How Many Signatures?

Federal, State, and Tribal Pathways to Indian Health Financing

Edward J. Fox, PhD
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Introduction

Most people who follow federal Indian health policy know that Congress writes the underlying statutes, that CMS interprets and implements them through regulation and guidance, and that the Indian Health Service administers the resulting programs on the ground. Fewer people—including some who work in tribal health finance every day—have a clear picture of a fourth actor sitting quietly in the middle of that chain: the individual state Medicaid agency, and the State Plan Amendment through which a federal policy may become an operational Medicaid payment rule for a particular state.

This distinction matters because federal Indian health financing policies can move through several different implementation tracks. The track a policy follows—and, in particular, whether state action is required after federal action—often determines how long it takes to become operational revenue and how uniformly it is implemented.

Some federal action is largely self-contained. When CMS or the Indian Health Service establishes a federal payment or price limitation—the Medicare-like rate ceiling on Purchased/Referred Care, probably the best-known example of this kind of authority in Indian health policy, or the VA's Federal Ceiling Price on IHS pharmaceuticals, less well known but structurally similar—no state Medicaid agency has to adopt the policy before it can operate. Once the federal rule takes effect, the federal payment or purchasing limitation applies according to its terms.

Other federal action is not self-contained. It establishes authority or a policy framework that requires state implementation. When CMS establishes that tribal facilities may be paid at a higher encounter rate, or that Medicaid may cover certain services delivered outside a clinic's four walls, the federal action does not by itself change every state's Medicaid payment system. The state must take the additional steps required under its Medicaid program, often including a State Plan Amendment, CMS review and approval, and an effective date for the new policy. The result can therefore vary substantially from state to state.

That second track—federal policy followed by state-by-state implementation through the SPA process—has been responsible for some of the most consequential Medicaid financing gains available to tribal health programs. It is also why those gains have often taken much longer to become operational and have looked different from state to state than the underlying federal policy might suggest. The earlier history of tribal-state policymaking shows, however, that this state role did not begin with CMS or with the federal consultation requirement. Tribes in several states had already learned how to work with state governments, and had created institutions for doing so, before those practices were incorporated into federal law.

What follows is a set of case studies drawn from that history. Some, like Medicare-like rates, operate primarily through federal action; others, like the encounter rate and the "received through" interpretation, require state-by-state implementation. Still others follow different paths entirely: a facility-specific federal-tribal agreement, a consultation requirement that can precede state-level Medicaid action, a defensive effort to protect an existing financing gain, and one request that so far has not succeeded.

The point is not that every policy literally requires a particular number of signatures. "How many signatures?" is a shorthand for a more useful question: how many governmental decisions, approvals, agreements, and implementation steps must occur before a policy becomes actual financing for an Indian health program? The answer differs by policy—and that difference helps explain both the pace and the unevenness of Indian health financing policy.

There is also a less visible part of the answer. Before tribes can present a unified position to federal or state officials, they often have to build agreement among themselves. That internal tribal process rarely appears in the formal record, but it can determine whether a policy proposal is strong enough to survive the federal and state implementation process.

Implementation pathways at a glance

A Typology of Indian Health Financing Policy Pathways

The case studies do not describe one policymaking system. They describe several pathways through which Indian health financing policy becomes operational. The State Plan Amendment is one formal implementation instrument within this larger system, not a synonym for policymaking.

Case study	Policymaking / implementation	Federal role	State role	Tribal / facility role	Principal

	pathway				bottleneck
Medicare-Like Rates	Federal → national implementation	Statute + federal rulemaking	None	Advocacy / implementation	Federal rulemaking
“Received Through”	Tribal advocacy → federal interpretation → state implementation	MOA, guidance, interpretation/rule	SPA where required	Advocacy / implementation	Federal interpretation + state implementation
Medicaid Encounter Rate	Federal authority → state Medicaid policy	Federal authority	SPA / payment methodology	Advocacy / implementation	State adoption + CMS approval
Tribal-State Consultation	Tribal-state policymaking → federal procedural floor	Federal requirement	Consultation process	Government-to-government participation	Quality of relationship
Nursing-Facility Per Diem	Federal framework → state policy → facility arrangement	CMS authority/approval	SPA + payment methodology	Facility negotiation	Multiple levels of implementation
Managed-Care Protections	Federal protection → state/MCO implementation	Statute + regulation	Contracts / operating arrangements	Monitoring / enforcement	Protecting an existing right
VA Federal Ceiling Price	Federal purchasing policy	Federal law/administration	None	Federal purchasing participation	Federal purchasing administration
VA I/T/U Reimbursement	Federal → tribal agreement → facility execution	National framework/agreement	None	Individual facility agreement	Facility-by-facility execution
Medicare Outpatient AIR Expansion	Tribal advocacy → federal consideration	RFI/rulemaking	None	Tribal advocacy	Federal policy adoption

