

Promoting Health Coverage of American Indian and Alaska Native Children

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Eighth in a series of briefs on the future of children's health care coverage

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Courtesy of Allison Shelley/The Verbatim Agency for American Education: Images of Teachers and Students in Action

Key Findings

- American Indian and Alaska Native (AI/AN) children are more likely than other American children to be uninsured and in poor health. Reducing the rate of uninsured AI/AN children is essential to reducing their health disparities.
- There are three main sources of coverage for low-income AI/AN children: the Indian Health Service (IHS), Medicaid, and the Children's Health Insurance Program (CHIP). The relationships among these coverage sources and how they apply to AI/AN children are highly complex. This increases the difficulty of reducing the uninsured rate for these children.
- The quality of national data on coverage and health disparities among AI/AN children is weak. Without sufficient and timely data, it will be difficult for federal, state, and Tribal policymakers to develop effective solutions for reducing the uninsurance rate and improving the health outcomes of this population.

Summary

Health disparities in the American Indian and Alaska Native populations (AI/AN) have existed since the arrival of the European settlers, who brought with them new germs and disease. Today, AI/AN children are more likely than other children to live in poverty, to die as infants, and to be exposed to violence. Yet for these children, access to quality health care is too often elusive. The types of coverage that do exist are patchwork, difficult to navigate, and under-resourced. The relatively small size of the population spread across a number of states makes it hard to find reliable information on health access and outcomes, especially for children. Given the special responsibility that the federal government has toward Indian Tribes, it is imperative that the federal government take steps to determine how well existing programs are working, to make any necessary improvements, and to provide the funding required to ensure AI/AN children live healthy and productive lives.



✓ Recommendations:

1. **Improve the performance of Medicaid and CHIP for AI/AN children** - The Centers for Medicare & Medicaid Services (CMS) should collect and analyze data on how well these programs are supporting children in each of the 10 states with the highest percentage of AI/AN children, and work with the states and Tribes to address problems that are identified.
2. **Increase access by AI/AN children to culturally competent, quality care** - The IHS should identify gaps in the ability of Indian Health Services (IHS), Tribal, and Urban Indian providers to serve this population and seek the necessary resources from the Congress.
3. **Ensure that CMS and IHS act to improve coverage and accessibility of care for AI/AN children** - The Congress should conduct oversight of each agency's efforts by obtaining analysis and recommendations from the Medicaid and CHIP Payment and Access Commission (MACPAC) and the Government Accountability Office (GAO).

Introduction

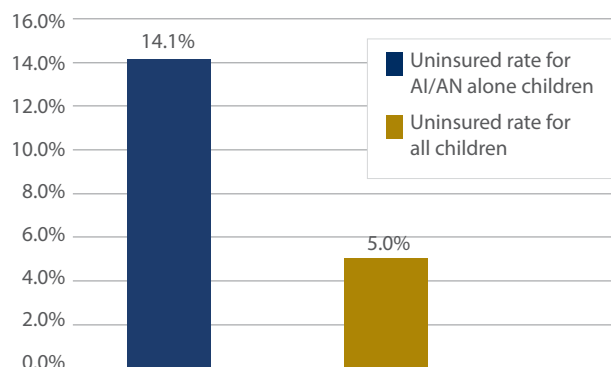
In 2017 there were approximately 774,000 American Indian and Alaska Native (AI/AN) children under age 19, comprising about 1 percent of the 78.1 million children nationwide.¹ AI/AN children are disproportionately poor, experience major health disparities, and are more than twice as likely to be uninsured as U.S. children overall. (Figure 1). It goes without saying that they represent the future of Tribal nations that survived the Native American Removal and forced assimilation.² Precisely because this population of children is so small and so disadvantaged, it merits special attention.

In 2017, over 80,000 AI/AN children, or 14.1 percent, were uninsured. In contrast, only 5 percent of all U.S. children were uninsured that year.³ It is well established that uninsured children are at greater risk for health disparities and poor health outcomes.⁴ Reducing the rate of uninsurance among AI/AN children requires an understanding of the current sources of coverage in order to identify gaps and develop policies for addressing them.

This brief begins with a discussion of AI/AN children and the health disparities they face. It then updates and expands a previous Center for Children and Families (CCF) analysis of coverage trends for this population between 2008 and 2015, with a particular focus on three public sources of coverage: the Indian Health Service (IHS), Medicaid, and the Children's Health Insurance Program (CHIP).⁵ There are, of course, other

sources of coverage for AI/AN children, including a parent's employer-sponsored insurance. But for AI/AN children whose families are disproportionately low income, the IHS, Medicaid, and, to a lesser extent, CHIP are the most important.⁶ The brief concludes with a set of recommendations for improving health care coverage for AI/AN children.

