Indian Health Service Population Metrics

An Institutional Research Report

Comparing Census-Based Eligible Population Estimates, Active Indian Registrants, and Three-Year Encounter Users Across IHS Service Areas

About this package: This consolidated document contains three parts with continuous pagination and footnote numbering. Part I — the institutional research report: Executive Summary; Definitions and Measurement Framework; Data Sources and Method; Area-Level Population Matrix; Discrepancy Analysis; Data Reconciliation Methods with Tribes; Funding Allocation Implications; Limitations; Recommendations. Appendix A — a comparison of the report with "How We Count Matters" (Indian Health Financing Series I, Paper 1). Appendix B — "Counting in Practice: What the IHS Administrative Record Shows," prepared as an appendix to that paper and written in its voice (sections A.1–A.7).

Executive Summary

The Indian Health Service (IHS) does not measure "its population" with a single number. It maintains at least three distinct population bases — a Census-derived **service population** (an estimate of eligible American Indians and Alaska Natives, or AI/ANs, living "on or near" reservations in Purchased/Referred Care Delivery Areas), a stock of **Indian registrants** in the National Patient Information Reporting System (NPIRS), and a rolling-period **user population** (registrants with at least one qualifying encounter in the preceding three years).[1][2] These measures answer different questions and rest on different data systems. The Census-derived service population and the registrant stock are not demonstrably nested, because their eligibility, residence, and identity rules differ — although active registrants are a subset of total registrants by construction, and the published user-population estimates closely track that subset, subject to documented adjustments. This report compares them descriptively, documents where they diverge, describes how IHS and Tribes reconcile counts, and traces the funding consequences.

1. **The national user-to-service-population ratio is falling.** The FY2025 user population (1,579,953) equals roughly **55.4%** of the 2025 projected Census-based service population (2,849,489), versus about **62.1%** in FY2021 (1,652,638 users against a 2,661,729 service population). Both denominators come from the same 2010-Census-based projection

[1]IHS, FY 2025 User Population Tables — Final (eFOIA reading room; memo dated December 19, 2025; finalized March 16, 2026). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[2]HHS ASPE, Indian Health Service Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

vintage, so the shift measures a change in a calculated ratio against a modeled denominator — a descriptive decline, not by itself evidence of declining access.[34]

2. **The registrant stock exceeds the projected service population in seven of twelve Areas.** Nationally, Indian registrants (3,211,702 as of September 30, 2025) exceed the projected 2025 service population (2,849,489) by roughly 13%. In Billings, Alaska, Great Plains, Oklahoma City, and Navajo, registrant stocks run 156–188% of the Census-based projection.[56] Candidate explanations — Census undercount of AI/ANs, projection vintage, and registration maintenance — are discussed below as hypotheses, not established causes.

3. **Area-level ratios span 21% to 113%.** The user-to-projected-service-population ratio ranges from **21.0% in California** and **23.5% in Nashville** to **83.7% in Billings**, **85.2% in Navajo**, and **112.8% in Alaska**.[78] A ratio above 100% signals that the two universes are defined differently — it is not evidence of "overuse" — and a low ratio is a mix of possible factors (access, enrollment outside IHS systems, definitional exclusions) that aggregate data cannot decompose.

4. **The user count is contracting while the registrant stock grows.** Between FY2021 and FY2024, the user population fell 1.9% (1,652,638 → 1,621,061) and active registrants fell 1.8% (1,648,314 → 1,618,828) while registrants rose 2.8%; the FY2025 tables show a further decline (active registrants 1,577,906; users 1,579,953), but the FY2025 document states a two-year encounter window (October 1, 2023 – September 30, 2025), inconsistent with the three-year design of prior years, so FY2025 comparisons carry that caveat.[9][10][11][12]

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[3] IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[4] IHS, User Population Estimates — Fiscal Year 2021 (FOIA release 19-139, including the projected AI/AN service population series, 2010–2040). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[5] IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[6] IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[7] IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[8] IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[9] IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

5. **User counts are the single most consequential data variable in IHS funding formulas.** The Indian Health Care Improvement Fund (IHCIF) federal-tribal workgroup stated that "user counts, because they represent numbers of patients receiving services, impact the formula results more than any other data variable."[13] Because formula-driven increments are small relative to base funding that historically followed prior-year patterns, population-measurement discrepancies shape the distribution of marginal dollars and persist over time.[14]

Definitions and Measurement Framework

The three population bases measure fundamentally different things. Conflating them is the most common analytical error in IHS population research.

Measure	What it counts	Data source	Key rules	Reference basis
Service population ("eligible" population)	Self-identified AI/ANs residing in counties "on or near" federal Indian reservations (CHSDA/PRCDA counties)	U.S. Census Bureau county data, bridged-race files; intercensal estimates and projections adjusted for AI/AN births and deaths (NCHS vital events)	Census self-identification, not tribal membership; county is the lowest geographic unit; county splits allocated by percentage splits developed by IHS Areas	Calendar-year estimate/projection
Indian registrants	All AI/AN registrants in the NPIRS Patient Registration database, tabulated by service unit of residence	NPIRS (IHS National Data Warehouse)	"Indian" if tribe code designated Indian, or tribal designation "unspecified" plus Indian classification or blood-quantum code	Point-in-time stock (as of September 30 of the fiscal year)

[10]IHS, FY 2023 User Population (eFOIA reading room). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202023%20USER%20POPULATION%20-%201-4-2024%20a_Redacted.pdf

[11]IHS, FY 2024 User Population Estimates (eFOIA reading room). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202024%20User%20Population%20Estimates%202025.01.08_Redacted.pdf

[12]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[13]IHS, Indian Health Care Improvement Fund (IHCIF) Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[14]GAO, Indian Health Service: Funding Based on Historical Patterns, Not Need (HRD-91-5, February 21, 1991). https://www.gao.gov/assets/hrd-91-5.pdf

Measure	What it counts	Data source	Key rules	Reference basis
Active Indian registrants / user population	Registrants with at least one direct or contract inpatient stay, ambulatory care visit, or dental visit in the prior three fiscal years	NPIRS registration matched to workload (encounter) records in the National Data Warehouse	Encounter must be "workload-reportable" and electronically submitted (HL7, ASD, or Structured Delimited); user attributed by community of residence, not facility	Rolling 3-year window (e.g., FY2024: October 1, 2021 – September 30, 2024)

Sources: IHS FY 2025 User Population Tables,[15] IHS population-methodology documentation,[16] NPIRS Basic Business Rules,[17] and IHS Behavioral Health, 2018 Edition.[18]

Three definitional cautions frame everything that follows:

- **Census self-identification is not IHS eligibility.** The Census Bureau's AI/AN count "is based on information about self-reported, self-identified race categories, which is not the same as registered tribal membership/tribal affiliation."[19] Some Census-identified AI/ANs are members of state-recognized tribes or tribes recognized by foreign governments and are not IHS-eligible; conversely, people of partial Indian descent may identify with another race and be omitted despite eligibility.[20]
- **"Active Indian registrants" and the "user population" are nearly the same measure by construction.** IHS notes that "in most cases the Active Indian Registrant count is the User Population," with only three documented exceptions: negotiated figures for tribes new to IHS (under three years), corrections of minor technical miscalculations, and county splits or community additions negotiated in advance with the tribes concerned.[21] In FY2025 the bridge between the two columns is 2,047 people nationally (1,577,906 active

[15]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[16]IHS, "Defining the IHS Population" (Division of Program Statistics methodology documentation, California Area Office). https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

[17]IHS, NPIRS Basic Business Rules (National Data Warehouse). https://www.ihs.gov/ndw/documents/WUPS/NPIRS_Basic_Business_Rules.pdf

[18]IHS, Indian Health Service Report: Behavioral Health, 2018 Edition (Division of Program Statistics). https://www.ihs.gov/sites/dps/themes/responsive2017/display_objects/documents/IHS2018BehavioralHealth.pdf

[19]ASPE, IHS Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[20]IHS, "Defining the IHS Population". https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

registrants versus 1,579,953 estimated users) — they are closely related series, not independent measures of demand. The analytically meaningful contrast is between the *total registrant stock* and the *encounter-active subset*.