I. Medicare-Like Rates: A Single Federal Clock

Medicare-like rates (MLR) are, among people who work in Indian health financing, probably the best-known example of federal cost-containment authority in the field. They provide the clearest baseline for what a primarily self-executing financing mechanism looks like.

If any mechanism in this essay belongs on the “self-executing” side of the ledger, it is the Medicare-like rate ceiling on Purchased/Referred Care. But its history also demonstrates an important qualification: a policy can require only federal action and still take years to become operational. The absence of a state-level approval does not eliminate the federal rulemaking process, competing federal priorities, or the time required to develop and finalize an implementing rule.

The statute and the first rule

Section 506 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173), enacted December 8, 2003, amended Section 1866(a)(1) of the Social Security Act to require hospitals furnishing inpatient services payable under Medicare also to participate in IHS, tribal, and urban Indian Purchased/Referred Care programs—and to accept no more than Medicare rates as payment in full for care purchased through those programs, once implementing regulations were issued.

Those regulations took time. A proposed rule was published April 28, 2006; the final rule followed on June 4, 2007 (72 FR 30706), with an effective date of July 5, 2007. That was roughly three and a half years from enactment of the statute to a binding regulation. A joint CMS-IHS committee worked the rule through the federal process, and the committee was chaired by the author.

The second phase

The 2003 statute’s inpatient hospital cap left the much larger category of physician, professional, and non-hospital-based PRC purchasing uncapped. IHS continued paying full billed charges for that care absent a negotiated contract.

In 2013, IHS’s Director’s Workgroup on Improving Contract Health Services recommended extending the MLR ceiling to non-hospital services. Tribal Leader Letters from the IHS Director in May and December 2013 sought and received strong tribal support for the cap. That same year, GAO Report 13-272 estimated that extending the cap could free roughly $32 million worth of care that IHS and tribal PRC programs could redirect to unserved patients.

A Notice of Proposed Rulemaking followed on December 5, 2014, adding Subpart I to 42 CFR Part 136. The final rule was

published March 21, 2016, and became effective May 20, 2016. Measured from the 2003 statutory authorization, this second phase took thirteen years to reach a final rule—more than three times as long as the first phase.

What the comparison shows

Both phases of MLR are “self-executing” in the practical sense relevant to this essay: no state Medicaid agency had to adopt the policy through a SPA. Once the federal rule was finalized, it applied nationally to the programs covered by the rule.

But self-executing describes who has to act, not how quickly they will act. The roughly four-year first phase and thirteen-year second phase demonstrate that a federal-only implementation path can still be slow. “No SPA required,” therefore, is not a reliable predictor of speed. It tells us that the state is not an additional governmental gate. It does not tell us when the federal gate will open.

II. Beyond the Four Walls: The Nineteen-Year Battle over “Received Through”

The history of “received through” provides a different example. Here the federal government established the basic policy framework, but the meaning of that framework became the subject of a prolonged administrative and legal struggle.

In the spring of 1997, the Health Care Financing Administration (HCFA), CMS’s predecessor, circulated draft guidance to state Medicaid directors implementing a Memorandum of Agreement it had signed with the Indian Health Service the previous December. The MOA addressed whether tribal health facilities operating under Public Law 93-638 self-determination agreements could be treated as “IHS facilities” for purposes of Section 1905(b) of the Social Security Act, which provides 100 percent federal matching funds for Medicaid services “received through an Indian Health Service facility.” HCFA’s answer, as of July 11, 1996, was yes—a 638 facility could function as an IHS facility for this purpose.