Figure 1. Comparing AI/AN Child Uninsured Rate with National Rate, 2017



Sources: In 2017, there were 3.9 million uninsured children in the United States (rounded to the nearest 1,000th). The data source was Table HIC-5, Health Insurance Coverage Status and Type of Coverage by State—Children Under 19: 2017, Health Insurance Historical Tables, U.S. Census Bureau American Community Survey (ACS). Information for the 'AI/AN alone' child population under 19 was calculated using 2017 ACS IPUMS data.

Georgetown University Center for Children and Families analysis of the U.S. Census 2017 American Community Survey data using one year estimate from the Integrated Public Use Microdata Series (IPUMS).



One clear finding is the lack of data—at least at the national level—that could inform policymakers’ understanding of the circumstances of AI/AN children with respect to coverage or health status. As this brief will discuss, the publicly available data are insufficient and not timely. This can be explained in part by the relatively small size of this population nationally and in most states, as well as the tendency of data collection and analysis to focus on AI/AN adults, whose coverage and health

status rank well below those of other adult populations.⁷ But this also reflects a failure by the federal government—which provides all or most of the funding for the IHS, Medicaid, and CHIP and which has a special responsibility to provide health care services to AI/AN people—to focus on this population in a meaningful way.

AI/AN Children

There is no single, universally agreed-upon definition of an AI/AN child. In arriving at the estimate of 774,000 children under 19, this brief uses the U.S. Census Bureau definition of AI/AN “alone”—that is “persons who [on the Census form] check only the box for American Indian or Alaska Native”—not AI/AN “in combination.”⁸ Our study methodology is discussed in Appendix A. The different definitions of AI/AN “alone” in comparison to “in combination” produce different estimates; the estimates produced by AI/AN “in combination” are set forth in Appendix B.

The majority—three fifths—of the overall AI/AN population lives in metropolitan areas, although a fifth still lives on or near a reservation.⁹ As shown in Figure 2, AI/AN alone children are concentrated in 10 states, which account for two thirds

of the entire AI/AN alone child population: Alaska, Arizona, California, Montana, New Mexico, North Carolina, Oklahoma, South Dakota, Texas, and Washington.

Health disparities affecting AI/AN children are stark: The most recent available data shows they are more likely than white, African-American, or Hispanic children to live in poverty, to be victims of violent crime, to die from accidents, to die during infancy, to suffer from fetal alcohol spectrum disorder and substance use disorder, and to commit suicide.¹⁰

But data sources are scarce and often incomplete: The AI/AN population is spread out across a number of states, meaning that descriptive studies are often based on regional samples, or limited to a culturally distinct group.¹¹ Researchers at the

Figure 2. States with Highest Number of AI/AN Children Alone under 19, 2017

State	Estimate, under 19 years	Percent of AI/AN alone children (under 19) in state *
Alaska	36,929	4.8%
Arizona	98,697	12.8%
California	78,137	10.1%
Montana	23,558	3.0%
New Mexico	60,962	7.9%
North Carolina	31,289	4.0%
Oklahoma	96,411	12.5%
South Dakota	30,501	3.9%
Texas	36,676	4.7%
Washington	28,554	3.7%
Total in Top 10 States	521,714	67.4%
U.S.	773,489	100%

* As a percent of all AI/AN alone children in USA.

Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017 American Community Survey data from American Fact Finder Table C27001C using 1-year estimates of AI/AN alone.

Kaiser Family Foundation have gathered data on health disparities for the AI/AN population as a whole, but in many cases information for children under 19 is not available.¹²

The same holds true for data on urban Indian health.¹³ State agencies have encountered the same data gap.¹⁴ This lack of robust, timely national data on AI/AN children is not a new problem, but it will be difficult to reduce the high uninsured rates without solving it. From a research perspective, national-level data is integral to unifying otherwise siloed voices to showcase similar experiences and shared needs across various states.¹⁵

