ANALYTICAL ESTIMATES

Medicare, Medicaid, and Total CMS Investment in the American Indian and Alaska Native IHS-Access Population

Data Sources: ACS 5-Year PUMS 2024 (U.S. Census Bureau) · CMS NHE Accounts 2024 · NIHB CMS/IHS Data Match Report, October 2025 (2023 enrollment)
Reference Year: 2023 (Data Match); 2024 (NHE rates); 2020–2024 (ACS 5-year)
Prepared: March 2026 · **Revised:** November 2026 (see Revision Note)

KEY FINDINGS

This paper presents quantitative estimates of CMS (Medicare and Medicaid) investment in the population reporting IHS access — 1,523,017 people of all races, of whom 1,294,264 are American Indian and Alaska Native (AI/AN) alone or in combination — drawn from a cross-tabulation of the 2024 ACS 5-Year PUMS and 2024 National Health Expenditure accounts. Four findings anchor the analysis:

1. 587,313 people reporting IHS access (all races) were enrolled in Medicaid per the 2024 ACS cross-tabulation — 60% below the CMS–IHS Data Match count of 941,168, consistent with the known ACS IHS undercount.

2. 51.1% of the IHS-access population — 778,438 individuals — have no CMS coverage and are entirely outside the Data Match scope. This majority is invisible to administrative data systems.

3. Total CMS investment across all three coverage groups (dual, Medicare-only, Medicaid-only) is estimated at $9.23B–$12.49B annually (low–high scenario range), with a midpoint of $10.86B.

4. Combined federal investment (IHS appropriations ~$8.6B + estimated CMS spending on the IHS-access population ~$9.2–12.5B + Population B Medicaid ~$1.88B) reaches approximately $19.7–23.0B annually — yet the IHS funding gap persists because of the population the CMS system excludes.

Section I — Purpose and Scope

The CMS/IHS Data Match — a linkage of IHS patient registration records with CMS Medicaid enrollment data (T-MSIS) — found 941,168 AI/AN IHS registrants enrolled in Medicaid in 2023. The match counts enrollment only; it contains no claims or spending data. This count, while the most precise enrollment figure produced for this population, captures only a portion of CMS involvement in AI/AN health financing.

This paper answers three questions the Data Match was not designed to address:

(1) What is the full CMS coverage distribution within the IHS-access population — including Medicare-enrolled individuals and those with no CMS coverage at all?

(2) What are the estimated total CMS expenditures across all coverage groups, not just Medicaid?

(3) How do the ACS-based enrollment counts compare to the Data Match counts, and what methodological factors drive the gap?

Answering these questions requires combining the Data Match findings with a cross-tabulation of the 2024 American Community Survey 5-Year PUMS (Medicare × Medicaid × IHS access) and 2024 National Health Expenditure (NHE) per-member-per-year rates. The result is the first integrated picture of CMS investment — Medicare and Medicaid combined — in the IHS-access population.

Scope note: All estimates in this paper refer to the IHS-access population (ACS HINS7 = 'Yes' or Data Match Population A). The ACS counts in this paper cover all races reporting IHS access (1,523,017), of whom 1,294,264 are AI/AN alone or in combination. This is not the total AI/AN Medicaid population; it excludes Population B (AI/AN Medicaid enrollees with no IHS registration, estimated at ~$1.88B in 15 states). The uninsured IHS population and Medicare estimates derive entirely from ACS data — they have no administrative data equivalent.

Section II — Data Sources and Methods

2.1 ACS 5-Year PUMS 2024

The American Community Survey 5-Year Public Use Microdata Sample (ACS PUMS), release year 2024, pools survey years 2020–2024. The analysis uses three insurance-status variables: HINS3 (Medicare coverage), HINS4 (Medicaid/means-tested public coverage), and HINS7 (Indian Health Service or Tribal health facility access). Cross-tabulating HINS3 × HINS4 × HINS7 — weighted by PWGTP — produces mutually exclusive coverage groups for the IHS-access population. Total weighted IHS-access population, all races: 1,523,017, of whom 1,294,264 are AI/AN alone or in combination. The cross-tabulations in this paper cover all races reporting IHS access.

