What Medicaid Data Cannot Yet Tell Indian Health Programs

Access to IHS, the CMS–IHS Medicaid Data Match, and a proposal for the next match

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Drafted with assistance from Claude (Anthropic); questions, analysis choices and conclusions are the author's.

Tribal health leaders need three answers. Who has Medicaid? Who receives care at an IHS-funded health program while enrolled? How much does Medicaid pay those programs for that care?

The companion paper, *Who Can Be Billed, and Who Could Be Enrolled*, answers the first question with the American Community Survey (ACS). This paper takes up the other two. Neither can be answered from published data. Answering them requires linking Medicaid enrollment to dated visits and to payments, which the next CMS–IHS Medicaid Data Match could do. Whether doing so is worth the effort and the risk of unintended harm is a question this paper leaves open.

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Why did fewer people report access to IHS?

Between 2019 and 2024, the number of American Indian and Alaska Native (AI/AN) people telling the ACS they have access to IHS fell from 1.51 million to 1.35 million, about 10%.

The 2020 change in the Census race question does not explain it. That change is important for many analyses of AI/AN people, but not for analyses of people reporting access to IHS. *Who Was Added?* found it raised the AI/AN count by 55% between 2019 and 2021, almost entirely among people reporting no access to IHS. And the number reporting access fell by a similar share whatever the respondent's race:

Reporting access to IHS	2019	2024	Change
AI/AN	1,508,652	1,351,209	−10%
Not AI/AN	254,108	223,615	−12%
All people	1,762,760	1,574,824	−11%

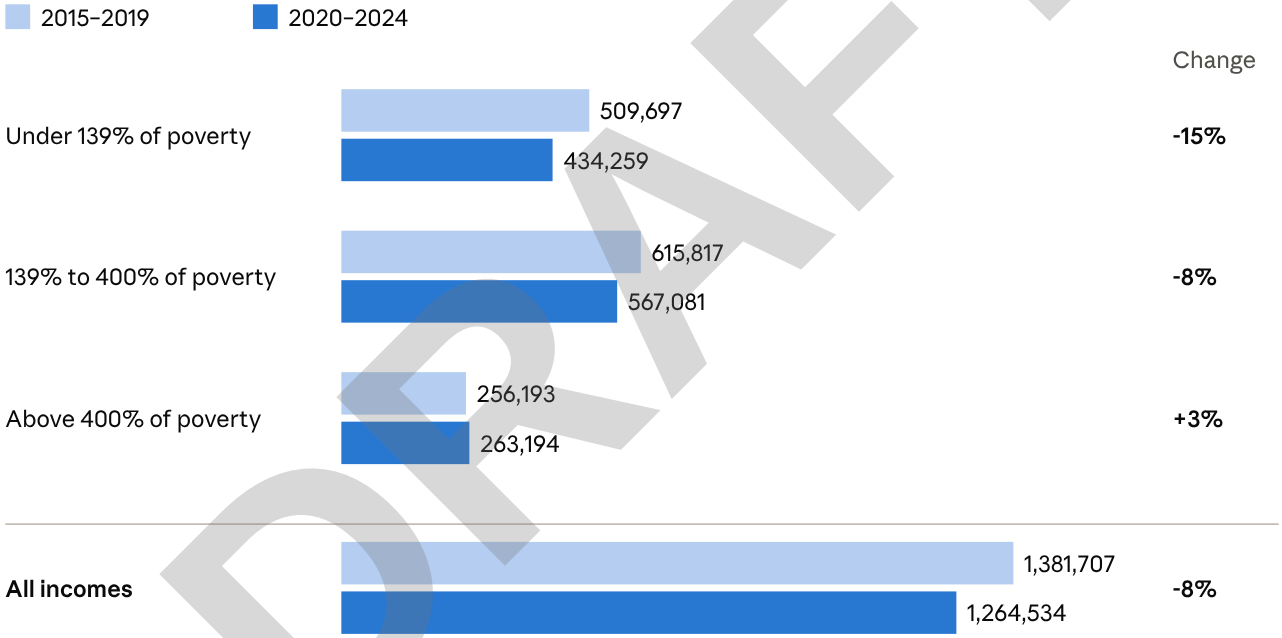
A shift caused by race coding would move people between the AI/AN and non-AI/AN rows. Instead both fell together.