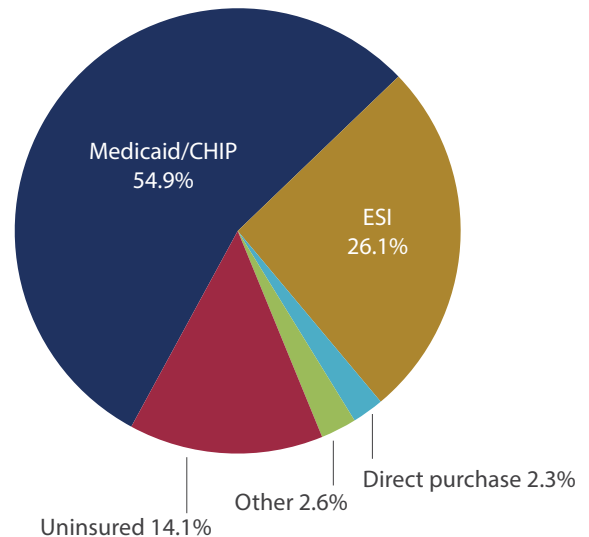
Sources of Coverage

The largest sources of coverage for AI/AN alone children are Medicaid and CHIP, covering more than half the population followed by employer-sponsored insurance which covers about a quarter of these children (see Figure 3). Of particular concern is that 14.1 percent of AI/AN children under age 19 have no public or private health insurance coverage.¹⁹ This is over two times the rate among all children in the United States.²⁰

The Census Bureau does not consider eligibility for IHS services to be coverage when identifying individuals with health insurance. Those who respond to the American Community Survey (ACS) or the Annual Social and Economic Supplement (ASEC) to the Current Population Survey who indicate they are only covered by the IHS “are considered to be uninsured. IHS coverage is not considered to be comprehensive.”²¹ The Congressional Budget Office (CBO), in contrast, “defines as publicly insured people who use the Indian Health Service” for purposes of its coverage analyses.²² For consistency with health insurance coverage data presented in other CCF analyses, this brief uses the Census Bureau definition. See Appendix C for an analysis and discussion of limitations on the single ACS question about IHS as it relates to “AI/AN alone” children.

Even the size of the population is subject to interpretation. The federal government formally recognizes 573 Tribes in 37 states.¹⁶ Each Tribe establishes and administers its own membership criteria. An estimated 1.9 million adults and children are enrolled in a federally-recognized Tribe.¹⁷ The Census Bureau population counts for AI/ANs are based on self-identification of race/ethnicity, not on legal status; the American Community Survey estimate of the AI/AN population for 2017 is almost 2.7 million.¹⁸

Figure 3. Health Coverage Sources for AI/AN Alone Children, Under 19, 2017



Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017 American Community Survey data using one-year estimate from the Integrated Public Use Microdata Series (IPUMS). Medicaid/CHIP here includes Medicaid alone and in combination with other coverage types in cases where someone has 2 or more types of coverage. ESI includes all employer-sponsored insurance. Other includes any non-Medicaid public or two or more sources of coverage that are non-Medicaid.



Indian Health Service

The federal government has a trust responsibility to Indian Tribes based on treaties and Supreme Court decisions.²³ This federal trust responsibility confers a range of services to members and descendants of federally-recognized Tribes, including eligibility for health services through the IHS. An agency within the U.S. Department of Health and Human Services (HHS), IHS is responsible for providing health services to members of federally-recognized Tribes.²⁴ (Note that the Census Bureau concepts of AI/AN “only” and AI/AN “in combination” used for population counts are not used in determining eligibility for IHS services).

The IHS operates a network of hospitals and clinics primarily on or near Indian reservations. It also supports facilities run directly by the Tribes and Urban outpatient clinics. It does so with a total budget of \$6.9 billion in fiscal year 2019, which, as the IHS’s own analyses indicate, represents a dramatic underfunding relative to need.²⁵ The IHS estimates that the population it is responsible for serving is about 2.6 million,²⁶ but the number of actual users of services is 1.6 million.²⁷ The IHS does not report how many patients who use its facilities are children.²⁸ If the number of children actually treated at IHS facilities is proportional to their representation in the AI/AN population overall, then about a third of the IHS user population, or roughly 500,000, would be children.²⁹

The IHS is a large, complex federal bureaucracy that faces daunting organizational challenges, including chronic underfunding. On a per capita basis, the system receives funding about half as much as Medicaid and a third as much as Medicare, according to a recent analysis by the U.S. Government Accountability Office.³⁰ To mitigate shortages, the IHS budget includes over \$900 million to purchase services—often from specialists—that are not available in IHS direct or Tribal hospitals and clinics. This Purchased/Referred Care (PRC) funding helps close some of the gaps but, with its formal system of determining payment for services based on “medical priorities” when funding is limited, it ultimately underscores the systemic rationing of care to which IHS patients, both adults and children, are exposed.