Known limitation: The ACS is known to undercount IHS coverage relative to administrative records. A Census Bureau linkage study found approximately a 41% undercount in ACS IHS coverage identification. The Data Match figure of 941,168 is 60% above the ACS Medicaid cross-tab count of 587,313, consistent with this undercount pattern.

2.2 CMS National Health Expenditure Accounts 2024

Per-member-per-year (PMPY) rates are drawn from the CMS National Health Expenditure (NHE) Accounts, 2024 actuals (published January 2026):

Program	Total Expenditure (2024)	Enrollees / PMPY Rate
Medicare	$1,118.0B	66.6M enrollees → $16,787 PMPY
Medicaid	$931.7B	84.3M enrollees → $11,052 PMPY
Dual Eligible (combined)	Medicare + Medicaid both apply	$27,839 combined PMPY

Source: CMS National Health Expenditure Accounts 2024 (Health Affairs, January 2026). Dual eligible combined PMPY = Medicare PMPY + Medicaid PMPY.

2.3 NIHB CMS/IHS Data Match Report 2025

The Data Match report (NIHB, October 2025) counts AI/AN IHS registrants enrolled in Medicaid for 2019 through 2023, by state and nationally. For 2023 it identified 941,168 AI/AN individuals who met two criteria: (1) IHS registrant status, established by administrative linkage with IHS patient registration records; and (2) Medicaid enrollment in T-MSIS. The report counts enrollment only. It did not include claims, so it does not show whether these registrants received Medicaid-paid services at IHS, Tribal, or Urban Indian facilities, and it contains no spending data.

Critical methodological distinction: The Data Match report does not say how Medicaid enrollment was defined. If it counts anyone enrolled for at least one month during 2023 ("ever enrolled"), its count will be larger than the Full-Year Equivalent (FYE) used in per-enrollee rates. National Medicaid FYE is approximately 4.5% below ever-enrolled counts (MACPAC FY2023). AI/AN churn rates are estimated at 10–15% above the national average due to reservation economics, seasonal

employment, and redetermination disruptions. On that assumption, FYE-adjusted Data Match counts would be ~847,000–899,000 enrollees. This distinction matters when comparing the Data Match enrollment count to ACS point-in-time figures.

Section III — CMS Coverage Distribution in the IHS-Access Population

Table 1 presents the cross-tabulation results: four mutually exclusive CMS coverage groups for the weighted IHS-access population, all races (N = 1,523,017; 1,294,264 AI/AN alone or in combination). This is the first nationally representative breakdown of Medicare, Medicaid, dual, and uninsured status within the IHS-access population. The Data Match captures only the 38.6% with Medicaid enrollment; 61.4% are outside its scope.

Table 1. CMS Coverage Distribution, IHS-Access Population, All Races (ACS 5-Year PUMS 2024)

Coverage Group	Weighted Count	% of IHS Pop.	Data Match Scope	Spending Est. (midpoint)
Dual Eligible (Medicare + Medicaid)	102,865	6.8%	Included	$2.86B
Medicare Only (no Medicaid)	157,266	10.3%	Not in scope	$2.64B
Medicaid Only (no Medicare)	484,448	31.8%	Included	$5.35B
No CMS Coverage (uninsured / other)	778,438	51.1%	Entirely invisible	—
Total IHS-Access Population	**1,523,017**	**100%**	**587,313 captured (38.6%)**	**$10.86B**

Source: ACS 5-Year PUMS 2024, U.S. Census Bureau. Weighted cross-tabulation of HINS3 × HINS4 × HINS7, weighted by PWGTP; all races reporting IHS access (AI/AN alone or in combination: 1,294,264). Spending estimates use 2024 NHE PMPY rates (midpoint scenario). Medicare total (any Medicaid): 260,131 (17.1%); Medicaid total (any Medicare): 587,313 (38.6%). Data Match Medicaid count: 941,168 (2023).