Income offers a clue. In the ACS 5-year samples, the number of AI/AN people reporting access to IHS fell from about 1.38 million in 2015–2019 to 1.26 million in 2020–2024. The entire decline came in the two lower income bands. The number under 139% of poverty fell from 509,697 to 434,259, and the number between 139% and 400% fell from 615,817 to 567,081. The number above 400% rose slightly, from 256,193 to 263,194.

Rising incomes, moving people into higher bands, could explain part of this pattern. So could a change in how lower-income people answer the IHS question. The data cannot tell these apart.

Access to IHS fell 8% overall, all of it in the lower income bands

AI/AN people reporting access to IHS, by income as percent of poverty



ACS 5-year PUMS, 2015–2019 and 2020–2024, all states. AI/AN alone or in combination. Poverty status not determined excluded.

AI/AN people reporting access to IHS declined 8% over five years, from 2015–2019 to 2020–2024.

The ACS question asks only whether a person has access to IHS. At one extreme, a yes means no more than “if I am desperate, I can travel to an IHS-funded program, because I am eligible.” It does not mean the person gets regular care there. A separate question

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matters more to those programs: where do people with both access to IHS and Medicaid go for care?

Consider a person with no Medicaid who gets some care at an IHS-funded program 50 miles from home. Under the ACA, that person gains Medicaid, often through a managed care plan with a broad provider network. Does the person keep driving 50 miles, or go to a nearby clinic that accepts the new coverage? Many would choose the nearby clinic. The person may still tell the ACS they have access to IHS, yet the program no longer sees them. Medicaid coverage among IHS-eligible people rises while Medicaid revenue at IHS-funded programs does not.

The published data cannot say how often this happens. The ACS does not record where people get care. The CMS–IHS match counts enrolled registrants, not where they were seen. State patterns offer no clear answer either. Access-to-IHS counts in Washington, Oregon and Minnesota rose between 2015 and 2019, after those states expanded in 2014, and counts also fell in states that never expanded.

We don't know why fewer people reported access to IHS, or whether Medicaid expansion moved AI/AN patients away from IHS-funded programs.

The CMS–IHS Medicaid Data Match measures something different, but a later section examines whether it can help explain the decline.

Adults with and without children

Among working-age AI/AN adults with Medicaid, the number who also report access to IHS rose between 2015–2019 and 2020–2024, but Medicaid grew much faster, so the share fell in every group. This section asks whether the pattern differs for adults living with children, the households most often connected to both Medicaid and IHS-funded maternal and child health care. It covers adults ages 19–64 in 20 states, by sex and by whether children under 18 live in the household.

Adults 19–64 with Medicaid	Medicaid enrollees, change	Also reporting access to IHS, change	Share reporting access, 2015–19	Share reporting access, 2020–24
Women living with children	+19%	+3%	41.7%	36.1%

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Adults 19–64 with Medicaid	Medicaid enrollees, change	Also reporting access to IHS, change	Share reporting access, 2015–19	Share reporting access, 2020–24
Women without children	+34%	+11%	32.7%	27.2%
Men living with children	+27%	+3%	43.4%	35.3%
Men without children	+37%	+18%	34.5%	29.8%

Source: ACS 5-year PUMS, 2015–2019 and 2020–2024, 20 states. Changes are in weighted counts between the two periods.

The count rose while the share fell. In every group, more Medicaid enrollees reported access to IHS in 2020–2024 than in 2015–2019. The share fell 4.7 to 8.2 points because Medicaid added many adults who do not report access to IHS. For planning, the count matters more than the share: a falling share does not mean fewer enrollees who might use IHS-funded programs.

Growth came mostly from adults without children. Among adults living with children, the number reporting both Medicaid and access to IHS grew about 3%, for women and men alike. Among adults without children it grew 11% for women and 18% for men. Adults living with children still report access to IHS more often, but for men the difference narrowed from 8.9 to 5.5 points.

Households with young children had the highest rates and some of the largest declines. Among women with Medicaid, the share fell 6.9 points in households with a child under six and 3.2 points in households with only children ages 6–17. Among men, it fell 8.6 and 7.0 points.

The decline is not specific to Medicaid. Among all working-age AI/AN adults in these states, the share reporting access to IHS fell 9 to 13 points in every group, more than among Medicaid enrollees. This matches the broad decline shown above.