Investigations and news reports also document appalling quality of care issues affecting children and families. The emergency room of a South Dakota hospital was shut down after authorities discovered incidents such as employees washing surgical instruments by hand, rather than sterilizing them, and a patient delivering a baby prematurely on a bathroom floor.³¹ In another instance, a doctor who sexually abused boys served in the IHS for more than two decades before he was finally arrested and convicted.³²

How the IHS Works

1. The IHS delivers services through three different systems, each with different procedures for reporting utilization and quality data, none of which focuses on children.
 - **Direct Care:** Services are provided through facilities operated and staffed by IHS. This system includes 25 hospitals, 50 health centers, and other smaller facilities. Direct services account for less than 40 percent of the total IHS budget.
 - **Tribal:** Services are delivered by Tribal government or organizations that have opted, under the Indian Self-Determination Act, to carry out the IHS’s responsibilities. This system includes 22 hospitals, 280 health centers, 134 Alaska village clinics, and other facilities, and accounts for more than 60 percent of the budget.
 - **Urban:** Clinics are operated by Urban Indian Health Organizations and serve AI/ANs regardless of whether they are members of federally-recognized Tribes with grant and contract funding from IHS. There are 40 such clinics that collectively account for less than 1 percent of the budget.
2. The IHS delivers funding for services through 12 Area offices. There are no Area-specific data on the IHS website for AI/AN children.
 - **The size** of the Areas varies, with some covering one state and others stretching across state lines.
 - **The number of users** varies, from 27,700 in the Tucson Area to 370,300 in the Oklahoma Area in FY 2017.
 - **Per-person funding** varies, ranging from \$2,075 in the Oklahoma Area to \$4,494 in the Alaska Area in fiscal year 2017. These variations do not appear to bear any relationship to child health needs. Within each area there are likely to be similar inequities among different hospitals and clinics, which contribute to shortages in staffing, equipment and service capacity.

Sources: FY 2017 Indian Health Services Level of Need Funded (LNF) Calculation: Resources Needed, Resources Available, and LNF Scores Summarized by IHS Area (Revised, 2/14/2018), Column I, [https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2018/FY_2017_LevelofNeedFunded_\(LNF\)_Table.pdf](https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2018/FY_2017_LevelofNeedFunded_(LNF)_Table.pdf).

FY 2020 Indian Health Service Justification of Estimates for Appropriations Committees (March 22, 2019), pp. 115-120, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2020CongressionalJustification.pdf.



Medicaid

Medicaid is the nation's largest health insurance program³³ for children, covering over 36 million³⁴ and offering a comprehensive pediatric benefit, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.³⁵

Because of the high poverty rates among AI/AN children and parents, Medicaid is a particularly important source of health insurance coverage for this population.³⁶ Nationally, about 55 percent of AI/AN children were enrolled in Medicaid or CHIP in 2017 (see Figure 3). In seven states (Alaska, Arizona, Montana, New Mexico, North Dakota, Oklahoma, and South Dakota), AI/AN children and adults represent at least 7 percent of Medicaid beneficiaries (see Figure 4).³⁷

All state Medicaid programs must cover children up through age 18 with family incomes at or below 133 percent of the Federal Poverty Level (FPL), or about \$28,369 for a family of three in 2019. When CHIP coverage is accounted for, median eligibility levels are higher: 255 percent FPL as of January 2019.³⁸

In the states with the greatest number of AI/AN children, Medicaid was the source of coverage for more than half of AI/AN children in all but California (48 percent), Oklahoma

(42 percent), and Texas (33 percent) in 2017 (see Figure 5). Estimated participation in Medicaid and CHIP for all eligible children—not just AI/AN children—varied from state to state, from a low of 85.7 percent in Alaska to a high of 95.9 percent in California.³⁹

Six of the 10 states with the highest shares of AI/AN children have expanded the program to allow more adults to qualify for health coverage. Four others—North Carolina, Oklahoma, South Dakota, and Texas—allow only smaller group of very poor parents to receive Medicaid benefits. Only in Oklahoma did the percentage of AI/AN children with Medicaid coverage decline between 2010 and 2017, from 44 to 42 percent (see Figure 5).

Medicaid has special rules relating to premiums and cost-sharing for AI/AN children and adults. All children under age 18 with family incomes at or below 133 percent FPL, including AI/AN children, are exempt from Medicaid premiums or cost-sharing. In addition, AI/AN adults, including parents, are exempt from Medicaid premiums or cost-sharing if they have received services from an IHS or Tribal facility or an Urban Indian clinic, or if they are eligible to do so.⁴⁰

Figure 4. States with at Least 7 Percent of their Child and Adult Medicaid Populations Who Are AI/AN Alone, 2017

State	Percent of the child Medicaid population that is AI/AN alone, 2017	Percent of the adult Medicaid population that is AI/AN alone, 2017
Alaska	29%	27%
Arizona	7%	8%
Montana	15%	11%
New Mexico	14%	15%
North Dakota	21%	19%
Oklahoma	8%	9%
South Dakota	33%	29%

Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017 American Community Survey data using one-year estimate from the Integrated Public Use Microdata Series (IPUMS).