The 1997 tribal objection

HCFA’s draft guidance answered the next question narrowly. Its proposed definition described a billable encounter as a documented visit occurring “in an IHS or 638 facility(ies),” tying the enhanced federal match to the physical location where care occurred.

The Northwest Portland Area Indian Health Board objected. In a May 1, 1997 letter to Zeita Cobb of HCFA’s Medicaid Bureau, NPAIHB argued that the location-bound definition did not fit the way Indian health care was actually delivered, where referrals, coordination, and purchased care routinely extended beyond the facility’s physical walls.

The tribes proposed replacing “in an IHS or 638 facility(ies)” with “through an Indian health program.” The proposed change would define the relationship to the Indian health program, rather than the physical location of the service. A parallel draft prepared by IHS and tribal representatives made the same substantive argument.

The legal fight

HCFA did not adopt the proposal. Its final May 1997 memorandum retained the facility-bound interpretation. States and tribes subsequently challenged the resulting “four walls” restriction through administrative appeals and federal litigation. The interpretation survived challenges involving North Dakota, South Dakota, Arizona, and Alaska, including circuit court decisions in the Eighth and Ninth Circuits.

The money was already moving

Fox and Boerner’s 2009 analysis of Medicaid and Indian health financing found that Medicaid’s share of Indian health program revenue had grown substantially after the 1996 MOA. In 1995, Medicaid accounted for less than 10 percent of revenue available to Indian health programs for patient care; by 2008, a typical program had 25 to 40 percent of patient bills paid by Medicaid. Their analysis identified 1997–98 as the period with the largest percentage increase in Medicaid payments to Indian health programs nationally.

The significance of the dispute is therefore clearer when placed against the development of Medicaid financing. The “in” versus “through” dispute was not an abstract question of statutory interpretation. It concerned an increasingly important source of Indian health program revenue.

The 2015–2016 turn

The turn came after South Dakota petitioned CMS in 2015 to revisit the interpretation. CMS’s State Health Official Letter #16-0002, issued February 26, 2016, reinterpreted “received through” to permit 100 percent FMAP when an AI/AN Medicaid beneficiary was referred by an IHS or tribal facility practitioner to a non-IHS provider under a documented care-coordination arrangement, provided the referring practitioner remained responsible for the patient’s care.

The historical connection is unusually direct. CMS's 2016 letter cited the July 11, 1996 MOA and the May 1997 HCFA memorandum—the same memorandum whose interpretation tribal representatives had sought to change nineteen years earlier. The 2016 letter followed CMS's solicitation and review of 182 comments from 91 commenters, including tribes, tribal organizations, urban Indian health programs, and states.

A federal interpretation still was not enough

The 2016 interpretation did not eliminate the separate "four walls" limitation on the Medicaid clinic-services benefit in 42 CFR 440.90. That limitation remained a separate barrier.

CMS ultimately finalized a mandatory exception for IHS and tribal clinics in 42 CFR 440.90(c) in its November 27, 2024 final rule, effective January 1, 2025. States then amended their Medicaid plans to incorporate the change; CMS records show that this state-level implementation continued through 2025 and into 2026.

This is perhaps the clearest example in the essay of the difference between federal authority and operational revenue. The federal government could reinterpret the policy. But the practical implementation of the policy still depended on the state Medicaid system.

III. Tribal-State Policymaking Before the Federal Consultation Requirement

The formal federal requirement for tribal-state consultation came in 2009. But the practice did not begin there.

This distinction is important because the history of consultation has sometimes been told backward—as though Congress and CMS created the practice and states and tribes subsequently learned how to use it. The surviving record shows a more complicated history. Tribes in several states had already developed mechanisms for regular health-policy interaction with state governments before the federal requirement existed.

The 1998 paper, *State Tribal Health Policymaking in the Northwest States of Oregon, Washington and Idaho: Institution Building for Health Care Policymaking*, provides unusually direct contemporaneous evidence. Prepared by the Northwest Portland Area Indian Health Board for review by the American Indian Health Commission for Washington State, it describes state-tribal policymaking as it was actually developing in the 1990s.