- **The user population is a rolling-period person count, not an access measure.** A service-population-minus-user difference is not an unmet-need count; it mixes eligible non-users, ineligible self-identifiers, and definitional residue. IHS planning documentation describes using the comparison to estimate "the number of Indians in the IHS service area who do not have current access to IHS services" as an input to some resource-allocation models.[22]

A fourth measure — the **GPRA/IDCS user population** used for performance reporting — is defined separately (AI/AN, alive at period end, residing in a community within the site's CHS catchment area, with a qualifying ambulatory or inpatient visit in the prior three years) and should not be substituted for the official user population.[2324]

Data Sources and Method

This report anchors its Area-level comparison on internally consistent public data:

- **User-side data:** IHS's official annual User Population tables, released through the IHS eFOIA reading room, for FY2021, FY2023, FY2024, and FY2025.[25262728] The FY2024 tables (issued November 2024) count registrants as of September 30, 2024, with

[21]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[22]IHS, "Defining the IHS Population". https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

[23]IHS, GPRA/GPRAMA 101 (California Area Office budget formulation presentation). https://www.ihs.gov/california/tasks/sites/default/assets/File/BP/BP2026-Presentation-GPRA101_Brennan.pdf

[24]IHS, Clinical Reporting System (BGP), GPRA Developmental Measures v26.0. https://www.ihs.gov/sites/crs/themes/responsive2017/display_objects/documents/crsv26/GPRADevMeasuresV260.pdf

[25]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[26]IHS, FY 2023 User Population. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202023%20USER%20POPULATION%20-%201-4-2024%20a_Redacted.pdf

[27]IHS, FY 2024 User Population Estimates. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202024%20User%20Population%20Estimates%202025.01.08_Redacted.pdf

[28]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

encounters from October 1, 2021 through September 30, 2024, and serve as the anchor for the formal three-year comparison; FY2025 is reported as the latest available counts, subject to the window caveat below.

- **Census-side data:** IHS's "Projected American Indian & Alaska Native IHS Service Population by Area and Service Unit, 2010 to 2040" series, included in the FY2021 FOIA release — the Area-level service-population series located for this review. It is based on **bridged 2010 Census data**, with intercensal estimates and projections using NCHS vital events.[29]
- **Corroborating sources:** ASPE's IHS funding disparities analysis,[30] the CRS overview of IHS,[31] the IHCIF federal-tribal workgroup reports,[3233] GAO analyses,[3435] and IHS budget-formulation materials.[36]

Comparability flags.

1. **Vintage mismatch.** The service-population series is a 2010-Census-vintage projection; the user tables run through FY2025. Ratios computed across them carry that caveat. The widely cited "2.2 million" national service population (used by GAO and CRS) reflects the older 2000-Census-bridged vintage and FY2017-era estimates;[373839] the 2010-based series implies roughly 2.66 million for 2021 and 2.85 million for 2025 — consistent with ASPE's

[29]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[30]ASPE, IHS Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[31]Congressional Research Service, The Indian Health Service (IHS): An Overview (R43330). https://www.congress.gov/crs_external_products/R/HTML/R43330.html

[32]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[33]IHS, IHCIF Workgroup Interim Report (2018). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2018/2018_IHCIF_WorkgroupInterimReport.pdf

[34]GAO, HRD-91-5 (1991). https://www.gao.gov/assets/hrd-91-5.pdf

[35]GAO, Indian Health: Actions Needed to Strengthen Contract Health Services (GAO-12-446). https://www.gao.gov/assets/gao-12-446.pdf

[36]Bemidji Area IHS Budget Formulation presentation (J. Douglas, November 13, 2025; Great Lakes Area Tribal Health Board). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[37]GAO, Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs (GAO-19-74R). https://www.gao.gov/assets/gao-19-74r.pdf

[38]CRS, The Indian Health Service: An Overview (R43330). https://www.congress.gov/crs_external_products/R/HTML/R43330.html

[39]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

independent estimate of a 2.7 million eligible population and its finding that the 2021 user population of about 1.7 million represented approximately 64% of that estimate.[40] No 2020-Census-based Area-level IHS service-population series was located for this review; that absence is a finding about public data availability, not proof that none exists.

2. **FY2025 encounter-window inconsistency.** The FY2025 tables state that Active Indian Registrants had a qualifying encounter "between October 1, 2023, and September 30, 2025" — a two-fiscal-year span, inconsistent with the three-year windows stated in the FY2021–FY2024 tables (e.g., FY2024: October 1, 2021 – September 30, 2024).[41][42] The document may contain a typographical error; this report does not substitute a corrected window and treats FY2025 figures as the latest reported counts with an unresolved window definition. Conclusions that depend on the precise FY2025 window are withheld accordingly.
3. **Non-equivalent universes.** The Census-derived and administrative populations are not demonstrably nested (identity rules, residence rules, and registration maintenance all differ). All ratios below are descriptive comparisons of differently defined universes, not coverage or engagement rates.

[40] ASPE, IHS Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[41] IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[42] IHS, FY 2024 User Population Estimates. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202024%20User%20Population%20Estimates%202025.01.08_Redacted.pdf

Area-Level Population Matrix

FY2025 counts by Area

IHS Area	Projected service population, 2025	Indian registrants, 9/30/2025	Active Indian registrants	User population estimate, FY2025
Alaska	139,517	250,738	157,374	157,374
Albuquerque	160,633	192,372	74,067	74,067
Bemidji	162,644	202,186	96,027	96,014
Billings	82,416	155,156	68,942	68,942
California	412,414	201,818	86,306	86,538
Great Plains	152,408	259,693	125,708	125,902
Nashville	245,496	100,968	57,593	57,593
Navajo	247,206	403,809	210,645	210,649
Oklahoma City	494,339	770,277	405,968	405,968
Phoenix	372,637	368,041	166,531	166,531
Portland	317,283	245,267	103,675	105,305
Tucson	62,496	61,377	25,070	25,070
All Areas	**2,849,489**	**3,211,702**	**1,577,906**	**1,579,953**

Counts from the IHS FY2025 User Population Tables[43] and the projected service-population series in the IHS FY2021 User Population Estimates;[44] the All-Areas service-population total is the sum of Area values.

Ratios by Area (descriptive, non-equivalent universes)

IHS Area	Users as % of projected service population, 2025	Registrants as % of projected service population, 2025	Users as % of projected service population, 2021
Alaska	112.8%	180%	122.0%
Albuquerque	46.1%	120%	56.1%
Bemidji	59.0%	124%	65.9%
Billings	83.7%	188%	90.4%
California	21.0%	49%	21.6%

[43] IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[44] IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

IHS Area	Users as % of projected service population, 2025	Registrants as % of projected service population, 2025	Users as % of projected service population, 2021
Great Plains	82.6%	170%	87.4%
Nashville	23.5%	41%	26.4%
Navajo	85.2%	163%	98.6%
Oklahoma City	82.1%	156%	87.0%
Phoenix	44.7%	99%	52.7%
Portland	33.2%	77%	39.1%
Tucson	40.1%	98%	47.4%
All Areas	**55.4%**	**113%**	**62.1%**

Calculated from the same two sources;[4546] denominators are 2010-Census-based projections of different vintage than the FY2025 administrative counts, and both years' denominators come from the same projection series.

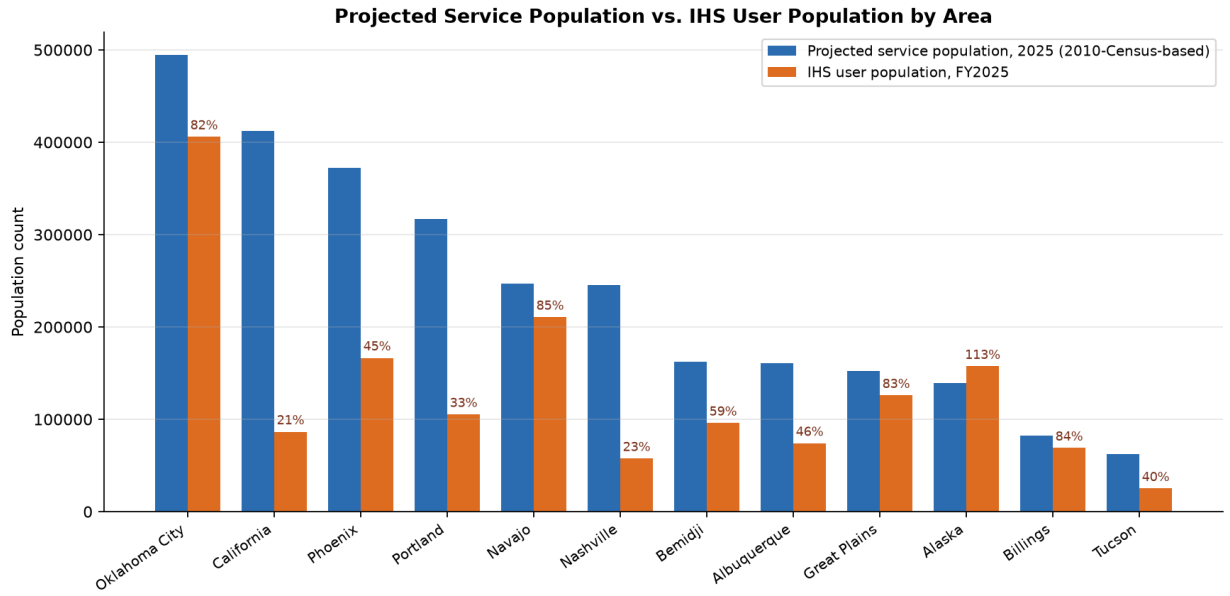


Figure 1. Projected service population (2025) versus IHS user population (FY2025) by Area. Percentages are user-to-projection ratios, not coverage rates.