Figure 5: Percent of AI/AN Children Alone with Medicaid Coverage, 2010 and 2017

State	Percent of AI/AN alone children with Medicaid coverage, 2010	Percent of AI/AN alone children with Medicaid coverage, 2017
Alaska	58%	67%
Arizona	54%	58%
California	41%	48%
Montana	60%	64%
New Mexico	52%	71%
North Carolina	53%	63%
North Dakota*	45%	52%
Oklahoma	44%	42%
South Dakota	60%	75%
Texas	28%	33%
Washington	48%	61%

* North Dakota is not among the 10 states with the highest number of AI/AN children (Figure 2), but it has the third highest percentage of AI/AN child and adult Medicaid population (Figure 4).

Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017 American Community Survey data using one-year estimate from the Integrated Public Use Microdata Series (IPUMS).

Medicaid Expansion and the AI/AN Population

The rate of uninsured AI/AN children and adults declined by 11 percentage points in states that expanded Medicaid between 2013 and 2017, compared to 4 points in places that did not accept the expansion. When parents are enrolled in Medicaid, their children are more likely to be enrolled.

- In expansion states, all adults with incomes at or below 138 percent of the federal poverty line (\$17,236 for an individual and \$29,435 for a family of three) are eligible for coverage (133 percent of poverty plus a 5 percentage point disregard). These include six of the 10 states with a high share of AI/AN children nationally (AK, AZ, CA, MT, NM, and WA), plus North Dakota.
- Non-expansion states set income eligibility levels for parents and caregivers under Medicaid's Section 1931. As of January 2019, the median eligibility level for these parents was 49 percent of FPL. That includes NC (42 percent); OK (42 percent); SD (49 percent); and TX (17 percent).

Sources: Artiga et al., "Changes in Health Coverage by Race and Ethnicity Since Implementation of the ACA, 2013-2017" (February 2019), available at <https://www.kff.org/disparities-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-implementation-of-the-aca-2013-2017/>.

J. Alker and O. Pham, "Nation's Progress on Children's Health Coverage Reverses Course" (Washington: Georgetown University Center for Children and Families, November 2018), available at https://ccf.georgetown.edu/wp-content/uploads/2018/11/UninsuredKids2018_Final_asof1128743pm.pdf.



Medicaid and IHS

The relationship between the IHS and Medicaid coverage is extraordinarily complex. In general, IHS eligibility is limited to members and descendants of federally-recognized Tribes, which in turn have their own criteria for membership. As described above, Medicaid eligibility rules vary from state to state. IHS delivery systems vary from those run directly by the federal government to those run by Tribes or Urban Indian programs. Medicaid delivery systems range from traditional fee-for-service to Primary Care Case Management (PCCM) to risk-based managed care. Here are some of the basic rules that apply.

Medicaid eligibility for AI/AN children and parents depends on age, family income, and residence; eligibility for IHS services is irrelevant to Medicaid eligibility. Similarly, Medicaid eligibility is irrelevant to eligibility for IHS services.⁴¹ If an individual is eligible for coverage from both programs, Medicaid is the first dollar payor. In such cases, the IHS facility bills Medicaid for services it provides to the eligible individual before using IHS funds to pay for their services. From the standpoint of IHS, Medicaid is an “alternate resource,” just like Medicare or private insurance.⁴²

Medicaid payments are an important revenue source for IHS facilities, accounting for \$807.6 million, or nearly 12 percent of the \$6.9 billion FY 2019 IHS budget. Even though not all states expanded Medicaid under the Affordable Care Act (ACA), the expansion resulted in a 26 percent increase in the number of AI/AN patients at IHS facilities with Medicaid coverage between 2012 and 2016. That in turn led to an increase in Medicaid revenues to support those facilities.⁴³ (Data are not available on the amount of Medicaid revenues received by Tribally operated programs).

The rate at which the federal government matches state spending for AI/AN Medicaid beneficiaries varies depending on the type of provider that treats the beneficiary. Generally, the federal government matches state Medicaid spending at rates ranging from 50 to 76 percent for most populations (90 percent for expansion adults).⁴⁴ In the case of AI/AN Medicaid beneficiaries, however, the federal government matches 100 percent of the cost of services furnished “through” an IHS facility, whether operated directly by the federal government or by a Tribe or Tribal organization. The 100 percent match rate does not apply to services received from an Urban Indian health clinic or from a non-IHS provider, whether public or private; in these situations, the state’s regular match rate would apply.⁴⁵

