A Primer for New Tribal Health Policy Analysts

What You Need to Know, and How to Find Out

Nov 5, 2026 · @Mr. Fox

> **IHF-AI.** This AI-written primer was drafted by Claude (Anthropic) from papers, graphics, and pages on edfoxphd.com, at the request of Edward J. Fox, PhD. It is an AI Sandbox draft, not part of the author's own work.

Why This Primer

Your most important job is to make sure Tribal leaders walk into every meeting with facts and figures that are current, correct, and their own. Leaders negotiate with federal agencies, state Medicaid programs, and Congress. The other side of the table always arrives with numbers. A leader who has better ones, and knows what they mean, is harder to dismiss.

This primer is for policy analysts newly hired by a Federally Recognized Tribe, a regional Tribal organization (an Area health board or Tribal consortium), or a national Tribal organization. It does not teach legislative or state politics; you will learn those on the job and from the people you work for. It covers two things:

- **What you need to know** — the foundations of Indian health, how the money moves, who is served, whether funding is adequate, and how policy actually gets made.
- **How you find out** — where the facts live, when they change, and how to tell a good figure from a misleading one.

Most of the material comes from the papers, graphics, data tables, and course on edfoxphd.com. Each section points you to the specific paper or page behind it, so you can go deeper when a leader asks a harder question. Material added from outside the site is marked *(added — verify current)*.

One caution runs through everything that follows. Numbers drawn from Indian health data look simple and rarely are. Population counts, funding comparisons, and coverage statistics all carry legal and historical context. An analyst's value lies less in finding a number than in knowing which number answers the question being asked.

Who You Work For

You work for Tribes. Even at a regional or national organization, the authority over Indian health policy belongs to Tribal governments, and your job is to support their decisions, not to make them. Tribes already know what their communities need; an analyst supplies evidence, options, and memory.

Three settings, one principle.

Where you work	Who directs you	What your analysis is for
A Tribe	Tribal council, health board, health director	The Tribe's own budget, programs, billing, and positions in consultation
A regional Tribal organization	A board of Tribal delegates from member Tribes	Shared analysis that helps member Tribes reach a common position
A national Tribal organization	Tribal leaders from across IHS Areas	National figures, federal budget and rulemaking, testimony, comment letters

Strategy lives between Tribes. Leadership changes often; Tribes endure. Tribal decisions grow out of relationships: close ties where Tribes learn directly from each other, ties through organizations where a proposal is heard and considered, and broader regional and national ties where a proposal must be convincing before it is adopted. Talk about "working with other Tribes," not "working with other leaders." The work Tribes do to reach a unified position before approaching a state or federal agency is the most consequential step in policymaking, and it rarely appears in the written record (*Making Indian Health Financing Policy*; *Building Consensus*).

Urban Indian organizations are a separate grounding. Tribes hold authority as sovereigns. Urban Indian organizations hold theirs under Title V of the Indian Health Care Improvement Act, through community boards and a history shaped by federal relocation. Treat the two distinctly in your analysis (Papers VI–VIII and Supplement I).

What leaders need from you. A one-page answer by tomorrow, with the source named. The number that will be used against them, and what is wrong with it. A clear statement of what is not known. And a record of what was decided last time, so the Tribe does not have to relearn its own history.

What You Need to Know: The Foundations

Indian health care is a federal obligation, not a charity or an entitlement program. Every analysis you write should start from that premise. The obligation rests on treaties and the federal trust responsibility, and it is carried out through a small set of statutes you should be able to name and summarize.

Foundation	What it does	Why an analyst cares
Trust responsibility	The federal obligation to Federally Recognized Tribes, including health care	Frames need as an unmet federal promise, not a community deficit
Snyder Act (1921)	General authority for federal spending on Indian health	The baseline appropriation authority for IHS
Indian Self-Determination and Education Assistance Act (1975)	Lets Tribes contract or compact to run IHS programs	Source of Contract Support Costs and Section 105(l) leases
Indian Health Care Improvement Act (1976; made permanent 2010)	Structure of Indian health programs, including Medicaid and Medicare billing (Title IV) and Urban Indian programs (Title V)	Defines most of the financing tools Tribes use today
ARRA Section 5006 (2009)	Cost-sharing protections, Tribal consultation by states, managed care protections	Shows how prepared Tribes turn a crisis into lasting policy

Three ways Tribes receive IHS services matter for every budget question: **direct service** (IHS operates the program), **self-determination contracts**, and **self-governance compacts**. Know which applies to each Tribe you serve.