[45]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[46]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

National trend in the three measures

Fiscal year	Indian registrants	Active Indian registrants	User population estimate	Active share of registrants	Stated encounter window
FY2021	3,092,940	1,648,314	1,652,638	53.3%	Oct 1, 2018 – Sep 30, 2021
FY2023	3,132,621	1,646,070	1,648,603	52.5%	Oct 1, 2020 – Sep 30, 2023
FY2024	3,179,945	1,618,828	1,621,061	50.9%	Oct 1, 2021 – Sep 30, 2024
FY2025	3,211,702	1,577,906	1,579,953	49.1%	Oct 1, 2023 – Sep 30, 2025 (as stated; see caveat)

Sources: IHS official User Population tables for FY2021, FY2023, FY2024, and FY2025.[47][48][49][50][51]

On the verified three-year windows (FY2021–FY2024), the active-registrant count fell 1.8% and the user estimate fell 1.9%, while the registrant stock grew 2.8% and the active share of registrants dropped from 53.3% to 50.9%. The FY2025 tables show a further decline (active registrants down 4.3% from FY2021; user estimate down 4.4%), but the stated FY2025 window is unresolved, so the FY2021–FY2025 change is reported with that caveat. Area-level changes between FY2021 and FY2025 in the user estimates: the largest declines were Navajo (238,951 → 210,649, −28,302), Phoenix (179,941 → 166,531, −13,410), Albuquerque (84,020 → 74,067, −9,953), and Portland (114,894 → 105,305, −9,589), while California rose (81,111 → 86,538) and Oklahoma City was essentially flat (405,015 → 405,968). Because the user population requires a qualifying, electronically submitted encounter, a decline can reflect genuine utilization change, data-submission gaps (facility EHR transitions, delayed workload exports), or registration maintenance; the official tables do not decompose the cause.[51][52]

[47] IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[48] IHS, FY 2023 User Population. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202023%20USER%20POPULATION%20-%201-4-2024%20a_Redacted.pdf

[49] IHS, FY 2024 User Population Estimates. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202024%20User%20Population%20Estimates%202025.01.08_Redacted.pdf

[50] IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[51] IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

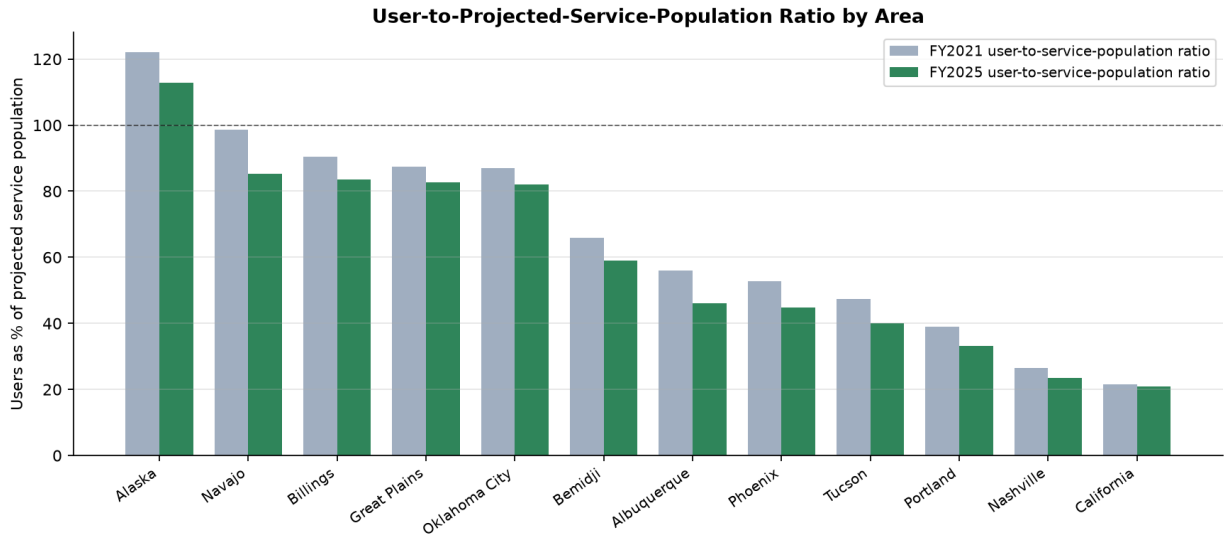


Figure 2. User-to-projected-service-population ratio by Area, FY2021 versus FY2025. Ratios above 100% reflect definitional mismatch between the two universes.

Discrepancy Analysis

Registrant stocks exceed the Census-based projection in much of Indian Country

In seven of twelve Areas — Alaska, Albuquerque, Bemidji, Billings, Great Plains, Navajo, and Oklahoma City — registrant counts exceed the projected service population, by margins from 20% (Albuquerque) to 88% (Billings). Alaska's user population alone (157,374) exceeds its Census-based projection (139,517). The two universes are defined differently, so this gap does not by itself establish a Census undercount; the candidate explanations, in varying states of documentation, are:

- **Census undercount of AI/ANs.** IHS methodology documentation observes that each decennial census "tends to enumerate American Indians more completely" than the preceding intercensal estimates, producing persistent upward revisions, and that race self-identification can miss people of Indian descent who identify with another race despite IHS eligibility.[53]
- **Vintage mismatch.** The Area series located for this review is bridged to the 2010 Census. Census self-identification of AI/AN has grown faster than vital-events arithmetic

[52]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[53]IHS, "Defining the IHS Population". https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

would predict: Census 2010 counted 5.2 million AI/AN (alone or in combination), a 21% increase over 2000 beyond population growth.[54]

- **Registration maintenance.** Unduplication is performed within each Area — "Everyone sent in by a given IHS Administrative Area will be counted just once within that Area's USERPOP report" — but the same person registered in more than one Area can appear in more than one Area's stock, and the IHCIF workgroup confirmed that "a small number of users are counted more than once due to the current regional un-duplication methodology."[5556] Whether stocks also retain deceased or relocated registrants is a validation question the aggregate tables cannot answer.

User counts fall far below the Census-based projection on the coasts and in dispersed populations

California (412,414 projected eligible; 86,538 users; ratio 21.0%), Nashville (245,496; 57,593; 23.5%), Portland (317,283; 105,305; 33.2%), and Phoenix (372,637; 166,531; 44.7%) show user populations far below their Census-based denominators. Plausible contributors include geographic dispersion relative to facilities, reliance on non-IHS payers (employer insurance, Medicaid managed care, VHA), and differences between Census self-identification and program-specific IHS eligibility.[5758] ASPE's cross-check is directionally consistent: California and Oklahoma City have the largest service populations, while Navajo and Oklahoma City have the largest user populations.[59] These low ratios are a measurement signal worth investigating — not proof of access barriers or funding disadvantage, which would require denominator validation and utilization analysis beyond the published aggregates.

Definitional residue between the measures

Several structural mismatches guarantee that the three measures will not reconcile:

- **Residence rules.** Users are counted where they live (community of residence within a PRC delivery area), not where they receive care; patients are not assigned to a tribe, and

[54]CRS, The Indian Health Service: An Overview (R43330). https://www.congress.gov/crs_external_products/R/HTML/R43330.html

[55]IHS, NPIRS Basic Business Rules. https://www.ihs.gov/ndw/documents/WUPS/NPIRS_Basic_Business_Rules.pdf

[56]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[57]IHS, "Defining the IHS Population". https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

[58]ASPE, IHS Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[59]ASPE, IHS Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

the official count excludes eligible users who reside outside any PRCDA ("non-PRCDA users") even when they receive services.[6061]

- **Cross-Area double-counting and non-PRCDA exclusion.** The IHCIF workgroup identified users "counted more than once due to the current regional un-duplication methodology (i.e., those receiving service in more than one IHS Area)" and others "not counted at all" because they live outside a CHSDA — approximately 49,000 AI/AN patients in the Phase I analysis.[6263]
- **Fractionalization.** A patient who visits facilities in multiple service delivery areas is credited to only one site under current rules; the workgroup endorsed fractionalization as potentially "the most accurate count of users by site" but noted IHS "had not yet achieved the ability" to implement it.[64]
- **Encounter capture.** The user count depends entirely on "workload-reportable" encounters electronically exported to the National Data Warehouse in standard formats; sites with weaker export pipelines undercount their users. IHS budget-formulation staff describe the result as an estimate for which "there is no such thing as an 'absolute' count of users."[65]

Headline-number confusion at the national level

Official and quasi-official statements variously describe the IHS-served population as 2.2 million (service population, older vintage), 2.7–2.8 million (IHS budget-justification language; ASPE eligible estimate), 3.2 million (registrants), or 1.6 million (users).[666768] These are not disagreements

[60]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[61]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[62]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[63]IHCIF Workgroup Interim Report (2018). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2018/2018_IHCIF_WorkgroupInterimReport.pdf

[64]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[65]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[66]IHS, Quick Look fact sheet. https://www.ihs.gov/newsroom/factsheets/quicklook/

[67]ASPE, IHS Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

about facts; they are different measures. Institutional consumers of IHS statistics should always ask which denominator is in use.

