Indian Health Financing Series
Paper VI

Urban Indian Health Programs and the Indian Health Non-System: A Structural Analysis

A Working Paper in the Indian Health Financing Series

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Author's Note

The Urban Indian Health papers extend the Indian Health Financing Series into an area in which my direct experience is more limited than it is with IHS and Tribal health programs.
My professional work included substantial experience with Tribal health financing and policy, including work with the Northwest Portland Area Indian Health Board, the National Indian Health Board, and Tribal health programs. I did not, however, serve as the executive director of an Urban Indian Organization or have the same operational experience with UIO administration that I have with Tribal and IHS health programs.
Accordingly, these papers should be read primarily as **Indian health financing and policy analysis applied to the Urban Indian health context**, rather than as a definitive account of Urban Indian health program operations.
Where the papers address UIO financing, Medicaid, population measurement, or federal policy, the analysis is intended to identify financing questions and test available evidence. Where conclusions depend on operational characteristics of individual UIOs or urban Indian communities, those conclusions should be regarded as more provisional and open to review by Urban Indian health leaders and other subject-matter experts.
That distinction is important to the purpose of the Indian Health Financing Series: the objective is to examine how federal Indian health financing works, where disparities appear, and how those disparities might be measured—not to claim expertise that the author does not possess.

Abstract

Urban Indian Organizations — the 41 entities funded under Title V of the Indian Health Care Improvement Act — are officially designated as the third pillar of the Indian health system, alongside IHS direct-service programs and Tribally operated 638 programs. In practice they occupy a structurally subordinate position on nearly every dimension that defines the other two pillars: legal authority, government-to-government standing, self-determination compact authority, eligibility rules, Medicaid reimbursement parity, and federal appropriations relative to population served.

This paper examines how Urban Indian health programs fit — and do not fit — the Indian health system, and why the "I/T/U" designation obscures more than it reveals. The central argument is

that the structural subordination of UIOs is the predictable consequence of how the Indian health enterprise was built: around reservation-based service delivery, for a population that the federal government subsequently spent two decades trying to relocate to cities while simultaneously failing to extend the institutional infrastructure of the system to follow them. The paper addresses the demographic reality of an urban AI/AN population, the financing gap, the mixed patient population complication, the trust responsibility argument, and what a genuine third-pillar structure would require.

1. The Urban Indian Population

The urbanization of the AI/AN population is a central fact of contemporary Indian demography that the IHS financing framework has never fully accommodated. Census data consistently show that the majority of people who identify as American Indian or Alaska Native live in urban areas — a demographic reality produced in part by the federal relocation program of 1948–1973, which provided one-way bus tickets and minimal resettlement assistance to Native people willing to leave reservation communities for designated relocation cities: Chicago, Los Angeles, Denver, Oakland, Dallas, Cleveland, and others.

The relocation program created urban Indian communities and then largely abandoned them. The IHS infrastructure — built on the reservation model under the Snyder Act and the Indian Health Care Improvement Act — did not follow. The result is a structural mismatch: a health care system designed for a reservation-resident population serving a population that is majority urban.

For purposes of the series's financing analysis, the relevant population is not Census AI/AN self-identifiers but enrolled Tribal citizens and their descendants — approximately 2.65 million people as of the 2021 Henson et al. enrollment compilation. The geographic distribution of that enrolled population is not fully documented in administrative data; the CMS–IHS Data Match captures only IHS-registered enrollees. The share of enrolled Tribal citizens living in urban areas and dependent on UIOs rather than IHS/638 programs for primary care is not precisely known, but is substantial.

2. The Legal and Institutional Framework

Title V Authority

UIOs are authorized under Title V of the Indian Health Care Improvement Act (P.L. 94-437, as amended through P.L. 111-148). Title V requires the IHS to contract with UIOs to provide health services to AI/AN people living in urban areas. UIOs are not Tribal governments; they do not hold the government-to-government status that anchors Tribal program authority under P.L. 93-638. They are nonprofit organizations — in many cases founded and governed by AI/AN community members — operating under grant and contract arrangements with IHS.

Eligibility

IHS eligibility under 42 CFR Part 136 extends to members and descendants of federally recognized Tribes and Alaska Natives who meet applicable criteria. Tribal enrollment is not required; descent from a member of a federally recognized Tribe is sufficient. UIOs serve this population in urban areas. The FQHC designation that most UIOs carry creates an additional obligation: FQHCs must serve all patients in their service area regardless of race, tribal status, or ability to pay. This creates the mixed patient population complication addressed in Section 5.