The Northwest experience came first

The paper identifies the growing number of tribes administering their own health programs, chronic underfunding of the IHS budget, and the increasing importance of state health policy as forces pushing tribes toward greater involvement in state Medicaid policymaking.

The response was institutional rather than episodic. Northwest tribes in Oregon, Washington, and Idaho established regularly scheduled meetings with state governments on health care issues. The NPAIHB had also developed its own capacity for tracking state policy and supporting those relationships.

The paper explicitly describes the role of tribal organizations in this process. The NPAIHB brought tribal concerns together across state boundaries, helped identify solutions, and provided a mechanism through which issues could move from state discussions to regional and national tribal organizations.

Oregon: consultation developed in response to Medicaid

Oregon provides a particularly clear example. The state's 1115 waiver and Oregon Health Plan began in 1994 without adequate tribal input. The resulting managed-care structure threatened the ability of Indian health programs to receive payment for services provided to AI/AN beneficiaries.

The response was a crisis, followed by institutionalization. In March 1995, Oregon tribes and the state Department of Human Resources reached an agreement under which the department would designate a point of contact and facilitate quarterly meetings. The meetings continued quarterly. By 1998, the paper reported that they had brought tribes into Medicaid and CHIP policymaking at an early stage.

Idaho: from difficult relations to regular participation

The 1998 paper describes tribal-state relations in Idaho as historically more contentious than in Oregon and Washington. But in 1995 Idaho tribes decided to establish regular interaction with the state.

By August 1998, the tribes and Idaho Department of Health and Welfare had met quarterly for three years. The paper describes the result as a real change in state policymaking: tribal representatives were routinely included on committees developing Medicaid and CHIP changes, and a tribal representative had a permanent place on the state's Medicaid Advisory Committee.

Washington: an especially developed institutional model

Washington provides the most elaborate example in the paper. The American Indian Health Commission was created in 1994 following a Tribal Leaders Health Summit. Tribes developed issue papers, brought state agency directors and the governor into the summit, debated the issues among themselves, revised and adopted their positions, and then created an ongoing policy institution.

The AIHC's authority came from the tribes themselves. Tribal councils designated representatives, the Commission developed positions, and state agencies participated through designated liaisons. The resulting structure was not merely a consultation meeting. It was an institutional mechanism for developing and communicating tribal policy positions to the state.

The paper also describes substantive work produced by the process, including AIHC work with the state and HCFA on an American Indian CHIP program and statewide tribal positions developed before negotiations proceeded.

What the 2009 requirement changed

Against this history, Section 5006(e) of the American Recovery and Reinvestment Act of 2009 looks different. The statute added Section 1902(a)(73) to the Social Security Act, requiring states in which Indian Health Programs or Urban Indian Organizations furnish health care services to provide a process through which the state seeks advice from designated tribal and urban Indian health representatives on Medicaid matters likely to have a direct effect on them. A parallel amendment extended the requirement to CHIP.

CMS subsequently operationalized the requirement through the Medicaid State Plan process, requiring states to establish and obtain approval for their consultation procedures.

The federal action therefore did something important—but different from creating consultation itself. It established a national procedural floor for a practice that tribes and some states had already been developing on their own.

The historical evidence available here supports the proposition that effective tribal-state health policymaking predated the federal requirement. A stronger claim—that particular states directly caused Congress to enact the 2009 requirement—would require additional documentation and should not be asserted without it.

The consultation SPA

The consultation SPA is different from a fiscal SPA. It does not itself establish a payment amount. It establishes the process through which the state is supposed to engage tribes before taking certain Medicaid actions.

Depending on the state, consultation SPAs address such matters as advance notice, issues requiring consultation, expedited procedures, and documentation of the consultation process.

This creates what can be called a precondition clock. Before a state can effectively negotiate a substantive financing change, it may first have to operate the government-to-government process through which that issue is supposed to be considered.

Formal consultation is not the same as effective consultation

The later Kauffman & Associates work commissioned by CMS provides an important qualification. The 2013 study examined consultation practices in Minnesota, Oregon, and Washington. It found that direct participation by tribal and state leaders with actual policymaking authority could strengthen government-to-government relationships, but it also found practical limitations, including tribal capacity constraints and inconsistent state follow-through.