Data Reconciliation Methods with Tribes

IHS's counting system embeds several distinct Tribal interaction mechanisms. Three different processes should not be conflated: (a) registration and encounter corrections; (b) negotiated allocation of users among shared counties or communities; and (c) formal PRCDA geographic redesignation.

Registration and encounter corrections

- **Duplicate-resolution reporting.** The central database unduplicates within each Area using probabilistic matching on names, SSN, date of birth, and gender to create Integrity Identifiers, with the most recently modified record counted and duplicates flagged out; the Data Center sends reports showing possible duplicate registrations to Areas, and "database accuracy depends heavily on Areas determining which records are duplicates" and correcting them. Records missing key fields (chart facility, chart number, name fields) are excluded from counts and surfaced in data-quality reports.[6970]
- **Annual submission cycle.** Facilities export registration and encounter data to the National Data Warehouse by the end of October each year; Area points of contact receive acknowledgment and post-load reports and can correct recipient lists through NPIRS.[71]
- **Exception handling in the official tables.** The three documented exceptions — negotiated figures for tribes receiving IHS services for less than three years, correction of technical miscalculations, and county splits or community additions "negotiated in advance with the Tribes concerned, calculated by the Area Office" — are the formal channels through which counts depart from the mechanical rule.[72]

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[68]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[69]IHS, NPIRS Basic Business Rules. https://www.ihs.gov/ndw/documents/WUPS/NPIRS_Basic_Business_Rules.pdf

[70]IHS, "Defining the IHS Population". https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

[71]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[72]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

Negotiated allocation among shared counties and communities

Shared PRCDA counties are divided among tribes by agreement: "affected tribes come to an agreement with the area's assistance (data). If no agreement, the Area Director makes a decision," producing "a variety of methods for dividing the users in a shared county" — straight percentage splits, splits by tribe of membership, or hybrid formulas allocating "unaffiliated" AI/AN users among the tribes whose PRCDA includes the county, based on workload data accepted at the National Data Warehouse.[73][74]

Formal PRCDA redesignation

Tribes may request changes to delivery-area counties through a published administrative process: submission to the Area Director with specified justifications (estimated populations included/excluded, cost estimates, impact on existing eligible users), Area analysis and recommendation, Headquarters review, Tribal consultation, a Federal Register notice with a 30-day comment period, and a final published notice.[75] This process changes the geographic eligibility boundary itself — it is not a general appeal route for disagreements about individual counts.

Consultation on formula inputs

The IHCIF user-count recommendations — national unduplication and addition of non-PRCDA users — were submitted to Tribal consultation and, per the workgroup report, IHS "approved and implemented the per-person benchmark and user-count recommendations based on consultation input."[76] Sites are also given an opportunity to validate alternate-resource enrollment data, with statewide ACS averages used as fallback where a site does not respond. Tribal epidemiology work has additionally compared IHS counting methods (tribe code, beneficiary classification, blood quantum) against tribal enrollment files.[77]

Gaps and a recommended workflow

The published materials do not describe a single end-to-end Tribal procedure for validating user counts, and the official tables remain on the unadjusted (regional-unduplication) basis even

[73]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[74]IHS, FY 2024 User Population Estimates. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202024%20User%20Population%20Estimates%202025.01.08_Redacted.pdf

[75]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[76]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[77]National Indian Health Board, National Data Symposium presentations (2023). https://legacy.nihb.org/resources/2023DataSymposium/MondayMorningPresentations.pdf

though adjusted counts are used in IHCIF calculations. Budget-formulation materials acknowledge that CHSDA splits "were agreed upon in the early 2000s and may be out of date" and that "for some tribes, current CHSDA designations may not accurately represent the geographic region in which their patients reside."[78] A reconciliation workflow consistent with documented practice and tribal data governance — offered here as a recommendation, not a description of current procedure — would proceed: (1) agree on definitions, cutoff dates, and the encounter window; (2) exchange and reconcile aggregate counts (registrants, actives, users by community) under existing data-sharing arrangements, without centralizing identifiable enrollment files; (3) investigate exceptions through the duplicate-resolution and data-quality reporting channels; (4) correct and resubmit registration and encounter records through the annual export cycle; (5) obtain joint validation of the tables before publication; and (6) retain an audit trail of negotiated splits, community additions, and redesignations.

Funding Allocation Implications

How each population measure enters the money

Funding mechanism	Population input	Documented operation
IHCIF / Level of Need Funded (LNF)	User population (adjusted count; see below)	Site per-capita funds available divided by a benchmark need (NHE categories 1–4 per person) yields an LNF percentage; IHCIF increments go to sites with the lowest LNF. FY2018: national LNF 48.6%; a $72 million increase was distributed to 40 SDAs below 34.8% LNF. User counts "impact the formula results more than any other data variable."[79]
Headquarters shares and congressional increases	HQ user population	User population "is used for distributing Headquarters funds," including IHCIF, HQ shares, and congressional increases.[80]

[78]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[79]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[80]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

Funding mechanism	Population input	Documented operation
Annual budget justification	Service population estimates and projections	Used to estimate the number of Indians to be served in the budget year and the population growth rate.[81]
Needs-based formulas (historical)	User population estimates	GAO's 1991 finding: IHS "applies user population estimates in its needs-based resource allocation formulas," but between 1980 and 1990 only about 2% of total funding ($187 million) moved through needs-based methods.[82]
Facilities planning (Resource Requirements Methodology)	User population	RRM staffing calculations for new/replacement facilities use user populations as the population variable.[83]
Urban Indian programs	Not a user-population input	UIOs are funded through grants and contracts; the population basis of urban allocations is not documented as the user population in these sources. In FY2016, urban programs received approximately 1% of the IHS budget.[84]

Row-level source citations are given in the operation column.

Two clarifications on the current state of the formulas. First, the IHCIF workgroup's user-count recommendations (national unduplication, addition of non-PRCDA users) were approved and implemented following consultation — for the IHCIF calculation. The official published User Population tables, by contrast, remain on the regional-unduplication basis described above. The FY2017 illustration of the difference: official user population 1,638,687 versus 1,666,230 adjusted for national unduplication and non-PRCDA users.[85] Analysts should confirm which count enters any given allocation before modeling it. Second, GAO's finding that base funding followed prior-year patterns — with Oklahoma Indians receiving about $697 per capita in FY1990 against a $1,014 IHS average while Oklahoma held about 20% of eligible Indians and 22% of active users — is a historical pattern from 1991, not a statement of the current allocation rule.[86]

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[81] IHS, "Defining the IHS Population". https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

[82] GAO, HRD-91-5 (1991). https://www.gao.gov/assets/hrd-91-5.pdf

[83] IHS, "Defining the IHS Population". https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

[84] CRS, The Indian Health Service: An Overview (R43330). https://www.congress.gov/crs_external_products/R/HTML/R43330.html

[85] IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[86] GAO, HRD-91-5 (1991). https://www.gao.gov/assets/hrd-91-5.pdf

What the discrepancies do to funding

The core structural tension: the count drives the formula, but need is broader than the count. The workgroup noted the user population "only accounts for unmet needs of AI/ANs who are currently accessing services, not the unmet need for all AI/ANs."[87] The LNF arithmetic divides funds available by users, so — holding funds and benchmark costs constant — additional counted users *lower* a site's calculated LNF and can flip it across the increment threshold; a site whose encounter capture is weak or whose PRCDA residence rules exclude eligible users appears smaller and better-funded than it is. Whether this produces actual inequity relative to eligible need depends on a validated denominator, which the published aggregates do not provide; what is established is the measurement incentive. The direction of any specific funding effect also depends on input years, allocation rules in force, and fixed appropriation levels — a count change does not automatically produce a proportional funding change.

Ratio divergence is a distributional variable to monitor, not a proven inequity. Because 82–85% of projected eligible residents in Navajo, Billings, and Great Plains are counted users, while only 21–33% are counted in California, Nashville, and Portland, formula mechanisms keyed to users can treat otherwise-similar eligible populations very differently. Whether that misallocates resources relative to eligible need is a question the current data cannot settle without denominator validation; it is the reason the reconciliation mechanisms above matter.