The Urban Confer

UIOs do not participate in Tribal Consultation — the government-to-government process that federally recognized Tribes have the right to demand when federal actions may substantially affect them. UIOs engage through a parallel process called the Urban Confer. The Urban Confer is a meaningful engagement mechanism, but it is structurally distinct: it does not carry the same procedural requirements for direct senior-official engagement, consensus-seeking, or formal documented federal response that government-to-government consultation requires.

3. Structural Position in the I/T/U Framework

The I/T/U designation — Indian Health Service, Tribal, and Urban — implies three pillars of roughly comparable standing. In financing and institutional terms, the comparison is not apt.

Dimension	IHS Direct	Tribal 638	Urban Indian (UIO)
Legal authority	Snyder Act; IHCIA	P.L. 93-638 compacts	IHCIA Title V grants
Gov-to-gov standing	Federal agency	Yes — sovereign Tribes	No — nonprofit grantee
Self-determination authority	N/A (federal)	Yes — compact authority	No compact pathway
Medicaid reimbursement	100% FMAP	100% FMAP	Standard state rate (FQHC PPS)
OMB rate billing	Yes	Yes (most)	No
Advance appropriations	Yes (FY2023+)	Yes (FY2023+)	Partial / not all accounts
FY2024 IHS appropriation share	Majority	Growing share	~1% of IHS Urban line

4. When Is a Tribal or IHS Program Also an Urban Program? A Classification Framework

The I/T/U designation — Indian Health Service, Tribal, and Urban — is a legal authority classification, not a description of patient geography or program function. An IHS-direct facility located in downtown Phoenix serves a functionally urban patient population. A Tribal 638

program on a reservation engulfed by metropolitan Tacoma serves the same kind of multi-tribal, geographically urban patient population that a Title V UIO serves in any other city. A tribe can deliberately extend its 638 authority off-reservation into a city to reach its own dispersed members, converting what would otherwise be an unserved urban Indian population into patients of a Tribal program with full access to 100% FMAP, the OMB rate, and Purchased/Referred Care.

These situations share a common consequence: the financing disparity that Paper VII quantifies is more pervasive than the UIO literature acknowledges. Every enrolled AI/AN patient receiving care at a Tribal or IHS facility inside a metropolitan area — at full I/T financing rates — is a patient who could have been designated an "Urban Indian" under Title V if the legal authority governing their program had been different. The financing gap is not primarily a rural-versus-urban disparity. It is a legal-authority disparity that correlates imperfectly with geography and increasingly less so as western cities expand to engulf reservations and as tribes choose to extend their health programs into cities to follow their members.

Four program types illustrate the range of overlap between Tribal or IHS program authority and the urban Indian population. Each type has a different mechanism, a different relationship to the I/T/U classification, and different implications for the trust responsibility and financing arguments in this series.

Type 1 — The Engulfed Reservation: Puyallup Tribal Health Authority, Tacoma, Washington

The Puyallup Indian Reservation is one of the most urban reservations in the United States. Parts of seven communities in the Tacoma metropolitan area extend onto reservation land, and the Puyallup Reservation encompasses all of Northeast Tacoma and parts of adjacent neighborhoods. The Puyallup Tribal Health Authority (PTHA) operates a comprehensive ambulatory care facility within reservation boundaries in the city of Tacoma, under P.L. 93-638 authority, serving more than 12,000 active patients representing more than 200 tribes — a multi-tribal urban patient population identical to what a Title V UIO would serve in any other city of comparable size. PTHA receives 100% FMAP on AI/AN Medicaid claims, accesses the OMB all-inclusive encounter rate, and participates in the Purchased/Referred Care system. Services are provided without charge to all eligible AI/AN individuals residing in Pierce County, Washington — a county that is part of the Seattle–Tacoma–Bellevue Metropolitan Statistical Area and is 100% urbanized.

The Type 1 mechanism is historical accident: the city grew around the reservation, not the reverse. No decision was made to extend Tribal program authority into an urban area — the urban area arrived. The equity anomaly is stark: an AI/AN patient in Tacoma receiving care at PTHA benefits from the full I/T financing stack because the Puyallup Tribe's reservation happened to be engulfed by metropolitan development. An identical patient in a city without an engulfed reservation — Milwaukee, Dallas, Chicago — is served by a Title V UIO at FQHC PPS rates with standard FMAP. The patient populations are not structurally different. The financing

outcome is determined by whether that city's metropolitan boundary happens to enclose a reservation.