Several explanations fit these figures, and none can yet be tested:

- **Medicaid expansion.** Idaho and Utah (2020), Oklahoma (2021) and South Dakota (2023) are among the 20 states. Expansion mainly adds adults without children, which matches the faster Medicaid growth in those groups.

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- **Continuous enrollment.** From March 2020 through March 2023, states could not disenroll most beneficiaries, as discussed in the next section.
- **Proxy reporting.** One household member often answers the ACS for everyone. A respondent whose children are seen at an IHS-funded program may report access for the whole household. A change in who answers could change reported access with no change in use.

The two periods are different samples, so the same adults cannot be followed over time. The estimates carry no margins of error and are not adjusted for age, income or state. Four further steps would sharpen the picture: margins of error from the ACS replicate weights; state comparisons separating late-expansion states from early and non-expansion states, as the companion paper does for income; income-to-poverty bands, to see whether new enrollees fall in bands newly eligible under expansion; and visits by household type, which only linked registration and encounter data can show. The next match could supply the last if it reported active patients with Medicaid on a visit date by age group, including children under six (recommendation 1).

Medicaid grew fastest among adults without children, but the ACS cannot show whether any of these adults use IHS-funded programs.

How many registrants are enrolled

The match documents Medicaid enrollment among AI/AN IHS registrants. Across the 27 states in this study, matched enrollment rose from 784,540 in 2019 to 878,439 in 2023, up 12.0%. These counts show the scale of Medicaid in the registered population. They do not show who was seen or whether a program was paid.

Most of that growth falls within the public health emergency. From March 2020 through March 2023, states could not disenroll most beneficiaries. Counts rose in nearly every state for that reason alone. The match ends in 2023, before states began removing people; the 2024 ACS reflects coverage after that process. The two sources therefore sit on opposite sides of the largest enrollment swing in the program's history.

Oklahoma shows why timing matters. Matched enrollment rose from 99,055 in 2020 to 132,126 in 2021, the year expansion took effect, and reached 160,339 in 2023. Expansion and continuous enrollment both contributed. Separating them requires knowing how many enrollees qualified as newly eligible adults.

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State	2019	2023	Change
Oklahoma	103,217	160,339	+55.3%
Arizona	151,408	159,375	+5.3%
New Mexico	103,512	104,700	+1.1%
California	71,607	71,304	−0.4%
Alaska	66,389	66,825	+0.7%
Washington	41,490	42,988	+3.6%
Montana	34,826	33,657	−3.4%
South Dakota	29,367	33,289	+13.4%
Minnesota	24,452	26,452	+8.2%
Wisconsin	20,259	23,332	+15.2%
Oregon	17,384	19,392	+11.6%
New York	16,437	18,533	+12.8%
North Dakota	13,595	15,051	+10.7%
Michigan	13,807	14,842	+7.5%
Texas	10,863	12,140	+11.8%
Colorado	8,624	9,357	+8.5%
Nevada	8,579	8,912	+3.9%
North Carolina	7,874	8,812	+11.9%
Utah	6,307	8,311	+31.8%
Florida	7,360	7,802	+6.0%
Nebraska	4,521	6,574	+45.4%
Idaho	4,163	6,065	+45.7%
Mississippi	3,964	4,047	+2.1%
Arkansas	4,739	4,842	+2.2%

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State	2019	2023	Change
Wyoming	4,103	4,593	+11.9%
Missouri	2,488	3,563	+43.2%
Kansas	3,205	3,342	+4.3%

Source: National Indian Health Board, CMS–IHS Data Match Report, October 2025, appendix pp. 4–5. The large percentage gains in Idaho, Nebraska, Missouri and Utah coincide with expansion in 2020–2021.

The match and the ACS count different people

The initial 2019 match used an IHS user population with at least one visit in a three-year window. The expanded NIHB report describes its population as IHS registrants, who may have had no visits. The ACS reports access to IHS and Medicaid at the time of the interview; the match reports enrollment for a reporting year. In 2019, the ACS estimated 496,717 people in the 27 states reporting both Medicaid and access to IHS. State rankings were similar across the two sources (Spearman correlation 0.91), yet ACS counts were lower in 25 states. The comparison shows where Medicaid populations are larger; it does not establish that the sources count the same people.

Can the match help explain the ACS decline?