Two things about the IHCIA reauthorization are worth knowing early. First, Tribes did much of the drafting: the 1999–2000 effort brought Tribes from every IHS Area together, and Title IV drew on practices already standard in Washington, Oregon, and Alaska (Paper I-B; *Who Built the Indian Health Care Improvement Act?*). Second, a statute is only the

first signature. Rules, state Medicaid action, and agreements follow, sometimes years later; ARRA's managed care protections took effect by statute in 2009, but plans were not required to comply until 2017 (*Hank Adams and the Policy Process*).

Find out more: Course Segment 1, *Begin with the Basics*, and Course Week 1, *The Trust Responsibility and the Architecture of Indian Health*.

What You Need to Know: How the Money Moves

Indian health is financed by an interconnected federal system, not a single appropriation. IHS appropriations are the foundation; Medicaid, Medicare, and other coverage are earned on top of it through enrollment, billing, and agreements with states. A leader who sees only the IHS budget sees half the picture.

The IHS budget

Learn the major categories and what drives each one.

Category	What it buys	What to watch
Health Services	Clinical care, behavioral health, public health, and more	Growth excluding Electronic Health Record modernization has lagged since FY 2023
Purchased/Referred Care (PRC)	Care bought from outside providers	Held at $996.8 million FY 2023–FY 2026; lost nearly 10% of purchasing power, about $107 million in FY 2026 alone
Contract Support Costs (CSC)	Administrative costs of Tribes running programs	Paid in full by statute and court order; a major share of recent budget growth
Section 105(l) leases	Tribal facilities leased to IHS	Also paid in full; estimates and actual costs differ, so treat lease figures as a reconciliation question
Facilities and Health IT	Construction, equipment, EHR	Largely non-recurring; set them aside when comparing operating funding across years

The key lesson from *Who Kept Pace? IHS Budget History, FY2020–FY2027*: the accounts that buy patient care did not keep up with medical prices, while the accounts the law requires IHS to pay in full grew fastest. The loss falls hardest where Tribes have no Indian hospital and where states have not expanded Medicaid. Always ask whether a budget increase reached patient care.

Medicaid

Medicaid is a structural pillar of Indian health financing, and a strength Tribes have built. In 2023, **941,168** AI/AN IHS registrants were enrolled in Medicaid, with about **$6.42–$6.56 billion** in annual expenditures attributable to them (Paper IV; NIHB CMS–IHS Data Match Report, October 2025). Two levers make Medicaid work differently in Indian Country:

- **100% FMAP.** For services received through an IHS or Tribal facility, the federal government pays the full cost, so the state pays nothing (Paper III).

- **The IHS-OMB encounter rate.** It sets what the provider is paid per visit; FMAP sets who pays. The Lower-48 outpatient rate rose from $172 in 2000 to $826 in 2026 (*The IHS-OMB Rate and FMAP*).

Medicare and dual eligibility

AI/AN Medicare enrollment grew from about 671,000 in 2014 to 792,000 in 2024 (Paper IV-C). In the IHS-access population, 61,648 people were enrolled in both Medicare and Medicaid, up 38.8% since 2013 (Paper IV-G). Dual eligibles are where 100% FMAP and Medicare payment meet (Paper IV-H).

How to find out

- **IHS Budget Basics: A Guide for Tribal Leaders and Communities** (course page) — categories, terms, and a sourced FY 2025 example.
- **Interactive IHS Budget Explorer** (Resources page) — FY 2021–FY 2025 by category.
- **IHS Congressional Justification** and the annual appropriations act — the primary sources for every budget figure *(added — verify current)*.
- **Graphics page: Purchased/Referred Care Does Not Keep Up With Inflation; 17A–17D; 18A–18B** — PRC versus inflation; operating funding excluding Facilities and Health IT.
- Your own Tribe's funding agreement, billing reports, and PRC referral and denial records — often the most persuasive local evidence.

What You Need to Know: Who Is Served, and How We Count

The first question to ask about any population figure is: which population? Tribal citizenship, Census self-identification, IHS eligibility, and IHS patients are different groups of people, and the wrong denominator quietly distorts every comparison built on it (Paper I, *How We Count Matters*).