Policy significance of the 51.1% figure: The majority of the IHS-access population — 778,438 individuals — has no CMS coverage. This group is entirely invisible to the Data Match and to administrative Medicaid data. They depend exclusively on IHS appropriations and Purchased and Referred Care (PRC) for health services. The Data Match covers Medicaid enrollment only; it says nothing about Medicare enrollees or about the 51.1% with no CMS coverage. Survey data (ACS) is the only available national source for estimating this population's size.

Section IV — CMS Spending Estimates by Coverage Group

4.1 Per-Capita Rate Assumptions

Table 2 presents the PMPY rate assumptions underlying all spending estimates. Rates reflect the 2024 NHE national averages. The dual eligible combined rate ($27,839) represents the sum of both Medicare and Medicaid PMPY, reflecting that dual-eligible individuals generate expenditures in both programs simultaneously. Three scenarios (±15% of national average) capture uncertainty about whether AI/AN IHS-access individuals' utilization differs from the national benchmark.

Table 2. Per-Capita Rate Assumptions (2024 NHE Basis)

Coverage Group	Rate Basis	Low (×0.85)	Mid (×1.00)	High (×1.15)
Dual Eligible	$27,839 (Medicare + Medicaid)	$23,663	$27,839	$32,015

Coverage Group	Rate Basis	Low (×0.85)	Mid (×1.00)	High (×1.15)
Medicare Only	$16,787 (Medicare NHE PMPY)	$14,269	$16,787	$19,305
Medicaid Only	$11,052 (Medicaid NHE PMPY)	$9,394	$11,052	$12,710

Note: Source rates: CMS NHE Accounts 2024. Medicare PMPY = $1,118.0B ÷ 66.6M enrollees = $16,787. Medicaid PMPY = $931.7B ÷ 84.3M enrollees = $11,052. Dual eligible rate = sum of both PMPYs ($16,787 + $11,052 = $27,839). Scenario range reflects ±15% adjustment for AI/AN population utilization variation relative to national average.

4.2 Three-Scenario Spending Estimates

Table 3 applies the Table 2 PMPY rates to the ACS coverage group counts. The result is a complete CMS investment picture across all three coverage groups for the first time — including Medicare-only spending, which has no administrative data equivalent. The $10.86B midpoint estimate represents total annual CMS expenditure attributable to the IHS-access population's 744,579 CMS-covered individuals.

Table 3. Estimated Annual CMS Spending by Coverage Group, Three Scenarios (ACS 2024 Enrollment × 2024 NHE PMPY)

Coverage Group	Population (ACS)	Low Scenario (×0.85 PMPY)	Mid Scenario (×1.00 PMPY)	High Scenario (×1.15 PMPY)
Dual Eligible (Medicare + Medicaid)	102,865	$2.43B	$2.86B	$3.29B
Medicare Only (no Medicaid)	157,266	$2.24B	$2.64B	$3.04B
Medicaid Only (no Medicare)	484,448	$4.55B	$5.35B	$6.16B
Total CMS-Covered (all three groups)	**744,579**	**$9.23B**	**$10.86B**	**$12.49B**

Notes: Population counts from ACS 5-Year PUMS 2024 cross-tabulation (Table 1). Spending = coverage group population × scenario PMPY rate. Medicare-only spending estimate is the first published estimate of Medicare expenditures for the IHS-access population derived from a nationally representative cross-tabulation. No CMS coverage group (778,438 individuals) generates no CMS expenditure; their care cost falls on IHS appropriations and PRC. These are modeled estimates of CMS spending on the IHS-access population wherever care is received; they are not payments to IHS-funded programs.

Section V — ACS vs. CMS–IHS Data Match: Reconciliation

The ACS Medicaid cross-tab (587,313) and the Data Match (941,168) are not measuring the same population. The gap of 353,855 — 60.2% above the ACS figure — is expected and methodologically explicable. Table 4 presents the head-to-head comparison.