Type 2 — The Metro-Adjacent IHS Direct Facility: Albuquerque Indian Health Center (and Phoenix Indian Medical Center)

The Albuquerque Indian Health Center (AIHC) is an IHS-direct ambulatory care facility in Bernalillo County whose own program description states explicitly that it provides services to tribal members who "live, work, or go to school in the urban centers of the Albuquerque Area." That language is effectively the statutory definition of Urban Indians under IHCIA Title V — applied to patients served under IHS-direct authority at 100% FMAP and the OMB rate, with approximately 97,000 visits per year. AIHC is the clean Type 2 example: its primary care, ambulatory function serves genuinely urban-resident AI/AN patients, and IHS's own description names that population explicitly. Phoenix Indian Medical Center (PIMC) is sometimes cited in this context but is better understood as a regional IHS community hospital whose formal service unit is composed of six reservation-based tribes whose lands border the Phoenix metro area — not a facility designed to serve urban Indian residents. Two features of PIMC's operations illustrate the distinction. First, IHS's own program description states that PIMC "provides specialty care to rural and remote reservation health care facilities in Arizona, Nevada, and Utah" — characterizing its specialty function as outbound to reservation communities, not inbound from an urban catchment. Second, PIMC's own Women's Health page states that labor and delivery care for patients over 16 weeks takes place at Valleywise Health Medical Center with PIMC midwives and physicians attending — meaning PIMC routes its own OB deliveries to an outside metropolitan hospital, a pattern more consistent with a community hospital operating within a larger metropolitan health system than with a self-sufficient tertiary referral center. The 67%-of-all-tribes patient statistic reflects IHS patients from across the Southwest presenting at PIMC for specialty services — the Navajo Nation is the top patient population — not a metropolitan catchment of urban-resident AI/AN people. PIMC's urban context is geographic coincidence, not program function: it is a reservation-serving community hospital that happens to be sited in a city, rather than a city-serving program that happens to hold IHS-direct authority. Its inclusion here is retained only as a cautionary contrast with AIHC — an illustration of how metropolitan siting alone does not make a program functionally urban in the Type 2 sense.

Albuquerque has a Title V UIO — First Nations Community HealthSource — serving urban AI/AN residents at standard FMAP and FQHC PPS rates alongside AIHC. The two-tier system operates within the same metropolitan area: AI/AN patients who access AIHC receive the full I/T financing stack; those who use First Nations Community HealthSource receive the UIO financing package. The Type 2 mechanism — in its cleaner form — is a federal siting decision: IHS placed a primary care facility in a metropolitan area that serves urban-resident AI/AN patients, and those patients receive 100% FMAP and the OMB rate by virtue of the legal authority governing their program, not by virtue of any difference in their patient need or trust responsibility status relative to UIO patients across the street.

A Note on the PIMC–Phoenix VA Partnership

The relationship between Phoenix Indian Medical Center and the Carl T. Hayden Veterans Affairs Medical Center is a product of both geography and federal policy. The two hospitals are located less than half a mile apart on Indian School Road in central Phoenix — PIMC at the northwest corner of 16th Street and Indian School Road, the VA at 650 East Indian School Road. That proximity is not coincidental: both facilities were sited in the same corridor of central Phoenix during the postwar federal expansion of Indian and veterans' health infrastructure. The Carl T. Hayden VA Medical Center was itself built on land transferred from the former Phoenix Indian School reservation, authorized by President Truman in 1947 and opened in 1951. Two federal health systems serving overlapping populations — AI/AN patients and veterans, with a substantial intersection of AI/AN veterans eligible for both — ended up on the same street, and their clinical relationship has been shaped by that adjacency ever since.

The practical expression of the partnership is shared physician staffing rather than formal patient transfer. Multiple physicians hold dual hospital affiliations at PIMC and the VA across several specialties, including cardiologists covering general cardiology, adult congenital heart disease, and interventional cardiology, as well as specialists in emergency medicine, thoracic surgery, obstetrics-gynecology, and internal medicine. PIMC's cardiology services are available in part through physicians whose primary or co-equal institutional base is the Phoenix VA — a facility classified by VA as a Level 1A tertiary care hospital with an independent cardiac catheterization program, electrophysiology services, and an annual operating budget exceeding $1 billion. PIMC accesses those subspecialty capabilities through the shared-physician model rather than maintaining fully independent cardiac subspecialty infrastructure of its own. This is the operational meaning of the IHS-VA resource-sharing framework in Phoenix: not a formal inter-hospital referral pipeline, but a shared clinical workforce made possible by geographic proximity and enabled by the national IHS-VA Memorandum of Understanding first signed in 2003, renewed in 2010, and extended through a 2012 reimbursement agreement allowing VA to compensate IHS for care provided to AI/AN veterans enrolled in the VA system. In July 2017, PIMC hosted a formal VA site visit from VA headquarters staff and the director of the Phoenix VA Medical Center, described by IHS as part of "ongoing relationship building between the Indian Health Service and VA."

