

INDIAN HEALTH FINANCING SERIES

III. Medicaid Financing and the 100% FMAP Mechanism

The Effective FMAP Subsidy

How Tribal and Indian Health Service Facilities Increase the Federal Share of Medicaid Spending

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Key Findings

Key Finding	Value
Estimated annual avoided state Medicaid expenditures across 8 states	\$2.2–\$2.4 Billion
Increase in effective FMAP in states with large Tribal health systems	8–12 Percentage Points
Federal reimbursement rate for services delivered through IHS and Tribal providers	100% FMAP

Executive Summary

Medicaid is jointly financed by federal and state governments through the Federal Medical Assistance Percentage (FMAP). One of the most significant enhanced matching provisions allows Medicaid services delivered through Tribal health programs or Indian Health Service (IHS) facilities to be reimbursed at 100 percent FMAP. When services are delivered through Tribal providers, the federal government finances the entire cost and states incur no matching obligation.

Across eight states with large American Indian and Alaska Native populations, the analysis suggests that Medicaid services delivered through Tribal health systems generate approximately \$2.2–\$2.4 billion annually in avoided state Medicaid expenditures.

Case studies of Alaska and Arizona provide empirical validation of the model. The study also introduces the concept of effective FMAP, which reflects the actual federal share of Medicaid expenditures after accounting for enhanced matching provisions. In states with large Tribal health systems, the effective federal share may exceed statutory FMAP rates by 8–12 percentage points.

Section 1 — Introduction

Medicaid is the largest public health insurance program in the United States, providing health insurance coverage to low-income individuals and families through a joint federal–state financing structure. The FMAP formula links federal reimbursement rates to state per capita income, ensuring that states with lower income levels receive higher federal reimbursement.

Federal law provides that Medicaid services delivered through Tribal health programs or Indian Health Service facilities qualify for reimbursement at 100 percent FMAP. When services are delivered through Tribal providers, the federal government pays the full cost and states incur no matching obligation.

This policy reflects the federal government's trust responsibility to provide health services to American Indian and Alaska Native populations, and has important implications for state Medicaid financing because it effectively shifts certain Medicaid expenditures from shared federal–state financing to full federal financing.

Section 2 — Literature Review

One of the least studied enhanced matching provisions applies to Medicaid services delivered through Tribal or Indian Health Service providers. Because federal appropriations for the Indian Health Service are insufficient to meet the health care needs of Tribal populations, Medicaid reimbursements provide an important supplemental funding source for Tribal health systems. Several studies have documented the importance of Medicaid financing for Tribal health programs—allowing expansion of services, improved health infrastructure, and recruitment of health professionals.

Section 3 — Institutional Background

The Indian health system consists of three primary components: federally operated Indian Health Service facilities; Tribal health programs operating under self-governance agreements; and Urban Indian health programs. Tribal health programs increasingly operate hospitals, specialty care facilities, and regional referral networks. When Medicaid services are delivered through these providers, they qualify for reimbursement at 100 percent FMAP—creating a unique interaction between the Indian health system and Medicaid financing. This paper analyzes that interaction for IHS and Tribally operated facilities. The parallel question for Urban Indian Organizations — which receive the standard state-specific FMAP rather than 100 percent, and for which the trust responsibility argument applies with equal force — is addressed in Paper VII.

Section 4 — Analytical Framework and Methodology

Conceptual Model

The analytical framework estimates the volume of Medicaid spending delivered through Tribal providers using four primary parameters: (1) the size of the IHS user population; (2) Medicaid enrollment among IHS users; (3) average Medicaid expenditures per enrollee; and (4) the share of services delivered through Tribal providers.

$$T = U \times M \times E \times S$$

Where: *U* = IHS user population | *M* = Medicaid enrollment rate | *E* = average Medicaid expenditure per enrollee | *S* = share of services through Tribal providers

Hospital Capacity Adjustment

The model incorporates a hospital-capacity adjustment factor (H), yielding $T_{adj} = T \times H$. States with Tribal hospitals capable of delivering inpatient services receive higher adjustment factors. Estimated factors: High Tribal hospital capacity = 1.6; Moderate capacity = 1.3; Primarily outpatient systems = 1.0.

Estimating State Fiscal Savings

State Savings = $T_{adj} \times (1 - \text{FMAP})$. Under standard Medicaid financing, states would normally finance the portion equal to $(1 - \text{FMAP})$. When services are delivered through Tribal providers, the state share falls to zero.

Section 5 — Data Sources and Estimation Procedure

The model assumes approximately 45 percent of IHS users are enrolled in Medicaid, consistent with available policy reports, and average Medicaid spending of \$8,000 per enrollee annually—within the national range of \$6,000–\$10,000. Approximately 65 percent of Medicaid services received by IHS users are assumed delivered through Tribal providers.