The match measures something different from the ACS, but it is worth examining whether it can help explain why fewer people reported access to IHS. The two sources point in opposite directions. Between 2019 and 2024, the number of AI/AN people reporting access to IHS in the ACS fell about 10%. Between 2019 and 2023, Medicaid enrollment among AI/AN IHS registrants in the 27 states rose 12%.

The difference does not show that either source is wrong. It may help separate two explanations:

- **Fewer people connected to IHS-funded programs.** If fewer AI/AN people were eligible for or registered with IHS-funded programs, registrant counts should fall as well. Rising matched enrollment among registrants does not support this, although continuous enrollment raised Medicaid counts everywhere and registrants may include people with no recent visit.

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- **A change in reporting.** If people stayed registered but fewer told the ACS they had access to IHS, ACS counts should fall where match counts hold steady or rise. A state-by-state comparison of the two sources could test this. The 2019 comparison above already found ACS counts lower than match counts in 25 of 27 states.

Three additions would make the comparison stronger:

- Total registrants by state and year, not only those enrolled in Medicaid, so the match can show whether the registered population itself grew or shrank.
- Matching years. The match ends in 2023, and the 2024 ACS reflects coverage after unwinding; an ACS 2023 count would line up with the last match year.
- Age groups in the match, so the finding that reported access fell most in households with young children can be checked against registrants with Medicaid by age.

The match cannot measure access to IHS as the ACS does. But if registrant counts held steady while ACS reports fell, the decline is more likely a change in reporting than a loss of connection to IHS-funded programs.

What Medicaid pays

No published source reports how much Medicaid paid for the health care of AI/AN people, at IHS-funded programs or elsewhere. Neither the ACS nor the match reports payments. Enrollment counts and coverage shares therefore cannot be translated into revenue for any program, state or year.

This is the largest gap in the evidence available to Tribal leaders.

What the next match could measure

If Tribes decide the benefits justify the effort, the next match could follow patients from enrollment to visits to payment, so leaders can see where the largest gaps occur, and could be designed to find out whether Medicaid coverage is reaching IHS-funded programs.

1. **Start with active patients and coverage at the visit.** Link IHS registration and dated program encounters to monthly Medicaid enrollment. Report the number of registrants, the number with at least one visit during the year, and the number with Medicaid on a visit date. Publish the share of active patients with Medicaid on at least one visit date, using all active patients as the denominator. Separate enrollment without a program visit from enrollment observed when care was delivered.

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2. **Count distinct visits and establish who paid.** Link encounters to adjudicated claims and managed care records. Count each visit once, using the IHS workload-reportable definition in the NPIRS Basic Business Rules, even when it generates several billing lines. Workload is IHS's existing count of services delivered or paid for, counted where care occurs; using it ties the match to a standard IHS and Tribal programs already report. Within a one-year window, report patients with zero, one, two to four, and five or more confirmed Medicaid-paid visits at IHS-funded health programs. Treat five visits as a proposed measure of regular Medicaid-supported use. Show how results change at other thresholds and flag encounters for which payment cannot be determined.
3. **Show where Medicaid dollars go.** Report visits, unique patients and net payments separately for IHS, Tribal, Urban Indian and other providers where data permit. Separate fee-for-service payments, managed care encounters, and supplemental payments where identifiable. Track whether patients receive most care at IHS-funded programs or elsewhere. This helps leaders distinguish a coverage problem from a payment or data-reporting problem.
4. **Report around the continuous-enrollment period.** Show 2019, 2020–2022 and the years after unwinding separately, so growth from continuous enrollment is not read as new coverage.
5. **Pilot the design with Tribal programs.** Ask participating Tribal programs to review linked counts against their own encounter and billing totals and their IHS workload reports under agreed data governance and privacy rules. Publish match rates, missing payment information and differences in state reporting before expanding the analysis.

Workload data have a serious limit: they are only as complete as what programs send to the IHS National Data Warehouse. User population and workload are separate reporting, with very different incentives. Several funding streams, including Tribal shares, are allocated by a program's share of total users, so nearly every program reports the registration and visit data needed for user population counts; in the author's experience, more than 95% do. No comparable incentive applies to workload. Far fewer programs submit workload data, and many do not know how. IHS does not publish how many IHS-funded programs submit complete workload data. The participation rate could be calculated by comparing user population reports with the list of IHS-funded programs in the IHS Facilities List, but program-level user population data are hard to obtain.