The IHS-VA relationship in Phoenix illustrates a recurring theme in the PIMC analysis: the hospital's specialty capabilities are integrated into the broader Phoenix metropolitan health system in ways that make it function less like an autonomous tertiary referral center and more like a well-resourced community hospital with preferential access to adjacent federal specialty infrastructure. The same pattern appears in obstetrics — PIMC's own Women's Health program routes patients over 16 weeks gestation to Valleywise Health Medical Center, with PIMC midwives and physicians attending — and in the outbound specialty care PIMC provides to reservation facilities in Arizona, Nevada, and Utah, which is the direction IHS itself emphasizes in describing PIMC's regional role. Taken together, these features describe a hospital that serves its reservation-community patient population comprehensively through a combination of direct services and structured dependencies on adjacent metropolitan health infrastructure. That is an arrangement well suited to its intended population, but it is categorically different from what a freestanding IHS tertiary referral center would look like, and it does not translate into a

meaningful urban Indian health function for non-veteran AI/AN residents of the Phoenix metropolitan area who are not enrolled in the VA system. AIHC — with its explicit, IHS-acknowledged mandate to serve tribal members living, working, or studying in Albuquerque — remains the analytically precise Type 2 example precisely because its urban patient function is the program's stated purpose, not a byproduct of geographic proximity to a co-located federal hospital.

Type 3 — The Urban Reservation Tribal 638 Program: Salt River Pima-Maricopa Indian Community, Scottsdale, Arizona

The Salt River Pima-Maricopa Indian Community (SRPMIC) is a federally recognized sovereign tribe whose 52,600-acre reservation is located in Maricopa County, bounded by the cities of Scottsdale, Mesa, Tempe, and Fountain Hills. FHWA documentation designates the SRPMIC as "located in an urbanized area." The Salt River Health Center at 10005 E. Osborn Road, Scottsdale, Arizona, is a Tribal 638 facility whose address is a Scottsdale ZIP code and whose transit connections are integrated with Valley Metro, the regional Phoenix metropolitan transit system. It operates under the same 638 financing structure as any reservation-based tribal health program: 100% FMAP, OMB rate, PRC eligibility.

Like Type 1, the Type 3 urban context is inherited rather than chosen — the metropolitan area developed around the reservation. Unlike Type 1, the Salt River reservation has not been administratively engulfed by a single city; it retains distinct boundaries inside the metropolitan fabric. The Type 3 program is operating on its own land, in its own community, which happens to be surrounded by one of the fastest-growing metropolitan areas in the United States. The financing outcome — full I/T rates for enrolled tribal members in a metropolitan setting — follows from the legal authority, not from any deliberate choice to address urban Indian health.

Type 4 — The Sovereign Urban Reach: Fond du Lac Band and the Center for American Indian Resources, Duluth, Minnesota

The Fond du Lac Band of Lake Superior Chippewa made a deliberate sovereign decision to extend its Tribal 638 health program off-reservation and into Duluth, Minnesota — a city built on the Band's ancestral territory at the head of Lake Superior, from which the Band was removed to the Cloquet reservation by the 1854 LaPointe Treaty. The Center for American Indian Resources (CAIR), operated at 221 West 4th Street in Duluth as a satellite of the Fond du Lac Human Services Division under the same 638 authority that governs the Min No Aya Win clinic on the reservation, opened in 1988 and added a full outpatient medical clinic in 1992. CAIR provides medical, dental, pharmacy, behavioral health, and chemical dependency services to enrolled Fond du Lac members living in Duluth and the surrounding region at the same financing rates as the on-reservation program: 100% FMAP, the OMB encounter rate, and Contract Health Services for referred care. Fond du Lac has extended this model further, operating the Mashkiki Waakaaigan Pharmacy in Minneapolis for members dispersed into the Twin Cities metropolitan area.