The user-count trend is a funding-policy event, whatever its cause. A falling user count flows directly into LNF denominators, HQ shares, and IHCIF distributions. If the decline reflects data-submission gaps (EHR transitions, workload export failures) rather than genuine utilization change, funding formulas are being fed noise. GAO has separately documented that IHS's data on purchased/referred care users are incomplete and inconsistently collected across Areas.[88]

Scale of the funding gap. The IHCIF workgroup estimated, on FY2018 data, that fully funding all 280 LNF service delivery areas required $16 billion in gross resources against $11 billion available — a roughly $5 billion deficiency — with the agency-wide LNF at 48.6%.[89] ASPE's per-capita comparison puts 2017 IHS spending at $4,078 per user against $8,109 for Medicaid, $10,692 for the VHA, and $10,742 in national health expenditures, while cautioning that "fundamental differences in the programs limit the extent to which comparisons of federal funding for each program can be used to assess the adequacy of program funding."[90] The Tribal Budget

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[87] IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[88] GAO-12-446. https://www.gao.gov/assets/gao-12-446.pdf

[89] IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[90] ASPE, IHS Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

Formulation Workgroup concluded $49.9 billion was needed for FY2023; IHCIF appropriations totaled only $259 million from FY2000 through FY2018.[9192]

Urban programs sit largely outside the user-count machinery. Approximately 70% of AI/ANs live in urban areas, and UIOs served 79,502 AI/ANs in 2020; urban residents, UIO patients, and IHS/Tribal users are overlapping populations, not mutually exclusive ones, so these figures cannot be netted against each other.[9394] Urban funding levels are a policy choice made outside the user-population formulas documented here.

Limitations

- **Vintage mismatch.** The Area-level service population compared here is the 2010-Census-bridged projection series located in the FY2021 FOIA release; the FY2025 user tables are current. No 2020-Census-based Area series was located for this review. Ratios across the two series inherit both vintages.
- **FY2025 window discrepancy.** The FY2025 document states a two-year encounter window; this report reports FY2025 as the latest counts with that unresolved caveat and anchors formal three-year comparisons on FY2024.
- **Projection error compounds with distance from the census base.** The service-population series applies county-level vital-events arithmetic without migration adjustment — a documented error source for smaller geographies.[95]
- **Registrants are a stock, not an estimate of current eligible residents.** The stock includes documented cross-Area duplicates; whether it also retains deceased or relocated registrants is a validation question, not an established fact from these tables.[96]
- **The user population is not unmet need.** Ratios above 100% (Alaska) demonstrate definitional mismatch between the universes, not overuse; ratios near 20% conflate possible access barriers with definitional exclusions.

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[91]ASPE, IHS Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[92]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[93]ASPE, IHS Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[94]CRS, The Indian Health Service: An Overview (R43330). https://www.congress.gov/crs_external_products/R/HTML/R43330.html

[95]IHS, "Defining the IHS Population". https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

[96]IHS, NPIRS Basic Business Rules. https://www.ihs.gov/ndw/documents/WUPS/NPIRS_Basic_Business_Rules.pdf

- **GPRA denominators are a separate definition** and are not comparable to the official user population.[97]
- **Encounter-capture completeness is unobserved.** The causes of the user-count decline are not decomposed in official releases; explanations offered here are labeled as hypotheses where undocumented.

Recommendations

1. **Publish a 2020-Census-based Area-level service-population series.** The Area series located for this review is 2010-based; every downstream ratio in IHS analysis inherits that vintage. A 2020-based release with bridged-race documentation is the single highest-value data fix.
2. **Reconcile the official and IHCIF user counts publicly.** Adjusted counts (national unduplication, non-PRCDA users) are used in IHCIF calculations while the published tables remain on the unadjusted basis; publishing both series side by side would make the national count auditable and prevent analysts from mixing them.[98]
3. **Resolve and document the FY2025 encounter window.** The stated two-year window is inconsistent with the three-year design; IHS should correct or clarify the definition so the FY2025 decline can be interpreted.
4. **Audit the FY2021–FY2025 user decline.** A fall of this size — concentrated in Navajo, Phoenix, Albuquerque, and Portland — warrants a data-quality review by export pipeline, facility, and EHR transition status before it is treated as a utilization trend in funding formulas.
5. **Refresh stale CHSDA splits on a scheduled cycle.** Split agreements dating to the early 2000s materially drive user counts; re-opening them on current encounter patterns, through the existing negotiation and Area Director decision mechanisms, would align counts with actual service geographies.[99]
6. **Report dual denominators in all funding analyses.** Any statement of IHS "population served" should disclose which measure it uses — service population, registrants, or users — and budget materials should present the service-population-to-user gap explicitly, as IHS planning documentation already contemplates.[100]

[97]IHS, GPRA/GPRAMA 101. https://www.ihs.gov/california/tasks/sites/default/assets/File/BP/BP2026-Presentation-GPRA101_Brennan.pdf

[98]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[99]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[100]IHS, "Defining the IHS Population". https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

Appendix A: Comparison with "How We Count Matters" (Fox, 2026)

This appendix compares the findings of this report with "How We Count Matters: Tribal Enrollment, Census Identity, and the Mismeasurement of American Indian Populations" (Indian Health Financing Series I, Paper 1, v5, March 2026, by Edward J. Fox).[101] The two analyses are complementary rather than competing: the Fox paper explains why population concepts must be matched to policy purposes, and this report shows how administrative counting rules enter IHS operations and funding distribution.

Overview of the compared paper

The Fox paper analyzes two data sources this report does not use: the April 2021 Treasury Tribal Enrollment Data Call, in which 573 federally recognized tribes submitted certified counts totaling 2,652,345 enrolled citizens, and the 2019 American Community Survey (ACS) five-year estimates of AI/AN individuals residing on 245 named tribal homelands (1,008,759).[102] It distinguishes four population concepts — tribal citizenship (enrollment), homeland residence, the tribal community (the full population a tribe intends to serve), and Census identity — and argues that each must be matched to program purpose: enrollment for governance allocations, homeland residence for physical infrastructure need, tribal community for service planning and facility sizing, and Census identity (pre-2020 methodology) for disparities analysis.[103]

The paper's strongest single finding concerns the 2020 Census race-question redesign. Between the 2010–2014 and 2020–2024 ACS PUMS periods, the AI/AN denominator (RACAIAN) grew from approximately 5.2 million to nearly 8.0 million — a 53% increase — while the count of AI/AN individuals reporting IHS access (ACS variable HINS7) was essentially unchanged: 1,294,785 versus 1,294,264, a difference of 521 persons. The paper attributes the fall in the IHS-access share from 24.9% to 16.2% "entirely" to the denominator change, concluding that trend lines crossing the 2019–2022 boundary must be labeled as discontinuous, and designates the stable HINS7 count of approximately 1.3 million as the most reliable post-2020 denominator for Indian health policy.[104]

Points of agreement

- **Non-interchangeable measures.** This report treats the service population, registrants, and users as differently defined universes whose eligibility, residence, and identity rules differ; the Fox paper reaches the same conclusion from the enrollment, homeland,

[101] Edward J. Fox, "How We Count Matters: Tribal Enrollment, Census Identity, and the Mismeasurement of American Indian Populations," Indian Health Financing Series I, Paper 1 (v5, March 2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[102] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[103] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[104] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

community, and identity side, adding the matching principle that each measure suits a distinct policy purpose.[105]

- **Caution about declining ratios.** Both analyses find falling ratios that should not be read as access deterioration without denominator validation: the user-to-service-population ratio here (62.1% in FY2021 to 55.4% in FY2025, against a modeled denominator of a single vintage) and the HINS7 IHS-access share there (24.9% to 16.2%, attributed to the question redesign).[106]
- **Critique of historical-base funding.** This report documents GAO's 1991 finding that IHS funding followed prior-year patterns rather than need;[107] the Fox paper's recommendation against allocating new resources "the way we distributed it last time" reaches the same conclusion from the measurement side.[108]

Numerical convergences

- **Service population.** The Fox paper's series basis of approximately 2.6 million is nearly identical to this report's 2021 projection (2,661,729), and its note that the FY2027 IHS Congressional Budget Justification reports approximately 2.8 million AI/ANs served is numerically consistent with this report's 2025 projection (2,849,489). The consistency is suggestive but not proof of provenance; the budget justification's population definition would need verification before the increase is attributed to the vintage change.[109]
- **Navajo.** Navajo Area NPIRS registrants (403,809, FY2025) fall within 1.1% of the Navajo Nation's enrolled citizens (399,494, 2021). The two figures are constructed differently — registration in an IHS Area versus tribal citizenship, in different years — so the proximity is a convergence, not a validation of either count.[110]
- **Order of magnitude of the actively served population.** The Fox paper's CMS–IHS Data Match (941,168 confirmed IHS-access Medicaid enrollees) and HINS7 count (~1.29 million), together with this report's NPIRS users (1.58 million), all fall in the same range, but they are not nested and do not establish population bounds — Medicaid matching, survey self-report, and qualifying administrative encounters have different inclusion rules. Their numerical similarity in scale is the strongest joint observation across the two analyses.[111]

