human Services. 2018. Profile: American Indian/Alaska Native. Rockville, MD: OMH. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62.

Oklahoma Health Care Authority (OKHCA). 2020. Medicaid expansion: Overview. https://www.okhca.org/soonercare2/.

Schmidt, R.W. 2012. American Indian identity and blood quantum in the 21st century: A critical review. *Journal of Anthropology.* January 15, e-publication. https://www.hindawi.com/journals/janthro/2011/549521/.

Schneider, A. 2019. What does the partial government shutdown mean for Medicaid and CHIP? January 4, 2019. Washington, DC: Georgetown Center for Children and Families. https://ccf.georgetown.edu/2019/01/04/what-does-the-partial-government-shutdown-mean-for-medicaid-and-chip/.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2020. *2018 National Survey on Drug Use and Health: American Indians and Alaska Natives.* January 14, 2020. Rockville, MD: SAMHSA. https://www.samhsa.gov/data/sites/default/files/reports/rpt23246/1_AIAN_2020_01_14_508.pdf.

Spruhan, P. 2018. CDIB: The role of the certificate of degree of Indian Blood in defining Native American legal identity. *American Indian Law Journal* 6, no. 2. https://digitalcommons.law.seattleu.edu/cgi/viewcontent.cgi?article=1185&context=ailj.

Tribal Self-Governance Advisory Committee (TSGAC), Self-Governance Communication & Education Tribal Consortium. 2020. *Clarification on federal policy and next steps for tribal health care facilities billing Medicaid for clinic services provided outside of their "four walls."* March 24, 2020. Tulsa, OK: TSGAC. https://www.tribalselfgov.org/wp-content/uploads/2020/03/TSGAC-Brief-CMS-Restrictions-on-Billing-Medicaid-for-Services-Outside-Four-Walls-2020-03-24b.pdf.

Tribal Self-Governance Advisory Committee (TSGAC), Self-Governance Communication & Education Tribal Consortium. 2019. *American Indian and Alaska Native (AI/AN) Marketplace enrollment, including access to cost-sharing protections, and Medicaid enrollment.* December 20, 2019. Tulsa, OK: TSGAC. https://www.tribalselfgov.org/wp-content/uploads/2020/01/TSGAC-Brief-AI-AN-Marketplace-Medicaid-Enroll-2018-2019-12-20f.pdf.

Urban Indian Health Institute (UIHI), Seattle Indian Health Board. 2020a. Urban Indian health. https://www.uihi.org/urban-indian-health/.

Urban Indian Health Institute (UIHI), Seattle Indian Health Board. 2020b. *Best practices for American Indian and Alaska Native data collection.* August 26, 2020. Seattle, WA: UIHI. https://www.uihi.org/resources/best-practices-for-american-indian-and-alaska-native-data-collection/.

U.S. Commission on Civil Rights (USCCR). 2018. *Broken promises: Continuing federal funding shortfall for native Americans.* December 20, 2018. Washington, DC: USCCR. https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf.

U.S. Department of Housing and Urban Development (HUD). 2014. *Continuity and change: Demographic, socioeconomic, and housing conditions of American Indians and Alaska Natives.* Washington, DC: HUD. https://www.huduser.gov/portal/publications/pdf/housing_conditions.pdf.

U.S. Department of the Interior (DOI). 2020. Bureau of Indian Affairs: Indian entities recognized by and eligible to receive services from the United States Bureau of Indian Affairs. Notice. *Federal Register* 85, no. 20 (January 30): 5462 – 5467. https://www.govinfo.gov/content/pkg/FR-2020-01-30/pdf/2020-01707.pdf.

U.S. Government Accountability Office (GAO). 2019. *Indian Health Service*: *Facilities reported expanding services following increases in health insurance coverage and collections.* Report no. GAO-19-612. https://www.gao.gov/assets/710/701133.pdf.

U.S. Government Accountability Office (GAO). 2018. *Indian Health Service: Agency faces ongoing challenges filling provider vacancies*. Report no. GAO-18-580. Washington, DC: GAO. https://www.gao.gov/assets/700/693940.pdf.

U.S. Government Accountability Office (GAO). 2016. *Indian Health Service: Actions needed to improve oversight of patient wait times.* Report no. GAO-16-333. Washington, DC: GAO. https://www.gao.gov/products/GAO-16-333.

U.S. Government Accountability Office (GAO). 2008. *Medicare and Medicaid: CMS and state efforts to interact with the Indian Health Service and Indian tribes.* Report no. GAO-08-724. Washington, DC: GAO. https://www.gao.gov/products/GAO-08-724.

Villarroel, M.A., T.C. Clarke, and T. Norris. 2020. *Health of American Indian and Alaska Native Adults, by urbanization level: United States, 2014–2018.* National Center for Health Statistics data brief no. 372. Hyattsville, MD: National Center for Health Statistics. https://www.cdc.gov/nchs/data/databriefs/db372-h.pdf.

Walker, M. 2020. Pandemic highlights deep-rooted problems in Indian Health Service. *The New York Times,* September 29. https://www.nytimes.com/2020/09/29/us/politics/coronavirus-indian-health-service.html.

Warne, D. and L.B. Frizzell. 2014. American Indian health policy: Historical trends and contemporary issues. *American Journal of Public Health* 104, no. S3: S263-S267. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035886/.