Type 4 is the analytically distinctive case because the direction of movement is deliberate and outward. Types 1, 2, and 3 involve programs whose urban context is inherited — the result of

metropolitan growth, federal siting decisions, or reservation history. Type 4 is a tribe exercising sovereignty to follow its own citizens into a city. The legal mechanism is ISDEAA, which does not confine 638 authority to reservation land. The financial logic is the same principle that animates the trust responsibility argument throughout this series: a Fond du Lac member in Duluth carries the same federal health obligation as a Fond du Lac member on the reservation, and ISDEAA provides the mechanism to operationalize that obligation off-reservation. The key constraint is not legal but practical: this model requires sustained tribal administrative capacity and a specific IHS area office relationship. It is replicable in principle but demanding in practice. Supplement II develops the Fond du Lac case in full, including the role of Phil Norrgard, Director of Human Services from 1979 to 2017, whose 37-year tenure as the program's architect is inseparable from what the model achieved.

The Policy Implication of the Four-Type Framework

The four types share a common consequence: in each case, enrolled AI/AN patients in a metropolitan setting receive the full I/T financing stack — 100% FMAP, OMB rate, PRC — not because of any determination that their urban residence triggers different obligations, but because the legal authority governing their program happens to be Tribal or IHS rather than Title V. The patients served by the Albuquerque Indian Health Center, Puyallup Tribal Health Authority, Salt River Health Center, and Fond du Lac/CAIR are urban residents by any geographic definition. They are not classified as "Urban Indians" in the program taxonomy and they receive categorically better federal financing than Title V UIO patients in comparable situations. PIMC is the partial exception within Type 2 — many of its patients are reservation residents receiving referral care, not urban residents — which is precisely why AIHC is the more analytically precise Type 2 illustration.

This is not an argument against the financing those programs receive — they receive what the trust responsibility requires. It is an argument that the trust responsibility requires the same for Title V UIO patients. The FMAP gap documented in Paper VII is not a gap between urban and reservation patients; it is a gap between patients whose programs hold I/T legal authority and patients whose programs hold Title V authority. That distinction has no basis in the trust responsibility doctrine. It is an artifact of how the Indian health system was built — from the reservation outward, by statute, without anticipating that the majority of enrolled Tribal citizens would eventually live in cities.

Feature	Type 1: Puyallup / Tacoma	Type 2: AIHC / Albuquerque	Type 3: Salt River / Scottsdale	Type 4: Fond du Lac / Duluth
How urban context arises	City engulfed reservation	Federal siting decision	City engulfed reservation	Tribe extended into city
Tribal agency in outcome	None — inherited	None — federal decision	None — inherited	Deliberate sovereign choice
Facility	On reservation	In metropolitan	On reservation	Off-reservation, in

location	land in city	area	land in city	city
Patient eligibility scope	All IHS-eligible in county (200+ tribes)	Urban residents living, working, or studying in city (AIHC); reservation referral patients (PIMC — cautionary contrast)	Tribal members + IHS-eligible	Primarily own tribal members
100% FMAP / OMB rate / PRC	Yes / Yes / Yes	Yes / Yes / Yes	Yes / Yes / Yes	Yes / Yes / Yes
Replicable by other tribes?	Only if reservation is engulfed	Only by IHS placement	Only if reservation is engulfed	Yes — any tribe with capacity and IHS agreement

5. The Financing Gap

The federal per-patient investment in UIOs is a fraction of IHS per-capita spending. IHS per-capita spending for the IHS-access population was approximately $4,400 in FY2023 — itself approximately 40% of U.S. per-capita health expenditure. The Urban Indian Health line in the IHS appropriation has consistently funded approximately $672–$800 per UIO patient annually at recent funding levels, against a national per-capita figure exceeding $11,000.

This disparity is not primarily explained by differences in the populations served. It reflects the political economy of the Indian health appropriations process: UIOs compete for a small, discretionary line item, while IHS and Tribal programs have a larger base and, since FY2023, advance appropriations protection.

The financing gap matters operationally. UIOs heavily depend on Medicaid reimbursement — in California, some UIOs derive more than 60% of operating revenue from Medicaid — making them acutely vulnerable to Medicaid contraction. A 20% reduction in Medicaid reimbursement to a UIO that derives 60% of operating revenue from Medicaid is a 12% operating budget reduction, potentially program-threatening at smaller UIOs with no financial reserve. Paper IV's fiscal risk scenarios, developed for IHS-access programs, apply with greater severity to UIOs.