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[105] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[106] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[107] GAO, HRD-91-5 (1991). https://www.gao.gov/assets/hrd-91-5.pdf

[108] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[109] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[110] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

Points of divergence and refinement

- **The characterization of HINS7.** The Fox paper states that HINS7 "is anchored to actual system contact rather than survey self-identification" and is the most reliable post-2020 denominator.[112] HINS7 is a self-reported response to the ACS health-coverage question — a Yes/No coverage-type item, not an administrative contact count. This report's user population (1.58 million) is the administrative counterpart and runs approximately 22% higher. The two series also move differently: HINS7 is stable across pooled five-year windows while the NPIRS user count fell 4.4% between FY2021 and FY2025. The differing constructs and observation periods prevent interpreting the divergence as evidence of either utilization change or administrative capture error; resolving it is the most productive open question between the two analyses.
- **Homeland residents as a proxy for the direct-service population.** The Fox paper's Exhibit 2 states that ACS homeland residents "approximate the IHS direct-service population" (~1.01 million).[113] This report's user population (1.58 million) is materially larger, though not cleanly comparable — the user count includes contract encounters and dental visits, and the two measures differ in year and geography. The defensible conclusion is non-substitutability: homeland residence cannot substitute for the published user population. The measures differ in reference year, geography, and inclusion rules; their difference does not establish a measured undercount of direct-service users.
- **Descendant eligibility as an explanation for registrants exceeding the Census base.** Federal regulation provides that services are available to "persons of Indian descent belonging to the Indian community served by the local facilities and program,"[114] which reaches beyond both enrollment and Census self-identification. This is consistent with — and supplies a legal mechanism for — this report's finding that registrants exceed the Census-based service population in seven of twelve Areas, by up to 88%. It is a possible explanation, not a demonstrated one; Census undercount, projection vintage, and registration maintenance remain candidate causes that the aggregate tables cannot distinguish.
- **The 2020-series recommendation.** This report recommends that IHS publish a 2020-Census-based Area-level service-population series, while the Fox paper shows that post-2020 identity measures overstate the AI/AN universe by design.[115] The two positions are compatible if the recommendation is read carefully: an updated series requires

[111]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf
[112]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf
[113]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf
[114]42 C.F.R. § 136.12, Persons to whom services will be provided (Cornell Legal Information Institute). https://www.law.cornell.edu/cfr/text/42/136.12
[115]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

documented race definitions, geographic crosswalks, explicit methodological breaks, and Tribal validation — not raw substitution of post-2020 self-identification counts. The discontinuity evidence strengthens, rather than defeats, the case for a transparent updated series.

Corrections noted for the compared paper

- **Regulatory citation.** The paper cites "25 C.F.R. § 136.12" for the IHS eligibility standard; the regulation is 42 C.F.R. § 136.12 (Title 42 contains the HHS Indian Health regulations; Title 25 covers the Bureau of Indian Affairs).[116] The operative language provides that services are available to "persons of Indian descent belonging to the Indian community served by the local facilities and program" — broader and more community-contingent than a categorical descendant-entitlement rule (see Appendix B).
- **The 38% homeland-residence figure.** The paper computes homeland residents as 38% of total enrolled citizens and infers that "nearly two in three enrolled tribal citizens do not live on a tribal homeland."[117] The 38% is an aggregate ratio of two non-equivalent universes — Census-identified AI/AN homeland residents over total enrolled citizens — in which the numerator can include unenrolled individuals and citizens of other nations, and the denominator includes citizens wherever they reside. The off-homeland inference requires linked membership-and-residence data that those two totals do not provide. This is the same non-equivalent-universe caution both analyses apply elsewhere.
- **The enrollment universe.** The paper cites 573 federally recognized tribes submitting certified counts but reports total implied enrollment across 578 funded entities (2,652,345), and does not reconcile the difference in the text.[118]

Complementary contributions

The Fox paper contributes what this report lacks: the enrollment and homeland-residence measures; the 2020 question-redesign discontinuity (the strongest evidence in either document that survey denominators broke); distributional concentration (seven tribes hold 47% of enrolled citizens; Oklahoma and the Navajo Nation hold over 60% of the homeland population); and the tribal-community concept, which captures non-Indian household members and other intended-service populations that the three IHS measures never include.[119]

This report contributes what the Fox paper lacks: the Area-level administrative counts themselves (registrants, active registrants, and users for all twelve IHS Areas, FY2021–FY2025); the FY2025 encounter-window inconsistency; the IHCIF/Level of Need Funded formula mechanics showing that user counts are the most consequential funding variable; the adjusted-versus-published

[116] 42 C.F.R. § 136.12. https://www.law.cornell.edu/cfr/text/42/136.12

[117] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[118] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[119] Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

count discrepancy in IHCIF calculations; and the documented Tribal reconciliation mechanisms (CHSDA splits, PRCDA redesignation, duplicate-resolution reporting).

Bottom line

Neither analysis supports a single universally best denominator. The approximately 300,000-person gap between HINS7 (~1.29 million) and the NPIRS user population (~1.58 million) cannot be resolved by the two instruments jointly, because self-reported coverage and qualifying administrative encounters measure different constructs. The most valuable next step is a direct reconciliation of ACS HINS7, the CMS–IHS Data Match, and NPIRS user counts for the same years — three survey and administrative measures that fall in the same range but do not validate one another or establish population bounds.

Data notes: All Area-level counts are transcribed from the IHS official User Population tables (FY2021, FY2023, FY2024, FY2025) and the IHS projected service-population series released under FOIA. Ratios and sums are computed from those transcriptions. The FY2025 tables were finalized March 16, 2026 (memo dated December 19, 2025); the FY2021 FOIA release is the source located for the Area-level Census-based service-population series.

Appendix B

Counting in Practice: What the IHS Administrative Record Shows

Prepared as an appendix to "How We Count Matters: Tribal Enrollment, Census Identity, and the Mismeasurement of American Indian Populations," Indian Health Financing Series I, Paper 1

Reproduced in this consolidated package for completeness; it is written in the voice of that paper, as an integral part of the Series, and follows the companion analysis, "Indian Health Service Population Metrics: An Institutional Research Report" (October 2026)

A.1 Purpose and Sources

The paper closes by asking whether available data systems can support the distinctions among tribal citizenship, homeland residence, tribal community, and Census identity, noting that federal administrative data have historically struggled to identify AI/AN populations accurately.[120] This appendix takes up that question from the administrative side. It draws on a companion institutional analysis of IHS population metrics (October 2026) and on the primary sources cited therein: the IHS's official annual User Population tables for FY2021 through FY2025,[121,122,123,124] the IHS projected AI/AN service-population series (2010–2040),[125] the Indian Health Care Improvement

[120]Edward J. Fox, "How We Count Matters: Tribal Enrollment, Census Identity, and the Mismeasurement of American Indian Populations," Indian Health Financing Series I, Paper 1 (v5, March 2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[121]IHS, FY 2025 User Population Tables — Final (eFOIA reading room; memo dated December 19, 2025; finalized March 16, 2026). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[122]IHS, User Population Estimates — Fiscal Year 2021 (FOIA release 19-139, including the projected AI/AN service population series, 2010–2040). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[123]IHS, FY 2024 User Population Estimates (eFOIA reading room). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202024%20User%20Population%20Estimates%202025.01.08_Redacted.pdf

[124]IHS, FY 2023 User Population (eFOIA reading room). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202023%20USER%20POPULATION%20-%201-4-2024%20a_Redacted.pdf

[125]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

Fund (IHCIF) federal-tribal workgroup reports,[126,127] and supporting GAO, ASPE, and budget-formulation materials.[128,129,130,131]

A.2 The Three IHS Measures and Their Mapping to the Paper's Concepts

The IHS maintains three distinct population bases. The **service population** is a Census-derived estimate of eligible AI/ANs living "on or near" reservations in Purchased/Referred Care Delivery Areas (PRCDA counties), built on bridged-race Census files and adjusted with vital events. **Indian registrants** are the AI/AN-classified registration records in the National Patient Information Reporting System (NPIRS). The **user population** comprises registrants with at least one qualifying inpatient, ambulatory, or dental encounter in the prior three fiscal years — a rolling-period person count anchored to qualifying recorded encounters.[132,133] The Census-derived service population and the administrative registration populations are not demonstrably nested; active Indian registrants, however, are a subset of Indian registrants by construction, and the published user-population estimates closely track that subset, subject to documented adjustments.