Measure	About how many	What it counts	Source
Enrolled Tribal citizens	2,652,345	Citizens of 578 funded Tribal entities	Henson, Jorgensen, Kalt & Leonaitis (2021), Ash Center Policy Brief No. 7

Measure	About how many	What it counts	Source
IHS Service Population	About 2.6 million	AI/AN people living in PRC counties — geographic eligibility, not patients	IHS, based on ACS
IHS Active User Population	1.580 million (FY 2025)	Registered AI/AN patients with a visit in the prior three years	IHS User Population Tables
AI/AN reporting IHS access	About 1.3 million	People who tell the Census they have access to IHS-funded care	ACS PUMS (Papers I, IV-A, IV-F)
AI/AN IHS registrants on Medicaid	941,168 (2023)	Matched administrative records, not a survey	CMS–IHS Data Match (Paper IV)

The IHS-access population is the denominator most useful for financing analysis. It has held steady at about 1.28–1.3 million across ACS periods.

Watch for the 2020 break. The redesigned 2020 race question raised the ACS AI/AN count from 5.65 million (2019) to 8.73 million (2021), a 55% jump, while the U.S. population grew about 1%. The entire increase was among people reporting no IHS coverage; the number reporting IHS coverage fell. Compare rates, not raw AI/AN counts, across 2020 (Paper IV-F and the Data Tables page).

Two habits to adopt now:

- Do not substitute one population for another without saying what difference it makes. Tribal citizenship is not the IHS-user population.
- Do not build analysis on Census "AI/AN alone" counts. The measure has severe non-sampling error and understates the population programs serve. Use AI/AN alone or in combination.

A facility count is not a measure of access. Only 500 of the 932 IHS and Tribal sites on the June 2023 facilities list (54%) report workload to IHS, so IHS service statistics understate the care Tribes deliver (*The IHS Facilities List, June 2023*).

Find out more: Graphics 1–3 and 2A on population definitions; the Data Tables page; Course Segment 7, *Working with the Data*.

What You Need to Know: Is It Enough?

The Indian health system has never been funded at the level of need, and leaders will ask you how large the gap is. There are two well-grounded answers. Know both, and know why they differ.

Estimate	Annual figure	What it measures
Paper V, *The Full-Funding Requirement*	Need of about $37–$38 billion against $19.3–$19.9 billion in current combined federal investment: a gap of $17.8–$18.0 billion	Cost of full-spectrum health services at a National Health Expenditure parity benchmark, counting Medicaid, Medicare, and other federal sources toward need
IHS National Tribal Budget Formulation Workgroup	$76.1 billion for IHS (FY 2028 recommendation, April 2026)	A line-by-line recommendation for the IHS budget itself, developed by Tribes from all twelve IHS Areas

Why they differ. Paper V counts coverage revenue toward meeting need; the Workgroup's figure is for IHS alone. Paper V treats facilities as a separate investment of about $30–$34 billion over 10–15 years; the Workgroup carries facilities, sanitation, maintenance, and other capital needs inside its annual total. Paper V's primary estimate also uses an unadjusted benchmark; its sensitivity analysis, adjusting for AI/AN disease burden, reaches about $45 billion. Paper V treats its gap as a floor, not a ceiling.

Using them. Either figure can be cited, as long as you say which one and what it measures. Federal reviewers tend to respond to the more conservative Paper V figure. The Workgroup figure carries Tribal consensus, and in consultation and advocacy that consensus is itself a source of strength.

Find out more: Paper V and its October 2026 addendum; the Synthesis Coda; the *Estimating Funding Equity* graphic; Course Segment 6, *Is Indian Health Adequately Financed?*; the Workgroup's annual recommendations *(added — check for the most recent year)*.

What You Need to Know: How Policy Gets Made

Indian health financing policy does not move through one process. It moves through several pathways, each with its own governmental actors and its own bottleneck. The question to ask of any proposal is: how many governmental decisions are required before it becomes money a program can use? (*Making Indian Health Financing Policy*).