6. The Mixed Patient Population Complication

UIOs with FQHC designation face a structural tension: FQHC status requires serving all patients in the service area regardless of race or tribal affiliation, while the trust responsibility argument for 100% FMAP and other policy preferences applies only to IHS-eligible AI/AN patients.

In California — where urban AI/AN populations are significant but where UIOs serve heavily non-Indian patient populations — this complication is not marginal. Some California UIOs serve patient populations that are 40–60% non-AI/AN. The trust responsibility basis for federalizing Medicaid costs does not extend to non-Indian patients. The IHS UIO Infrastructure Study (2024) confirms that the mixed-patient-population complication is not limited to California: 23 of 32 UIOs with primary care data serve non-Urban Indian patients, with 116,210 unique non-Urban Indian patients annually — approximately 46% of total unique patients across those programs. Paper VIII of the IHF Series reviews the Infrastructure Study's findings and their limitations in detail.

The appropriate policy response is a blended rate mechanism, not blanket 100% FMAP across all UIO Medicaid billing. A blended rate would apply 100% FMAP to the AI/AN patient share and standard state FMAP to the non-Indian share, using a verification-based methodology tied to IHS eligibility documentation. Paper VII develops this mechanism in detail for California.

Analytical Note: 100% FMAP and the Trust Responsibility Argument

The trust responsibility basis for 100% FMAP at IHS and Tribal facilities is the government's obligation to provide health care to IHS-eligible AI/AN patients — an obligation that does not diminish when those patients present at a UIO rather than an IHS clinic. The argument is about the patient, not the facility. Extending 100% FMAP to UIOs on the AI/AN patient share is therefore consistent with the same trust responsibility logic that applies to IHS direct-service facilities. It does not require treating UIOs as equivalent to Tribal governments; it requires applying the same patient-centered trust obligation regardless of which I/T/U facility the patient uses.

7. Current Threats and Policy Context

Medicaid Contraction Risk

The 2025–2026 federal budget environment poses significant fiscal risk to UIOs. Proposals to cap or reduce Medicaid through block grants or per-capita caps would reduce both patient coverage and UIO operating revenue simultaneously. For Type C programs — urban-dominant programs with minimal IHS infrastructure where UIOs are the primary provider — Medicaid contraction at the 10% scenario may threaten program closure. There is no PRC buffer: UIOs do not receive Purchased/Referred Care funding, so they cannot refer patients whose primary care they can no longer afford to maintain.

Advance Appropriations Coverage

IHS advance appropriations enacted in the FY2023 omnibus apply to IHS and Tribal programs. UIOs are not fully covered for all accounts, meaning a government funding lapse that leaves IHS clinics and Tribal health centers operational can still interrupt UIO federal grant funding. This asymmetry illustrates the structural gap between the nominal third pillar and operational reality.

IHS Realignment Concerns

NCUIH raised concerns in September 2025 about proposed IHS organizational realignment that could affect the Office of Urban Indian Health Programs. Administrative reorganization that reduces the structural independence of the Urban Indian program line within IHS would compound the institutional subordination documented throughout this paper.

8. What a Real Third Pillar Would Require

Genuine third-pillar status for UIOs would require closing four structural gaps:

- Mandatory funding or full advance appropriations coverage — removing annual funding uncertainty that makes long-term planning nearly impossible for many UIOs
- 100% FMAP with a blended rate mechanism for mixed patient populations — extending the trust responsibility Medicaid obligation to UI patients regardless of which I/T/U facility they use
- OMB rate billing access — allowing UIOs that demonstrate capacity to bill at the all-inclusive encounter rate, as IHS and Tribal facilities do, rather than being limited to FQHC PPS rates
- Self-determination compact authority — creating a statutory pathway for capable UIOs to enter self-determination agreements, as Tribes do under P.L. 93-638

These are not radical proposals. They are the application of the same principles that govern the IHS and Tribal program sides of the system to the urban side. The cost is modest relative to the obligation — Paper VII provides the quantitative estimate for the 100% FMAP component. The obstacle is not analytical. It is political.

Cross-References Within the Series

Paper I: How We Count Matters — population denominator for urban AI/AN; Census vs. enrollment distinctions

Papers III-A through III-D — ACS and Data Match limitations for urban AI/AN populations; CMS–IHS Data Match covers IHS-registered enrollees

Paper V: The Full-Funding Requirement — full-funding benchmark applies to IHS-access population; UIO fiscal risk scenarios in Part IV

Paper VII: 100% FMAP Cost Estimate — program-level quantification of the financing reform proposed in Section 8

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