The lesson is therefore not that formal consultation failed. It is that a formal mechanism and an effective relationship are not the same thing. That conclusion is consistent with the earlier 1998 Northwest paper, which had already described the importance of regular meetings, institutional capacity, trust, and continuity.

Where the substantive negotiation occurred

The formal consultation process was not necessarily where the substantive language of federal policy was negotiated. Specific provisions in waivers, encounter-rate SPAs, billing definitions, and other documents were often worked out through recurring federal-tribal discussions.

In the author's experience over roughly twenty-five years, many of those discussions occurred through national CMS-tribal telephone calls rather than formal meetings in Washington. States were not necessarily participants in those federal-tribal negotiations, even though a state might later be responsible for implementing the resulting policy.

That creates an important limitation in the simple "three-government" model. There may be three sovereign governments involved in the ultimate implementation of a policy, but they do not necessarily participate together in every stage of its development.

IV. The Magnitude: Large, Once Measured Seriously, and Still Not Fully Countable

The financing mechanisms discussed here are not small administrative adjustments. Medicaid alone became a major source of revenue for Indian health programs.

Fox and Boerner's 2009 analysis documented Medicaid's growing role and assembled state-by-state Medicaid spending estimates for AI/AN beneficiaries. Their 2005 estimates for eleven states totaled more than $2 billion. Across 1990–2008, their working estimate for third-party collections reaching Indian health programs—including Medicaid, Medicare, and private insurance—was approximately $2.5 billion.

But those numbers require care. The MAX data captured AI/AN Medicaid beneficiaries generally, not only people who actually used Indian health programs. States also did not have a uniform requirement or methodology for reporting payments specifically to Indian health programs. Fox and Boerner therefore could document the magnitude of the Medicaid population and expenditures without producing an authoritative national total of payments actually received by Indian health programs.

What can be said about the current scale

More recent CMS-IHS data work indicates that the population with IHS access and associated Medicaid expenditures is substantially larger than the numbers available to Fox and Boerner in 2009. But the newer numbers inherit some of the same unit-of-analysis limitations.

It is therefore better to use the current data to demonstrate scale rather than to claim that a particular percentage of total CMS spending is caused by the encounter rate itself. Medicaid expenditures associated with people who have access to IHS are not synonymous with payments made to tribal health programs, and neither figure should automatically be attributed to the encounter-rate mechanism.

The safe conclusion is nevertheless substantial: Medicaid financing has become one of the major financial components of the Indian health system.

Why the cumulative number remains elusive

The absence of a precise cumulative total is not simply evidence that nobody has tried to measure the value. Fox and Boerner made a serious effort using CMS data and documented both the magnitude of the Medicaid financing stream and the limitations of the available data.

What matters operationally is often much more specific: Does the state's SPA permit the encounter categories the facility needs? Can same-day services be billed? Does the state recognize the relevant referral? Has the four-walls exception been implemented? Those questions determine whether a tribal health program can turn federal authority into billable revenue.

V. Beyond the Encounter Rate: A Cost-Based Per Diem for Tribal Nursing Facilities

The encounter rate works unusually well for outpatient tribal health care because it converts a collection of services into an administratively simple payment rate. Long-term nursing facility care is fundamentally different. A resident occupies a bed continuously, and the facility incurs daily costs associated with nursing care, food, building operations, staffing, and capital investment. A daily per diem therefore makes more sense than an outpatient encounter rate.

Washington's 2019 SPA provides a useful example. On September 19, 2019, CMS approved Washington SPA WA-19-0016, amending Attachment 4.19-D to establish a new cost-based per diem rate for tribal nursing facility services, effective retroactively to July 1, 2019. The approved rate was $639.57 per patient per day for calendar year 2019.

Rather than requiring a new facility cost report every year, the SPA established an annual adjustment tied to changes in the IHS inpatient hospital per diem rate published in the Federal Register. The SPA also separated a capital component from the operating rate and provided for the capital component to sunset after the specified period.

Precedent, not an isolated instance

The Washington SPA is not merely an isolated facility rate. Its methodology illustrates how a genuinely novel tribal payment structure can become a precedent for later negotiations. Montana's later Tribal Residential Treatment Facility rate-setting work used language closely resembling Washington's annual IHS-per-diem escalator.