Table 4. ACS 5-Year PUMS 2024 vs. CMS–IHS Data Match 2023: Methodological Comparison

Dimension	ACS PUMS 2024	Data Match 2023	Interpretive Note
Method	Self-Report Survey	Admin. Linkage (T-MSIS)	
Reference Period	2020–2024 (5-yr pooled)	2023 (report pub. 2025)	ACS pools five years including peak COVID continuous enrollment; Data Match is single-year.
Population Universe	Self-reported IHS access (HINS7), all races	Formal IHS registrants matched to T-MSIS	ACS is broader: captures IHS access regardless of formal registration, and includes non-AI/AN respondents (1,523,017 all races; 1,294,264 AI/AN). Data Match counts AI/AN registrants and requires successful administrative linkage.
Enrollment Basis	Point-in-time (survey week)	Enrolled during year (T-MSIS); definition not	If the Data Match counts anyone enrolled at least one month, an FYE adjustment

Dimension	ACS PUMS 2024	Data Match 2023	Interpretive Note
		stated in report	would yield ~847K–899K, narrowing the gap. See Section VI.
Medicaid Enrollees with IHS Access	587,313 (all races)	941,168	Data Match is 60% larger. ACS captures only 62.4% of Data Match count — consistent with known ~41% ACS IHS undercount.
Enrollment Gap (Data Match minus ACS)	—	+353,855 (+60.2% above ACS)	Gap reflects: (1) ACS IHS undercount ~41%; (2) ever-enrolled vs. point-in-time basis; (3) 5-yr vs. 1-yr reference periods; (4) race-coding variation; (5) the ACS figure includes non-AI/AN people reporting IHS access.
Medicare Enrollees with IHS Access	260,131	Not in scope	ACS uniquely provides a Medicare count for IHS-access persons. Data Match scope was limited to Medicaid/T-MSIS.
IHS-Access with No CMS Coverage	778,438 (51.1%)	Not in scope	Entirely invisible to Data Match. ACS is the only national source for this population — the majority of IHS-access persons.
Estimated Medicaid Spending	~$5.35B midpoint (ACS enrollment × 2024 NHE PMPY)	Not reported	The Data Match report contains no claims or spending data. The ACS-based figure is a modeled estimate of Medicaid spending on these enrollees wherever they receive care, not payments to IHS-funded programs.

Sources: ACS 5-Year PUMS 2024, U.S. Census Bureau. NIHB CMS/IHS Data Match Report, October 2025 (2023 enrollment). CMS NHE Accounts 2024. Census Bureau ACS–IHS linkage study (re: 41% IHS undercount).

Section VI — Methods Note: Ever-Enrolled vs. Full-Year Equivalent

The NIHB report does not say how Medicaid enrollment was defined. If the 941,168 figure counts anyone enrolled for at least one month during 2023 ("ever enrolled"), it will be larger than the full-year equivalent (FYE) denominator used in per-enrollee rate calculations. This affects how the Data Match count should be compared to ACS figures.

6.1 The National Pattern

MACPAC FY2023 data shows 96.0 million ever-enrolled Medicaid beneficiaries vs. 91.7 million FYE — a 4.5% gap nationally. AI/AN churn is likely higher (10–15%) due to reservation economies with seasonal employment, periodic redetermination disruptions, and eligibility category cycling.

Table 5. FYE Adjustment Scenarios for Data Match Enrollment

Scenario	Churn Rate	FYE Enrollees	vs. ACS (587,313)
Reported (ever-enrolled)	—	941,168	+60.2%
National avg. churn (−4.5%)	×0.955	~899,000	+53.1%
Moderate AI/AN churn (−10%)	×0.90	~847,000	+44.3%
High AI/AN churn (−15%)	×0.85	~800,000	+36.3%

Note: Recommended denominator for per-enrollee spending calculations: ~847,000–899,000 FYE enrollees (moderate to national-average churn scenarios). The reported 941,168 figure should be retained in advocacy contexts as the officially published count; FYE-adjusted figures are appropriate when computing per-enrollee rates or comparing to ACS point-in-time data.

Analytical recommendation: Retain 941,168 as the reported Data Match figure in policy contexts.

Use the FYE-adjusted denominator (~847K–899K) when computing per-enrollee spending rates or making direct comparisons to ACS survey counts.

Section VII — Total Federal Investment Framework

Table 6 assembles the federal investment picture for AI/AN health, combining the ACS-derived CMS estimates from Table 3 with IHS appropriations and the Population B estimate.