Beyond the increased match rate, other special rules govern the relationship among Medicaid managed care, AI/AN Medicaid beneficiaries, and Indian health care providers. States have the option to contract on a risk basis with managed care organizations (MCOs) to furnish covered services to Medicaid beneficiaries; 39 states, including five out of the 10 states with the greatest share of AI/AN children nationally (AZ, CA, NM, TX, and WA) plus North Dakota, currently do so.⁴⁶ States may require most Medicaid beneficiaries to receive services through an MCO rather than on a fee-for-service basis; AI/AN beneficiaries, however, are exempt from mandatory enrollment in MCOs except in the case of freedom of choice waivers and section 1115 demonstrations.⁴⁷ AI/AN beneficiaries may voluntarily enroll in MCOs. There are no data publicly available at the national level on the number of AI/AN children enrolled in Medicaid MCOs.

Indian health care providers and Urban Indian health programs also have a special regulatory status vis-à-vis Medicaid MCOs. For example, if an MCO has AI/AN enrollees, it must either include sufficient Indian health care providers in its network so that those enrollees have timely access to those providers, or it must allow the AI/AN enrollees to access the services of those providers on an out-of-network basis.⁴⁸

Children’s Health Insurance Program (CHIP)

After Medicaid, the next largest source of health insurance coverage for children in all low-income families is CHIP, which is designed to cover those whose families make too much to qualify for Medicaid but who do not have health insurance through an employer or otherwise.⁴⁹ As of February 2019, nearly 6.7 million individuals were enrolled in CHIP.⁵⁰ Data are not available on how many of those are AI/AN children.

As in the case of Medicaid, eligibility for IHS services is not a bar to eligibility for CHIP, and vice versa.⁵¹ Similarly, CHIP is the first dollar payor when an AI/AN child is enrolled in CHIP and receives services from an IHS or Tribal facility; from IHS’s vantage point, CHIP is, like Medicaid, an “alternate resource.”⁵² As with Medicaid, state CHIP programs may not impose premiums, deductibles, coinsurance, copayments or any other cost sharing on AI/AN children.⁵³ Finally, the provider network requirements with respect to AI/AN enrollees and Indian health care providers in Medicaid MCOs also apply to managed care plans in CHIP.⁵⁴



There are some differences between the rules for CHIP and Medicaid, however. Notably, the federal government does not match the cost of services to AI/AN children under CHIP at a higher rate than the rate that would apply to other children; that said, CHIP's matching rates are

substantially higher than Medicaid's.⁵⁵ Also, AI/AN children and parents are not exempt from mandatory enrollment in CHIP managed care plans. Enrollment numbers for AI/AN children in CHIP managed care are not publicly available at the national level.

Recommendations

Despite the availability of three coverage sources—IHS, Medicaid, and CHIP—and despite the marked improvement in coverage since the implementation of the ACA Medicaid expansion in most states, the rate of uninsured AI/AN children remains unacceptably high (see Figure 6).

AI/AN children would benefit from an IHS with adequate funding and higher quality services; efforts to expand its resources are essential. It is not, however, realistic to expect the agency, which is a health care delivery system, to assume the role of a health insurer for the children it serves. Instead, the policy focus should be on reducing the number of AI/AN children who are eligible for but not enrolled in Medicaid or CHIP, and on holding those programs accountable for addressing health disparities.

This is much easier said than done. Because of the large variation among Medicaid and CHIP programs from state to state, as well as the differences in geographic distribution of Tribes and of low-income AI/AN children, solutions will likely have to be state-specific. A fair amount is known about the characteristics of individual state Medicaid and CHIP programs as they affect children generally.⁵⁶ Despite efforts

by the National Congress of American Indians and others to address the data “invisibility” of AI/AN youth,⁵⁷ relatively little is known about how effectively these programs are reaching eligible AI/AN children or serving those who are enrolled. The lack of accurate, actionable data makes it difficult to understand the causes of high rates of uninsured children, much less develop and implement solutions.

Despite the lack of useful data, this much is known: The IHS system—with its direct, Tribal, and Urban Indian components—is grossly underfunded relative to the needs of the AI/AN population it is tasked with serving, the federal trust responsibility to the contrary notwithstanding.

Beyond funding concerns, there are important advantages to ensuring that culturally competent providers are available to AI/AN children, including higher patient satisfaction and compliance, which can lead to improved outcomes.⁵⁸ As discussed above, funding for providers in the IHS system now comes directly from the federal government as well as from revenues received for serving Medicaid or CHIP beneficiaries. Increasing resources for these providers will necessarily involve both funding streams.