The significance is not that Montana necessarily copied Washington in a formal sense; the SPA documents should be the evidence for that conclusion. The more defensible point is that a novel methodology developed in one state can reduce the time, expertise, and negotiating risk required to solve a similar problem in another state.

This is one of the places where the paper's larger argument becomes visible: the first successful negotiation can be as important as the final payment rate because it creates a model that later tribes and states can adapt.

VI. Protecting What Was Won: Managed Care and the Encounter Rate

Not every policy fight is about obtaining a new financing gain. Sometimes the problem is protecting an existing gain from being undermined by an unrelated change in the Medicaid system.

Beginning in the 1990s, states increasingly moved Medicaid beneficiaries from fee-for-service systems into managed care. Without specific protections, an encounter-rate requirement could become much less valuable if a managed-care organization did not contract with an Indian health provider or paid below the applicable rate.

The protection, and where it comes from

Section 5006(d) of ARRA added Section 1932(h) to the Social Security Act, establishing specific Indian protections applicable to Medicaid and CHIP managed care. CMS's implementing final rule, published April 25, 2016, codified those protections at 42 CFR §438.14 for Medicaid and §457.1209 for CHIP.

The core financial protection requires, in specified circumstances, that an Indian health care provider not enrolled as an FQHC receive the applicable IHS encounter rate or the state plan's fee-for-service rate where no encounter rate applies. If a managed care organization pays less than the applicable rate, the state must make a supplemental payment for the difference.

The regulations also address network sufficiency, beneficiary choice of Indian health providers, cost-sharing protections, and tribal consultation before certain managed-care requirements are imposed. CMS also developed a model Indian Managed Care Addendum that states and Indian health care providers can attach to managed-care network agreements.

Another gap between statute and operational reality

The Section 1932(h) protections were effective by statute in 2009, but CMS's implementing rule did not require Medicaid managed-care plans to comply until rating periods beginning on or after July 1, 2017, with separate CHIP implementation extending into state fiscal year 2018. The gap illustrates again that statutory protection and operational enforcement are not always the same thing.

The managed-care provisions therefore represent a different kind of policy achievement. The encounter rate created a financing opportunity. Managed-care protections helped prevent the structure of Medicaid delivery from undermining that opportunity.

In Medicaid financing, winning a gain and keeping a gain are not the same accomplishment.

VII. The VA Ceiling: Drug Pricing as a Third Cost-Containment Mechanism

Distinct from both the Medicare-like rate ceiling on purchased care and the 340B program's outpatient pricing structure, IHS-funded programs also benefit from the Federal Ceiling Price system created by the Veterans Health Care Act of 1992. It is a separate program, created by a separate section of the Act and operating on different legal logic.

Section 603 of Public Law 102-585 requires manufacturers of covered drugs to make those drugs available through the VA Federal Supply Schedule at a price no higher than the Federal Ceiling Price, calculated from the statutory formula. The obligation runs to the "Big Four": the VA, the Department of Defense, the Public Health Service—including IHS—and the Coast Guard.

IHS accesses this purchasing structure through the VA's Pharmaceutical Prime Vendor program, with the IHS National Supply Service Center managing participation for federal IHS facilities and participating tribal and urban Indian programs.

Where the mechanism is weaker than it looks

A 2019 VA Office of Inspector General report on temporary price reductions found that when VA separately negotiates a further discount below the statutory ceiling for its own purchasing, that deeper discount does not automatically extend to the other members of the Big Four. The report's illustrative example showed VA receiving a lower temporary price while Public Health Service remained at the higher statutory ceiling.

The Federal Ceiling Price is therefore a real and meaningful protection against full commercial pricing, but it does not guarantee that IHS receives every deeper discount negotiated by VA. No public GAO or CMS estimate establishes the total annual savings generated specifically for IHS-funded programs.

VIII. A Third Track: The VA-I/T/U Reimbursement Agreement

The VA's reimbursement of IHS, Tribal Health Program, and Urban Indian Organization facilities for care given to AI/AN

veterans does not fit neatly into either the self-executing federal cost-containment track or the state-mediated Medicaid track. It borrows the encounter-rate concept but reaches it through a different legal channel and with a different bottleneck.