Mapped against the paper's four concepts, the administrative measures line up as follows:

[126]IHS, Indian Health Care Improvement Fund (IHCIF) Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[127]IHS, IHCIF Workgroup Interim Report (2018). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2018/2018_IHCIF_WorkgroupInterimReport.pdf

[128]GAO, Indian Health Service: Funding Based on Historical Patterns, Not Need (HRD-91-5, February 21, 1991). https://www.gao.gov/assets/hrd-91-5.pdf

[129]HHS ASPE, Indian Health Service Funding Disparities Report. https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[130]Congressional Research Service, The Indian Health Service (IHS): An Overview (R43330). https://www.congress.gov/crs_external_products/R/HTML/R43330.html

[131]Bemidji Area IHS Budget Formulation presentation (J. Douglas, November 13, 2025; Great Lakes Area Tribal Health Board). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[132]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[133]IHS, "Defining the IHS Population" (Division of Program Statistics methodology documentation, California Area Office). https://www.ihs.gov/california/tasks/sites/default/assets/File/Training/DefiningIHSPopulationEs.pdf

Concept (this Series)	Closest IHS measure	Key differences
Census identity	Service population	Same self-identification basis, but restricted to PRCDA counties and adjusted through bridged-race files. Runs far below the national identity count by design: the 2021 service population (2,661,729) against a 2010–2014 RACAIAN denominator of roughly 5.2 million.[134,135]
Tribal citizenship (enrollment)	Indian registrants (NPIRS)	Registration is not a citizenship roll. The general service-eligibility provision, 42 C.F.R. § 136.12, makes services available to "persons of Indian descent belonging to the Indian community served by the local facilities and program";[136] it is not a descendant-entitlement rule and does not by itself govern NPIRS registration. Registrant counts can help explain why registration differs from enrollment, though they do not establish the cause of registrants exceeding either enrollment or the Census-based estimates. Registrants (3,211,702 in FY2025) exceed the 2021 total of enrolled citizens (2,652,345).[137,138]
Homeland residence	Service population (geography)	PRCDA geography is broader than homeland geography: reservations plus adjacent counties, plus the entirety of Alaska, Nevada, and Oklahoma. The 2021 service population (2.66 million) is roughly 2.6 times the ACS 2019 homeland count (1.01 million) — a difference in definitions as much as in populations.[139,140]

[134]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[135]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[136]42 C.F.R. § 136.12, Persons to whom services will be provided (Cornell Legal Information Institute). https://www.law.cornell.edu/cfr/text/42/136.12

[137]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[138]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[139]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[140]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

Concept (this Series)	Closest IHS measure	Key differences
Tribal community	User population	The closest administrative proxy for recorded service contact, but not a measure of the tribal community: it counts people with qualifying recorded encounters, subject to the published adjustment rules — not the population a tribe intends to serve — and depends entirely on electronically submitted "workload-reportable" encounters.[141]

Sources: IHS FY2025 User Population Tables; IHS FY2021 User Population Estimates; 42 C.F.R. § 136.12; IHS budget-formulation materials (see footnotes).

A.3 The Area-Level Administrative Record

Exhibit A-1 presents the FY2025 counts by IHS Area alongside the 2025 projected service population; Exhibit A-2 charts the comparison; Exhibit A-3 shows the national trend since FY2021. Three findings stand out.

1. **The registrant stock exceeds the Census-based projection in seven of twelve Areas** — by 20% in Albuquerque and 88% in Billings; Alaska's user population alone (157,374) exceeds its Census-based eligible projection (139,517).[142,143] The administrative record thus shows the paper's central gap from the other side: the registered population outruns the survey-based estimate in much of Indian Country. The candidate causes — Census undercount, projection vintage, descendant registration, registration maintenance — cannot be separated using aggregate counts.
2. **User-to-projection ratios span 21.0% (California) and 23.5% (Nashville) to 83.7% (Billings), 85.2% (Navajo), and 112.8% (Alaska).**[144,145] The ratios are descriptive comparisons of two differently defined populations, not validated engagement rates; whether the paper's homeland-enrollment variation corresponds to this pattern would require a direct comparison that these data do not provide.

[141]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf
[142]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf
[143]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf
[144]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf
[145]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

3. **The user count is falling while the registrant stock grows.** On the verified three-year windows, the active share of registrants fell from 53.3% (FY2021) to 50.9% (FY2024) while the registrant stock grew 2.8%; the FY2025 tables report a further decline (49.1% active share; user estimate 4.4% below FY2021) but state a two-year encounter window (October 1, 2023 – September 30, 2025) inconsistent with the three-year design of every prior release.[146,147,148,149] The window statement is a published documentation discrepancy — it could reflect a documentation error rather than an error in the underlying count — and is treated here as a caveat on the FY2025 figures rather than as a finding about the count itself.

A further structural point: the service-population projection series is bridged to the 2010 Census, and no 2020-based Area-level series was located in this review. The projection's Census base therefore predates the discontinuity this paper documents — the two strands of the measurement problem have not yet met in a single series.

[146]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[147]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[148]IHS, FY 2024 User Population Estimates. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202024%20User%20Population%20Estimates%202025.01.08_Redacted.pdf

[149]IHS, FY 2023 User Population. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202023%20USER%20POPULATION%20-%201-4-2024%20a_Redacted.pdf

Exhibit A-1. FY2025 counts by IHS Area

IHS Area	Projected service population, 2025	Indian registrants, 9/30/2025	Active Indian registrants	User population, FY2025	Users as % of projection
Alaska	139,517	250,738	157,374	157,374	112.8%
Albuquerque	160,633	192,372	74,067	74,067	46.1%
Bemidji	162,644	202,186	96,027	96,014	59.0%
Billings	82,416	155,156	68,942	68,942	83.7%
California	412,414	201,818	86,306	86,538	21.0%
Great Plains	152,408	259,693	125,708	125,902	82.6%
Nashville	245,496	100,968	57,593	57,593	23.5%
Navajo	247,206	403,809	210,645	210,649	85.2%
Oklahoma City	494,339	770,277	405,968	405,968	82.1%
Phoenix	372,637	368,041	166,531	166,531	44.7%
Portland	317,283	245,267	103,675	105,305	33.2%
Tucson	62,496	61,377	25,070	25,070	40.1%
All Areas	**2,849,489**	**3,211,702**	**1,577,906**	**1,579,953**	**55.4%**

Counts from the IHS FY2025 User Population Tables[150] and the projected service-population series in the IHS FY2021 User Population Estimates;[151] the All-Areas service-population total is the sum of Area values. The projection is based on bridged 2010 Census data; ratios are descriptive comparisons of differently defined universes, not coverage rates.

[150]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[151]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

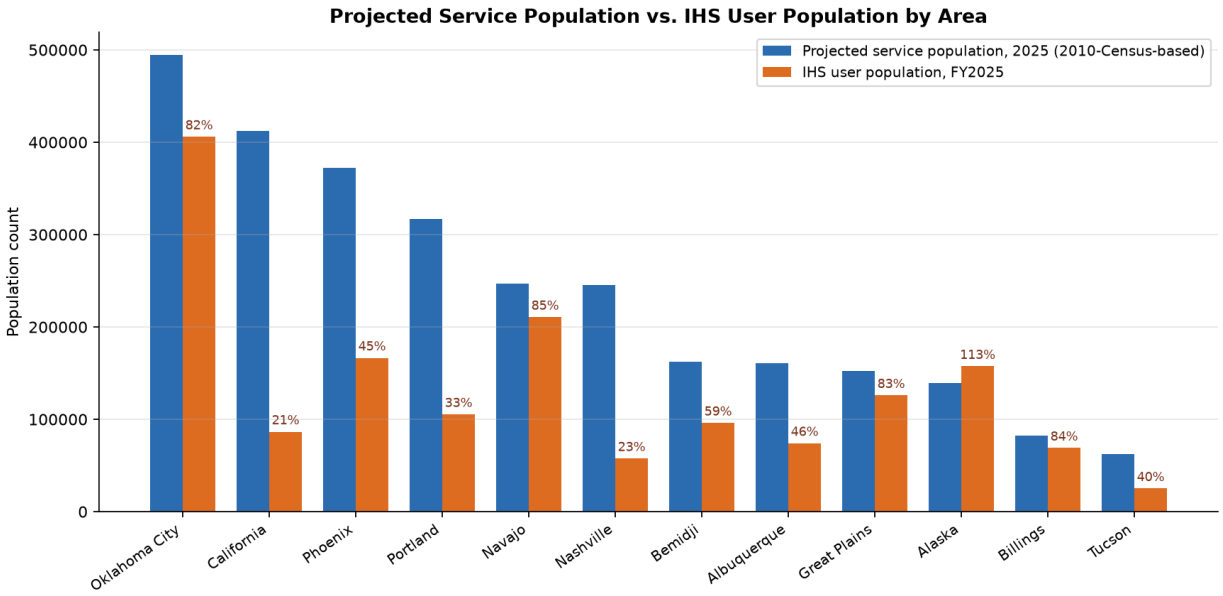


Exhibit A-2. Projected service population (2025) versus IHS user population (FY2025) by Area. Percentages are user-to-projection ratios, not coverage rates.