Figure 6: Rate of Uninsured AI/AN Alone Children, 2010 and 2017

State	Rate of uninsured AI/AN alone children, 2010	Rate of uninsured AI/AN alone children, 2017
Alaska	22%	14%
Arizona	29%	16%
California	16%	9%
Montana	25%	25%
New Mexico	29%	14%
North Carolina	17%	10%
North Dakota*	35%	18%
Oklahoma	21%	19%
South Dakota	30%	17%
Texas	19%	11%
Washington	20%	10%

* North Dakota is not among the 10 states with the highest number of AI/AN children (Figure 2), but it has the third highest percentage of AI/AN child and adult Medicaid population (Figure 4).

Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017 American Community Survey data using one-year estimate from the Integrated Public Use Microdata Series (IPUMS).



To address the lack of data, the Centers for Medicare & Medicaid Services (CMS), which administers both Medicaid and CHIP at the federal level, should work with states and Tribes to make those programs work better for AI/AN children. Specifically:

1. CMS should conduct a state-specific analysis of Medicaid and CHIP enrollment of AI/AN children in the 10 states with the greatest share of such children (see Figure 2 on page 3). In conducting these analyses, CMS or its contractor should not only work with the state Medicaid and CHIP agencies but also consult with all Tribes in the state. Congress should provide the funding necessary for such analyses, including the costs of meaningful Tribal consultation. The analyses should address two issues: (1) how to reach eligible but unenrolled children and (2) whether enrolled children are receiving the EPSDT services to which they are entitled.
2. With respect to eligible but unenrolled children, for each state, the CMS analysis should:
 - a. Estimate how many AI/AN children are eligible for Medicaid or CHIP but not enrolled;
 - b. Identify the reasons eligible AI/AN children are not enrolled or have become unenrolled; and
 - c. Set forth specific steps to be taken by the state Medicaid and CHIP programs, CMS, Tribes, the IHS, and Indian health providers to bring the share of eligible but unenrolled AI/AN children down below the national average for all children.
3. With respect to EPSDT services for those AI/AN children enrolled in Medicaid and, where applicable, CHIP, the CMS analysis should for each state:
 - a. Determine how many of the AI/AN children have received screening services as required;
 - b. Determine how many of those who received these screenings were referred for follow-up diagnostic or treatment services;
 - c. Determine how many of those who were referred for follow-up diagnostic or treatment services received such services within three months of referral;
 - d. In the case of a state that requires eligible AI/AN children to enroll in a Medicaid MCO (or CHIP managed care plan), present the above screening and referral data on an MCO-specific basis;
 - e. Set forth specific steps to be taken by the state Medicaid and CHIP programs, CMS, Tribes, the IHS, and Indian health providers to ensure that for 90 percent of enrolled AI/AN children, required screenings and all necessary follow-up diagnostic and treatment services are delivered on a timely basis.
4. CMS should present each of the state-specific analyses to the state Medicaid and CHIP agency and to the Tribes with which it has consulted in the state. It should also post each state analysis in its entirety on the Medicaid.gov website to enable state-to-state comparisons by states, Tribes, the Congress, and the public.
5. CMS should monitor the implementation of the steps recommended in each analysis and post its findings with respect to each state annually for five years or until the state meets both of the performance metrics described in 2c and 3e above, whichever comes earlier.



To address the underfunding of IHS direct care, Tribal, and Urban Indian providers, the Indian Health Service should:

1. Identify gaps in the ability of each of its direct care and Tribal facilities, and Urban Indian clinics to deliver medically necessary, culturally competent services to AI/AN children in their service areas. (This may require the submission of encounter data by these facilities that is not currently submitted to IHS).
2. The IHS should include in its annual budget proposal to Congress a request for the resources necessary to fill in the gaps in capacity identified in item 1.



To ensure that CMS takes steps to address the lack of data and that IHS requests the resources necessary to address funding gaps, Congress should conduct oversight of the coverage of AI/AN children and their access to needed services. In particular, Congress should:

1. Direct the Medicaid and CHIP Payment and Access Commission (MACPAC) to conduct an analysis of Medicaid and CHIP data on coverage of AI/AN children and make recommendations for actions the Congress, CMS, and IHS should take to improve the accessibility and quality of services for eligible AI/AN children.
2. Direct the Government Accountability Office (GAO) to review the actions taken by CMS and IHS to address data gaps and underfunding and make recommendations for steps each agency should take to improve coverage of AI/AN children and their access to needed services.

Conclusion

There are about three quarters of a million American Indian/Alaska Native children in the United States. About 14.1 percent of these are uninsured—more than twice the rate of all U.S. children. A portion of those uninsured AI/AN children are eligible to receive services from IHS or Tribal hospitals and clinics, but it is far from clear that all IHS and Tribal providers have the capacity to deliver the services needed, since it is undisputed that the IHS delivery system as a whole is badly under-resourced. It is also undisputed that the health status of AI/AN children is poorer than that of other children.