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The next match therefore cannot rely on workload reports alone. Where a program's workload data are missing, it should draw on Medicaid claims and the program's own records, and report separately which programs' visit counts come from which source. Helping programs learn to submit workload data would strengthen the match and every other analysis that depends on knowing who is seen.

Is there a downside to measuring payments?

Adding payments to the match would produce something new: a federal count of Medicaid dollars flowing to IHS, Tribal and Urban Indian programs. Some Tribal leaders will see a risk in that. A large national total could be used to argue that IHS patients and their programs are funded at a much higher level than appropriations suggest, and that the case for higher appropriations is weaker than Tribes have argued.

The concern is reasonable. A single dollar figure travels well and loses its context quickly. Appropriators and budget examiners could treat Medicaid revenue as a substitute for appropriated funds, or read a national total as if every program and every patient shared in it.

There are strong reasons why such a reading would be wrong, and the match itself can show them:

- **Medicaid pays for services to enrolled patients, not for the population a program serves.** About half of AI/AN people reporting access to IHS have neither Medicaid nor Medicare. Their care is funded from appropriations and Purchased/Referred Care alone, and Medicaid revenue does nothing for them.
- **The money is uneven.** Programs in states with high enrollment and favorable payment arrangements collect far more than programs in non-expansion states or in Areas that depend on Purchased/Referred Care. A national total hides that variation; program- and state-level reporting would expose it.
- **Medicaid paid to providers outside IHS-funded programs is not IHS funding.** If newly covered patients go to nearby clinics, Medicaid spending on AI/AN people can rise while revenue at IHS-funded programs does not. Recommendation 3 separates the two.
- **Federal law addresses the offset argument directly.** The Indian Health Care Improvement Act (section 401(a), 25 U.S.C. § 1641(a)) provides that Medicare, Medicaid and CHIP payments received by an Indian health program or an Urban Indian organization are not to be considered in determining appropriations for health care and services to Indians.

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There is also a cost to not knowing. Without payment data, the debate runs on partial figures that are easy to misread and hard to rebut. Data showing who is enrolled, who is seen and what was paid, program by program, give Tribal leaders a way to show where Medicaid helps, where it does not, and where the gap between need and resources remains.

If payments are collected, the risk could be managed in how the match is designed and released:

- Report payments per active patient and by program, state and provider type, never only as a national total.
- Publish payments alongside the share of the population with no billable coverage.
- Keep Tribal programs' own data under agreed Tribal data governance, with Tribes deciding what is released at the program level (recommendation 5).
- State in every release that Medicaid revenue is earned for services delivered and does not offset appropriations.

Whether these safeguards would be enough is left open, as is the larger question: do the benefits of the changes proposed here outweigh the effort they would take from Tribal programs, IHS, CMS and state Medicaid agencies, and the risk of unintended harm? Those are questions for Tribal leaders to discuss, to see whether consensus can be reached on how the problem is defined and on which of the alternatives, if any, to adopt. Research needs do not set Tribal priorities. Where there is no consensus on the problem or its solution, incomplete information may be the price.

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Methods and sources

ACS. ACS 1-year PUMS state extracts for 2015, 2019 and 2024, weighted with the person weight (PWGTP). AI/AN is the alone-or-in-combination recode (RACAIAN). Access to IHS is HINS7 and Medicaid is HINS4. Estimates do not carry margins of error. The section on adults with and without children uses ACS 5-year PUMS for 2015–2019 and 2020–2024 in 20 states (Alabama, Alaska, Arizona, California, Colorado, Idaho, Michigan, Minnesota, Mississippi, Montana, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin and Wyoming), adults ages 19–64, and household presence and age of children (HUPAC), which counts children under 18 regardless of their relationship to the adult. People in group quarters are excluded.

Expansion dates. Cross-checked against Census Appendix Table 1 and the KFF expansion tracker.

Sources

- U.S. Census Bureau, ACS 1-Year PUMS state extracts, 2015, 2019 and 2024; ACS 5-Year PUMS custom extracts, 2015–2019 and 2020–2024.
- National Indian Health Board, CMS–IHS Data Match Report, October 2025, and initial 2019 match results.
- Edward J. Fox, *Who Was Added?* and *Who Can Be Billed, and Who Could Be Enrolled*, edfoxphd.com.

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