Exhibit A-3. National trend in the three measures

Fiscal year	Indian registrants	Active Indian registrants	User population estimate	Active share of registrants	Stated encounter window
FY2021	3,092,940	1,648,314	1,652,638	53.3%	Oct 1, 2018 – Sep 30, 2021
FY2023	3,132,621	1,646,070	1,648,603	52.5%	Oct 1, 2020 – Sep 30, 2023
FY2024	3,179,945	1,618,828	1,621,061	50.9%	Oct 1, 2021 – Sep 30, 2024
FY2025	3,211,702	1,577,906	1,579,953	49.1%	Oct 1, 2023 – Sep 30, 2025 (as stated; see text)

Sources: IHS official User Population tables for FY2021, FY2023, FY2024, and FY2025.[152,153,154,155]

[152]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf
[153]IHS, FY 2023 User Population. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202023%20USER%20POPULATION%20-%201-4-2024%20a_Redacted.pdf
[154]IHS, FY 2024 User Population Estimates. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202024%20User%20Population%20Estimates%202025.01.08_Redacted.pdf

A.4 Convergent Totals — and Two Cautions

The paper designates the stable HINS7 count (approximately 1.3 million) as the most reliable post-2020 denominator.[156] In the Census Bureau's PUMS data dictionary, HINS7 is a Yes/No item in the health-insurance coverage battery labeled simply "Indian Health Service" — a self-reported coverage-type response; the dictionary does not specify what a "yes" response requires.[157] The main text's interpretation — that reporting IHS coverage requires physical proximity, prior registration, and actual utilization — goes beyond what the variable records.[158] The administrative record shows a similar order of magnitude: the NPIRS user population was 1.65 million in FY2021 and 1.58 million in FY2025,[159,160] and the CMS–IHS Data Match reported in the main text identified 941,168 confirmed IHS-access Medicaid enrollees.[161] Three survey and administrative measures — self-reported IHS coverage (HINS7), the CMS–IHS Data Match, and the published user population — fall in the same order of magnitude, between roughly 0.9 and 1.7 million. These totals are numerically similar in scale, but they measure different constructs and do not validate one another or establish population bounds.

Two cautions follow. First, HINS7 is a self-reported coverage-type response; the published user population is the administrative counterpart and runs about 22% above it — a gap the two instruments cannot jointly resolve. Second, the series move differently: HINS7 is stable across pooled five-year windows while the user estimate fell 1.9% on the verified FY2021–FY2024 windows (and 4.4% including FY2025 as reported). The differing constructs and observation periods prevent interpreting the divergence as evidence of either utilization change or administrative capture error. The user count's dependence on electronically submitted encounters does make it a utilization-and-infrastructure measure as much as a population measure: sites with

[155]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[156]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[157]U.S. Census Bureau, 2020–2024 ACS PUMS Data Dictionary (HINS7: "Indian Health Service," Yes/No coverage-type item). https://www2.census.gov/programs-surveys/acs/tech_docs/pums/data_dict/PUMS_Data_Dictionary_2020-2024.pdf

[158]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

[159]IHS, FY 2021 User Population Estimates (FOIA release 19-139). https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/19-139ResponsiveDocuments.pdf

[160]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[161]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

weaker export pipelines undercount their users, and IHS budget-formulation staff describe the result as an estimate for which "there is no such thing as an 'absolute' count of users."[162]

A.5 Why the Counting Matters for Money

The encounter-based measure is also the one that moves money. The IHCIF federal-tribal workgroup stated that "user counts, because they represent numbers of patients receiving services, impact the formula results more than any other data variable,"[163] and the Level of Need Funded (LNF) arithmetic divides funds available by users — while the workgroup itself cautioned that the user population "only accounts for unmet needs of AI/ANs who are currently accessing services, not the unmet need for all AI/ANs."[164] A further distinction matters for modeling: the IHCIF calculation uses adjusted user counts — national unduplication plus non-PRCDA users, approved and implemented following Tribal consultation — that need not equal the official published totals shown in Exhibit A-3; for FY2017, the official count was 1,638,687 against 1,666,230 adjusted.[165] Analysts should confirm which count enters any given allocation. Base funding, meanwhile, has historically followed prior-year patterns rather than need.[166] A utilization-based denominator can omit people with unmet need who have no qualifying recorded encounter — a measurement concern for allocation analysis, although the direction and magnitude of any funding effect depend on the complete formula and validated inputs.

The counts are also partly negotiated artifacts. Shared-county splits among tribes were negotiated largely in the early 2000s and are acknowledged as possibly out of date; delivery-area (PRCDA) boundaries change only through a published Federal Register process; and duplicate-resolution reports route correction responsibility to the Areas.[167,168] A service population projection, an enrollment count, and an encounter-based user count are therefore not three readings of one

[162]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[163]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[164]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[165]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

[166]GAO, HRD-91-5 (1991). https://www.gao.gov/assets/hrd-91-5.pdf

[167]Bemidji Area IHS Budget Formulation presentation (2025). https://glathb.org/wp-content/uploads/2025/11/2025-Budget-Formualtion-Meeting-JDouglas-11.13.25.pdf

[168]IHCIF Workgroup Final Report (2023). https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2023/IHCIFWorkgroupFinalReport.pdf

underlying quantity; they are three administratively constructed measures, each shaped by a different set of rules and negotiations.

A.6 Implications for Interpreting the Main Text

Three passages of the main text take on different emphasis in light of the administrative record:

- **Homeland residents as a proxy for the direct-service population.** Exhibit 2 of the paper states that ACS homeland residents "approximate the IHS direct-service population."[169] The published user population (1.58 million in FY2025)[170] is materially larger than the homeland count (1.01 million, ACS 2019).[171] The two are not cleanly comparable — the user count includes qualifying direct and contract encounters and dental visits, and the measures differ in year and geography — and the comparison does not establish a measured undercount of direct-service users. The defensible conclusion is non-substitutability: homeland residence cannot stand in for the published user population.
- **The 38% homeland-residence figure.** The ratio divides Census-identified AI/AN homeland residents by total enrolled citizens — two non-equivalent universes.[172] The numerator can include unenrolled individuals and citizens of other nations; the denominator includes citizens wherever they reside. The inference that nearly two in three enrolled citizens live off-homeland requires linked membership-and-residence data that the two totals do not provide — the same caution the paper applies to other ratios.
- **A note for manuscript integration.** Two details in the main text warrant attention before the next revision. The eligibility citation: the regulation is 42 C.F.R. § 136.12 (the cited 25 C.F.R. § 136.12 sits in the Bureau of Indian Affairs' Title 25; the Indian Health regulations are in Title 42), and its operative language provides that services are available to "persons of Indian descent belonging to the Indian community served by the local facilities and program"[173] — the descendant framing in the main text should be checked against the full regulation and the Indian Health Manual. And the enrollment universe: the text cites 573 federally recognized tribes but totals across 578 funded entities, unreconciled.[174]

[169]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf
[170]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf
[171]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf
[172]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf
[173]42 C.F.R. § 136.12. https://www.law.cornell.edu/cfr/text/42/136.12
[174]Fox, "How We Count Matters" (2026). https://edfoxphd.com/wp-content/uploads/2026/10/01_Paper_I_Oct2026.pdf

A.7 Conclusion: The Reconciliation Agenda

The administrative record both extends and complicates the paper's framework. It extends the framework by adding three measurable distinctions — registration, recorded utilization, and Census-based planning populations — and by confirming the concentration of the served population (Oklahoma City and Navajo account for roughly 39% of published users)[175] and the order-of-magnitude convergence of the survey and administrative measures. It complicates the framework by showing that the administrative user count is itself a moving, capture-dependent, partly negotiated measure, published with a definitional inconsistency in its most recent release.[176]

The IHS administrative measures reinforce the need to match each denominator to its purpose; they do not identify a single preferred denominator or establish population bounds. The next analytical step is a same-period comparison of ACS HINS7, the CMS–IHS Data Match, and NPIRS user counts with documented eligibility, residence, encounter, and matching rules, conducted with Tribal participation — together with an updated IHS service-population series whose race definitions, geographic crosswalks, and methodological breaks are published alongside the counts.

Data notes: All Area-level counts are transcribed from the IHS official User Population tables (FY2021, FY2023, FY2024, FY2025) and the IHS projected service-population series released under FOIA. Ratios and sums are computed from those transcriptions. The FY2025 tables were finalized March 16, 2026 (memo dated December 19, 2025); the FY2021 FOIA release is the source for the Area-level Census-based service-population series.

[175]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf

[176]IHS, FY 2025 User Population Tables. https://www.ihs.gov/sites/foia/themes/responsive2017/display_objects/documents/FY%202025%20User%20Population%20Tables%20-%20Final%20-%203-16-2026a_Redacted.pdf