The program rests on federal interagency and federal-tribal sharing authorities, including 25 U.S.C. §1645(c) and 38 U.S.C. §8153. No state Medicaid agency is a party and no Medicaid SPA is filed. Current reimbursement templates specify outpatient direct-care payment at the applicable All-Inclusive Rate, with other categories governed by separate provisions.

A program with real history, recently expanded

The reimbursement program began in 2012 for IHS and Tribal Health Programs and was extended to Urban Indian Organizations in 2022. On December 6, 2023, following tribal consultation, VA and IHS signed a revised and expanded agreement. Separate templates followed for Tribal Health Programs in the lower 48 states, Alaska Tribal Health Programs, and Urban Indian Organizations in 2024.

Unlike a Medicaid SPA, which a state submits once and which can govern eligible facilities across that state, the VA reimbursement agreement is executed facility by facility. A participating program must initiate onboarding and execute the applicable agreement. The result is therefore a federal program with uniform basic terms but separate implementation clocks for participating facilities.

IX. A Failed Attempt: Extending the Encounter Rate to Medicare Outpatient Payment

Not every attempt to extend the encounter-rate logic succeeded. The unsuccessful Medicare outpatient proposal is useful precisely because it shows tribes and IHS pursuing the same administrative principle that has worked extensively on the Medicaid side.

Under Medicare, IHS and tribal hospital outpatient departments receive special treatment rather than ordinary Hospital Outpatient Prospective Payment System rates. That treatment has not been extended uniformly to all IHS and tribally operated outpatient clinics. Depending on provider classification, some clinics encounter other Medicare methodologies, including facility-specific cost-report processes.

In June 2020, the Tribal Technical Advisory Group formally requested that CMS expand Medicare payment at the IHS outpatient All-Inclusive Rate to all IHS and tribally operated outpatient facilities. The proposal sought to replace more facility-specific rate-setting with the simplified, annually published encounter rate.

Where it actually got

CMS did not adopt the proposal. It went as far as a Request for Information in the CY2025 OPPS proposed rule in July 2024, seeking information about the number and type of affected facilities, enrollment issues, and relative costs. The CY2025 final rule did not adopt the broader proposal, and the CY2026 final rule did not show it advancing further.

The logic of the proposal is structurally similar to the argument tribes made to HCFA in 1997: an administratively simple, annually published rate can fit tribal health care better than a facility-by-facility bureaucratic process designed for a different provider system. On Medicaid, versions of that argument have produced major changes. On Medicare, the broader proposal remains unresolved.

X. How Many Signatures—and the One Nobody Watches For

Nine mechanisms, one underlying question: how many governmental decisions, approvals, agreements, and implementation steps does a federal Indian health financing policy require before it becomes money in a tribal facility’s account?

Counted conceptually, the mechanisms fall into several patterns. The Medicare-like rate ceiling and the VA Federal Ceiling Price are primarily federal: once the relevant federal action is complete, no state Medicaid approval is required. The Medicaid encounter rate and the “received through” changes require federal action followed, where applicable, by state implementation through the SPA process. The VA-I/T/U reimbursement program uses a federal framework followed by individual facility agreements.

The tribal consultation SPA sits underneath much of the state-mediated process rather than simply beside it. In states subject to the federal requirement, it establishes the process through which the state is supposed to engage tribes before taking certain Medicaid actions affecting them. But an approved consultation SPA on paper is not the same thing as an effective government-to-government relationship.

Managed-care protections add another category: a policy mechanism whose principal purpose is not to win a new financing gain but to prevent an existing gain from being eroded by a change in the surrounding delivery system.

The visible signatures do not tell the whole story

Counting governmental approvals helps explain why some policies move faster than others, but it risks missing the most important step. It counts only the signatures that appear on the final document.

Before a tribe, tribal organization, or national tribal body can present a unified position to a state or federal agency, tribes with different circumstances and sometimes different preferences often have to work through those differences among themselves.

The 1997 NPAIHB letter was not simply one tribe's view; it reflected a regional tribal position. The 2016 "received through" process involved 182 comments from 91 commenters. The 2020 Medicare AIR request was a national tribal position. And the Medicare-like rate committee chaired by the author required substantial internal reconciliation of tribal views before a federal position could be negotiated.