Section 6 — Results: State-Level Estimates

Table 1. State-Level Fiscal Effects of Tribal Medicaid Participation

State	IHS User Pop.	Est. Tribal Medicaid Spending	Est. State Savings	Effective FMAP Increase
Oklahoma	320,000	~\$1.6B	~\$650M	+9–11 pct. pts.
Alaska	160,000	~\$920M	~\$460M	+13–16 pct. pts.
Arizona	210,000	~\$786M	~\$236M–\$300M	+5–7 pct. pts.
California	150,000	~\$520M	~\$260M	+3–4 pct. pts.
New Mexico	180,000	~\$960M	~\$240M	+4–6 pct. pts.
Washington	65,000	~\$375M	~\$150M	+3–4 pct. pts.
South Dakota	70,000	~\$235M	~\$94M	+5–7 pct. pts.
Montana	70,000	~\$260M	~\$91M	+4–6 pct. pts.

Case Study: Alaska

90,968 Alaska Native and American Indian enrollees in Alaska Medicaid (FY2024) per Alaska DOH Long-Term Medicaid Forecast — exceeding the model’s enrollment estimate of 72,000.

100% Of services through Tribal providers. Alaska has no IHS-direct facilities and no managed care — the entire Tribal health system operates under PL 638 self-governance compacts.

Policy reports indicate that approximately \$900 million to \$1.1 billion in Medicaid spending flows through Tribal providers in Alaska annually. Under Alaska’s statutory FMAP of approximately 50 percent, the state avoids expenditures equal to approximately \$450 million to \$520 million annually.

The model developed in this study produced an estimate of approximately \$460 million in annual state savings—falling squarely within the range suggested by available policy reports.

Case Study: Arizona

~160,843 Total AI/AN AHCCCS enrollees (January 2026), representing 8.73% of total AHCCCS enrollment. Source: AHCCCS Population Demographics, January 2026.

~101,138 Fee-for-service AIHP members receiving care through IHS/638 Tribal facilities — the population to which the 100% FMAP policy applies. Source: AHCCCS Population by Contractor, March 2026.

Applying the model to Arizona produces estimated Tribal Medicaid spending of approximately \$750 million to \$800 million annually after accounting for hospital capacity. Given Arizona’s statutory FMAP of approximately 70 percent, Tribal Medicaid participation generates estimated state savings between \$236 million and \$300 million annually.

Section 9 — Model Validation

Table 2. Model Validation: Estimated vs. Observed Medicaid Spending and State Savings

State	Model Est. Tribal Medicaid	Observed Tribal Medicaid	Model State Savings	Observed State Savings
Alaska	~\$920 million	\$900M–\$1.1B	~\$460M	\$450M–

				\$520M
Arizona	~\$786 million	~\$700M–\$850M	~\$236M–\$300M	~\$200M–\$300M

Independent administrative data reporting for Washington State by the American Indian Health Commission (AIHC, 2023) further corroborates the model, with reported state savings of \$189–\$206 million exceeding the model’s \$150 million estimate for that state—consistent with the expectation that parametric national assumptions understate savings in states with mature Tribal health systems.

Section 12 — Effective FMAP

Effective FMAP = Federal Medicaid Spending ÷ Total Medicaid Spending. Two major policy provisions increase the federal share above statutory FMAP levels: (1) enhanced federal matching for Medicaid expansion populations (90 percent FMAP), and (2) full federal reimbursement for services delivered through Tribal or IHS providers (100 percent FMAP). In states with large Tribal health systems, effective FMAP may exceed statutory rates by 8–12 percentage points.

Section 13 — Sensitivity Analysis

Across plausible parameter ranges, estimated state savings varied between \$1.7 billion and \$3.1 billion annually. Even under conservative assumptions, the fiscal effects of Tribal Medicaid participation remain substantial.

Section 15 — Conclusion

This study examined how Medicaid services delivered through Tribal and Indian Health Service health systems affect the fiscal structure of state Medicaid programs. Using estimates derived from Indian Health Service user populations and Medicaid spending patterns, the analysis suggests that Tribal Medicaid participation generates approximately \$2.2–\$2.4 billion annually in avoided state Medicaid expenditures. Understanding this interaction between federal Indian health policy and Medicaid financing is essential for policymakers seeking to design sustainable Medicaid programs while improving access to care for Tribal communities.

This analysis demonstrates that Medicaid is not simply a supplemental payer within the Indian health system but a structural component of its financing architecture, with significant fiscal implications for states. This raises a critical empirical question: how has coverage among AI/AN populations actually changed over time, particularly in the ACA era when Medicaid expansion was expected to increase insured rates? The following paper examines these trends, with particular attention to the relationship between insurance coverage and IHS access.

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