Pathway	Example	Where it stalls
Federal rulemaking alone	Medicare-like rates for PRC; VA Federal Ceiling Price	Federal agency priorities and timelines
Federal action, then each state	The IHS encounter rate in Medicaid; the nineteen-year "received through" dispute	State Medicaid agencies, plan amendments, and budgets
Facility by facility	VA–I/T/U reimbursement agreements	Each program's capacity to sign and bill
Not yet achieved	Extending the encounter rate to Medicare outpatient payment (2020 effort)	Congress

Where your analysis enters. The policy cycle, illustrated on the site through the career of Hank Adams, has six stages. Your work is needed at every one (*Hank Adams and the Policy Process*; Graphics 16A–16B):

1. **Define the issue and Tribal priorities** — build the record that says what the problem really is.
2. **Set the agenda** — supply the figure that makes the issue impossible to ignore.
3. **Develop policy options** — help Tribes reach agreement among themselves first.
4. **Advance and negotiate** — testimony, comment letters, and consultation positions.
5. **Implement** — track rules, state plan amendments, and agency guidance until the money flows.
6. **Evaluate and adjust** — measure whether it worked, and start the cycle again.

Forums you will work in. Tribal consultation with IHS, CMS, and other agencies; the CMS Tribal Technical Advisory Group (TTAG); the IHS budget formulation process, from local Tribal meetings to Area sessions to the National Workgroup; and state–Tribal consultation on Medicaid, required since 2009 but practiced in the Northwest more than a decade earlier. Each has its own calendar and its own record; learn both.

Find out more: *Making Indian Health Financing Policy*; *Building Consensus*; Paper II (TTAG and the path to the Data Match); Course Segment 8, *From Evidence to Policy*, and the optional Hank Adams case studies.

How You Find Out: A Source Guide

Use the source that matches the question. Survey estimates and administrative records are complementary, but they do not measure the same population or outcome. This table, adapted from the Resources page, is the one to keep at hand.

If the question is about…	Go first to	It can tell you	Main caution
Population size, income, poverty, geography	American Community Survey (ACS); Census *My Tribal Area*	Estimates for states, counties, reservations	Sampling error; the 2020 race question break
IHS registrants enrolled in Medicaid	CMS–IHS Data Match (NIHB report, October 2025)	Matched enrollment by state, 2019–2023	Not all AI/AN people; no claims or payments; not a Medicare match
Medicare coverage	ACS; CMS *Mapping Medicare Disparities*	Coverage estimates; county Medicare data by race	The Data Match does not cover Medicare
IHS patients	IHS User Population Tables	Active users by Area and year	Only sites that report workload are counted
IHS funding	IHS Congressional Justification; appropriations acts; Budget Explorer	Category amounts and trends	Separate non-recurring Facilities and Health IT
Service use, diagnoses, payments	Your own billing, claims, encounter, and PRC records	What your program actually does	Follow your Tribe's data governance rules
Data access and governance	Tribal law and policy; consultation records	Who may use what, and how	Technical feasibility never replaces Tribal authority

Your best local source is usually your own program. Billing, claims, and especially PRC referral and denial records often tell a more accurate story than national figures. Where a national and a local figure point in different directions, the local one usually wins (*Your Tribe Already Has Excellent Health Data*; *Turning Tribal Health Clinic Data into Management Information*).

When the facts change *(added — verify dates each year)*

Figures go stale on a schedule. Keep a calendar and refresh your fact sheets when each source updates.

When	What updates	Why it matters
October 1	Federal fiscal year begins	Enacted or continuing-resolution IHS funding levels
Late fall	Next year's FMAP rates published	State Medicaid cost-sharing for non-IHS services
Winter or spring	President's budget and IHS Congressional Justification	Proposed IHS levels by category
Spring	National Tribal Budget Formulation Workgroup recommendations	Tribal consensus on IHS need
Annually	IHS-OMB encounter rate published in the Federal Register	Medicaid and Medicare payment per visit
Annually	IHS User Population Tables	Active users by Area
September	ACS 1-year estimates	State and large-area coverage and population
December	ACS 5-year estimates	Small areas, reservations, IHS-access tabulations
Irregular	CMS–IHS Data Match reports; IHS facilities list	Medicaid enrollment; facility counts

On edfoxphd.com: Resources (Choosing a Data Source; External Data Tools; NIHB reports), Data Tables (ACS PUMS tabulations with downloadable spreadsheets), Graphics (each with key figures and a related paper), Bibliography (APA 7th edition), and the *Ask Dr. Fox* site chatbot for paper-grounded answers.