None of that internal work necessarily generates a signature visible to CMS, a state Medicaid agency, or a court. It may appear only as a single tribal comment letter, a single TTAG position, or a short reference to extensive tribal input in a Federal Register notice.

The invisible signature

That is the invisible signature: the agreement that tribes have to build among themselves before asking a state or federal government to act.

The recovered 1998 Northwest history makes the process especially visible. In Oregon, Washington, and Idaho, tribes developed regular state relationships, institutional mechanisms, and regional capacity for turning individual tribal concerns into positions that could be presented in state policymaking. The Washington experience in particular shows tribes developing issue papers, debating them, adopting positions, and creating a standing institution to carry those positions into government-to-government negotiations.

The federal consultation requirement of 2009 should therefore be understood as institutionalizing a national procedural floor, not as inventing the underlying practice of effective tribal-state consultation. The practice had already been demonstrated in some states. Federal law subsequently gave it a national legal and administrative framework.

The formal record tends to make consensus look as though it was simply supplied. In reality, consensus is often the product of considerable work that occurs before the first visible government signature.

Conclusion

The useful question is therefore not literally "How many signatures?" It is: how many governmental decisions and implementation steps stand between a policy idea and money in a tribal health program?

Sometimes the answer is one federal rule. Sometimes it is federal action followed by state action. Sometimes it is federal action followed by individual facility agreements. Sometimes a procedural consultation requirement must be satisfied before the substantive state action can begin.

But there is one more step that rarely appears in the official count. It is the step in which tribes with different circumstances, different treaty and trust histories, different geographies, different health systems, and different state relationships work through their differences and decide what they can support together.

That is the invisible signature. It is not signed by CMS. It is not signed by a governor. It is not signed by a state Medicaid director. It may never appear in a Federal Register notice. Yet it can be the prerequisite for the visible signature that follows.

The history examined here suggests that Indian health financing policy is best understood not as a single federal process, but as a series of pathways. Some are federal. Some are state-mediated. Some are facility-specific. And beneath all of them is a tribal policymaking process that is essential to the ability of Indian Country to turn policy ideas into durable financing gains.

Author's note on sources

This essay draws on public regulatory and legal records—the Federal Register, CMS State Plan Amendment materials, GAO and VA Office of Inspector General reports, and federal court and Departmental Appeals Board decisions—alongside primary documents from the author's files.

A particularly important source for the consultation history is the 1998 *State Tribal Health Policymaking in the Northwest States of Oregon, Washington and Idaho: Institution Building for Health Care Policymaking*, prepared by the Northwest Portland Area Indian Health Board for review by the American Indian Health Commission for Washington State. It is used here as contemporaneous evidence of the development of tribal-state health policymaking before the 2009 federal consultation

requirement.

The principal policy sources used in the paper include the 2003 Medicare-like-rate statute and subsequent CMS rules; the 1996 IHS-HCFA MOA, 1997 HCFA memorandum, and 2016 CMS “received through” guidance; ARRA §5006(e) and its Medicaid and CHIP consultation provisions; the 2013 Kauffman & Associates consultation study; Washington SPA WA-19-0016; ARRA §5006(d), 42 CFR §438.14, and the Indian Managed Care Addendum; the Veterans Health Care Act of 1992 Federal Ceiling Price provisions; VA-I/T/U reimbursement agreements; Fox & Boerner (2009), *Medicaid and Indian Health Programs 1996 to 2008*; and the Tribal Technical Advisory Group’s 2020 Medicare outpatient AIR request.

The paper deliberately distinguishes documented history from the author’s interpretation and experience. Where the surviving sources establish sequence and outcome but not motive or causation, the text does not infer more than the record supports.

Final source-verification note

Primary federal sources checked for this revision include CMS Medicaid State Plan Amendment records, CMS and Federal Register materials concerning 42 CFR 440.90 and the IHS/Tribal clinic four-walls exception, GAO-13-272 on Medicare-like rates, and current Department of Veterans Affairs materials on I/T/U reimbursement agreements. Exact historical figures and quotations should remain tied to the underlying primary documents identified in the paper’s source note.