Table 6. Total Federal Investment in AI/AN Health, FY2023–2024

Investment Component	Low Estimate	High Estimate	Source / Basis
IHS Direct Appropriations	$8.6B	$8.6B	IHS FY2023 enacted appropriations
CMS (Medicare + Medicaid) — IHS-Access (ACS-derived)	$9.23B	$12.49B	Table 3: 744,579 ACS enrollees × 2024 NHE PMPY ±15%; midpoint $10.86B
AI/AN Medicaid — Non-IHS-Access (Pop. B)	$1.88B	$1.88B	15-state reconciliation estimate; illustrative
Other Federal (CHIP, VA, etc.)	est.	est.	Not estimated in this analysis
TOTAL (IHS + CMS + Population B)	**~$19.7B**	**~$23.0B**	**Midpoint ~$21.3B**

Notes: CMS figures for the IHS-access population are modeled from ACS enrollment and NHE rates; they estimate spending wherever care is received, not payments to IHS-funded programs. Population B is an illustrative 15-state estimate. Totals do not include CHIP, VA, BIA, or other federal sources. The combined total does not constitute fulfillment of the trust responsibility; per-capita spending remains below national benchmarks.

Section VIII — Analytical Limitations and Caveats

8.1 ACS Limitations

All coverage group counts in this analysis derive from self-reported ACS data. The ACS is known to undercount IHS coverage by approximately 41% relative to administrative records (Census Bureau linkage study). The 587,313 Medicaid cross-tab count is therefore a lower bound; the true Medicaid enrollment is higher, as the Data Match confirms. The ACS IHS-access population of 1,523,017 (all races; 1,294,264 AI/AN alone or in combination) likely also understates the true IHS-access universe. Medicare and uninsured counts inherit these limitations.

8.2 PMPY Rate Assumptions

All spending estimates use 2024 NHE national average PMPY rates. These rates may not accurately reflect AI/AN IHS-access population utilization patterns. Known differences include higher acute care burden, lower long-term care relative to elderly national average, and IHS billing constraints that may suppress observed utilization even where need is higher. The ±15% scenario range is intended to span plausible variation but is not derived from AI/AN-specific claims data.

8.3 Data Match Scope Constraints

The Data Match counts Medicaid enrollment among IHS registrants (941,168 in 2023); it contains no spending data. Population B (AI/AN Medicaid enrollees without IHS registration) accounts for an estimated additional $1.88B in 15 states. Neither this paper nor the Data Match produces a national AI/AN Medicaid spending total from administrative data.

8.4 What This Analysis Does Not Establish

These estimates establish the scale of CMS investment, not its adequacy. Even combined federal investment of ~$21.3B annually (midpoint) does not close the IHS funding gap, because: (1) the 778,438 IHS-access individuals without CMS coverage receive no benefit from the CMS investment stream; (2) Medicaid coverage does not guarantee access to IHS-capacity care; and (3) the per-capita funding gap relative to national health expenditure benchmarks persists at the population level regardless of aggregate investment scale.

Sources

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U.S. Census Bureau. (n.d.). ACS–IHS coverage linkage study. [Internal Census Bureau validation study documenting ~41% ACS undercount of IHS coverage identification relative to administrative records.]

Revision Note, November 2026

This revision corrects how the paper describes the NIHB CMS/IHS Data Match Report (October 2025). The report counts AI/AN IHS registrants enrolled in Medicaid; it has no claims or spending data, and it does not state how enrollment was defined. The March 2026 text described a third inclusion criterion (a paid Medicaid service) and attributed $6.4–$6.6 billion in Medicaid expenditures to the match; both are removed. Where the paper needs a Medicaid spending figure, it now uses its own ACS-based estimates (Table 3). Table 4, Section VI and Table 5 no longer carry Data Match spending or the implied per-enrollee figure derived from it. Table 6 now combines the Table 3 CMS total with IHS appropriations and Population B, which changes the combined federal total from ~$19.6B to ~$21.3B (midpoint). The revision also clarifies that the ACS cross-tabulations cover all races reporting IHS access (1,523,017), of whom 1,294,264 are AI/AN alone or in combination; the counts and estimates are unchanged.