Working Habits: Facts Leaders Can Stand On

A figure quoted without its context can mislead, and later it can be used against the Tribe that relied on it. These habits keep that from happening.

Every number carries four labels. What it counts, the year, the source, and what it cannot tell you. "941,168 AI/AN IHS registrants enrolled in Medicaid in 2023 (CMS–IHS Data Match); not a count of all AI/AN people" is a usable fact. "About a million Indians on Medicaid" is not.

Cite estimates as ranges. If the source gives $6.42–$6.56 billion, say so. False precision invites challenge.

Know the number the other side will use. Agencies and states often quote figures built on a different population or a narrower definition. Prepare the comparison in advance and explain the difference in one sentence.

Lead with obligation, not deficit. Need exists because a federal promise is underfunded, not because a community is lacking. Present Medicaid and other coverage as resources Tribes have built.

Write for the meeting. A leader's briefing is usually one page: the ask, three facts with sources, the likely counterargument, and what is unknown. Put the detail in an attachment.

Keep organizational memory. Save every briefing, comment letter, and testimony with its sources and date. The next analyst, and the next council, will need to know what was argued and decided before.

Respect data sovereignty. Before sharing any community data, follow your Tribe's data governance rules. Reporting aggregate figures for a Tribal purpose is an exercise of sovereignty, not a surrender of it.

Common pitfalls

- Treating a Census AI/AN count as the population an IHS program serves.
- Comparing AI/AN counts across 2020 without accounting for the race question change.
- Calling a budget increase a gain without checking whether it reached patient care or went to accounts paid in full by law.
- Counting facilities as evidence of access.

- Using an old figure because it is the one everyone remembers. Check the date before every use.

Your First Month: A Reading Path

Read these in order over your first four weeks. Each week ends with a question to answer for your own Tribe or member Tribes.

Week	Read on edfoxphd.com	Answer for your Tribes
1	Homepage and Research Map; Course Segments 1–2; *IHS Budget Basics*	How does each Tribe receive IHS services: direct, contract, or compact?
2	Paper I; Graphics 1–3 and 2A; Data Tables	What are the active user, IHS-access, and enrolled-citizen counts for each Tribe?
3	Papers III and IV; *The IHS-OMB Rate and FMAP*; *Who Kept Pace?*	How much Medicaid revenue does each program bill, and how is PRC holding up?
4	Paper V and Synthesis Coda; *Making Indian Health Financing Policy*; *Hank Adams and the Policy Process*	Which policy issues are your leaders pursuing, and at what stage of the cycle?

After the first month: the Resources page for outside tools, the Grant Proposals page for writing statements of need, *Managing a Tribal Health Program* for how health programs are run, and Papers VI–VIII if you work with Urban Indian organizations.

Glossary

Term	Meaning
ACS	American Community Survey, the Census Bureau's annual survey; source of IHS-access estimates
Active User Population	IHS's count of registered AI/AN patients with a visit in the prior three years
CSC	Contract Support Costs, paid to Tribes that operate IHS programs

Term	Meaning
Data Match	The CMS–IHS match of IHS registrants with Medicaid enrollment records
Dual eligible	A person enrolled in both Medicare and Medicaid
FMAP	Federal Medical Assistance Percentage, the federal share of Medicaid costs; 100% for services received through IHS and Tribal facilities
I/T/U	IHS, Tribal, and Urban Indian health programs
IHCIA	Indian Health Care Improvement Act
IHS-OMB rate	The all-inclusive per-visit encounter rate paid to IHS and Tribal facilities
ISDEAA	Indian Self-Determination and Education Assistance Act
PRC	Purchased/Referred Care, care bought from outside providers
Section 105(l) lease	A Tribe's lease of its facility to IHS for program use
SPA	State plan amendment, how a state changes its Medicaid program
TTAG	The CMS Tribal Technical Advisory Group
UIO	Urban Indian organization, under Title V of the IHCIA

Sources

All content is drawn from edfoxphd.com as of November 5, 2026: the Publications and Papers Index pages, Other Indian Health Finance Papers, Graphics, Resources, Data Tables, Grant Proposals, Hank Adams and the Policy Process, Managing a Tribal Health Program, and the Indian Health Finance course. Items marked *(added — verify)* are general background not taken from the site.