The federal government has a trust responsibility toward Indian Tribes to ensure the welfare of the Tribes and their members and descendants. At minimum, that responsibility implies an obligation to make every effort to reduce health disparities between AI/ANs and other populations.

Reducing health disparities, in turn, requires reducing the rate of uninsurance and assembling robust and timely data at the national level relating to coverage, access and disparities.

Currently, the data necessary to understand the problems are not publicly available at the national level. We need to know: How many uninsured AI/AN children are eligible for Medicaid or CHIP but not enrolled? Why are they not enrolled? Do they have access to needed services through IHS, Tribal, or Urban Indian providers? If not, why? In the case of those enrolled in Medicaid or CHIP, are they receiving the EPSDT services to which they are entitled? If not, why? CMS and IHS, with Congressional oversight and adequate funding, can and should address the coverage and data gaps that AI/AN children now face.

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Appendix A: Methodology and Data Sources Relating to American Indians and Alaska Natives

The data presented in this report derives from the American Community Survey (ACS) conducted by the U.S. Bureau of the Census from two sources: 1) American Fact Finder and 2) an augmented version of the 2010 and 2017 ACS - the Integrated Public Use Microdata Series (IPUMS) prepared by the University of Minnesota Population Center.

We report on national population estimate statistics for the AI/AN population from the 2017 American Fact Finder tables, since they are created from a larger sample of the ACS and results in more reliable estimates. However, American Fact Finder recently changed the age range between 2016 and 2017 for children from 0-17 or Under 18 to under 19 (now 0-18). To examine state trends over time (in our prior report and this report) we continue to use IPUMS which harmonizes the longitudinal data allowing us to examine trends of the same age group for AI/AN children across time. Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error. The values computed have a 95 percent margin of error. The margin of error can be interpreted roughly as providing a 95 percent probability that the interval defined by the estimate plus/minus the margin of error (the lower and upper confidence bounds) contains the true value. Margin of error values are not published in this report, but are available upon request.

The data presented in this report are for children under 19 who are “AI/AN alone,” consistent with that in our 2017 report, “Coverage Trends for American Indian and Alaska Native Children and Families.” We do however produce some estimates of Medicaid coverage of “AI/AN in combination” which are available in Appendix B. Alignment of this definition allows for apples-to-apples comparisons in the rates of uninsured AI/AN children over time. In our 2017 report, we used two criteria for selecting states with substantial AI/AN Medicaid populations: (1) 8 percent or more of a state’s child or adult Medicaid population reported their race as AI/AN, or (2) a state had more than 10,000 AI/AN children or adults with Medicaid coverage. In this new report, we used only criterion (1), adjusted from 8 to 7 percent (see Figure 4) in order to avoid excluding Arizona, where the percent of the child Medicaid population that is “AI/AN alone” was 7 percent in 2017. Medicaid coverage includes enrollees with Medicaid alone and Medicaid in combination with another health coverage source.

Undercount

In assessing the data presented in this report, readers should be aware that there was an undercount of the AI/AN population in the 2010 Census, primarily among AI/ANs living on reservations, as well as children under age 5 generally. These populations are also at risk of undercount in the 2020 Census. It is not clear whether the inter-decennial census ACS survey data analyzed in this report are also subject to undercounts. The AI/AN population is considered one of the “hard to count” populations in the U.S. Census (see source notes).

Supplementary Information on Figures in the Text:

Figure 2: Data were analyzed from the American Fact Finder tables C27001C and S2701 with one-year estimates. Percentages were calculated with the total estimated number of AI/AN children in the United States (under 19) as the denominator and the estimated number of AI/AN children (under 19) residing in each state as the numerator. States were considered to have a high percentage of total AI/AN child population if “AI/AN alone” children (under 19) accounted for 3 percent or more of all children (under 19) in the state.

Figure 4: Data were analyzed using data from the Integrated Public Use Microdata Series (IPUMS). States included in this figure had at least 7 percent or more of their Medicaid populations (child and adult) identifying as “AI/AN alone.” Medicaid coverage includes enrollees with Medicaid alone and Medicaid in combination with another health coverage source. As in our 2017 report covering ACS data from 2008-2015, we establish national and state-level estimates of Medicaid coverage and uninsured rates for “AI/AN alone” children (under age 19) and “AI/AN alone” adults (ages 19 to 64).

Figures 5 and 6: Data were analyzed using data from the Integrated Public Use Microdata Series (IPUMS). The 11 states selected are the same as those selected for this analysis in our 2017 report.

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Appendix B: AI/AN in Combination – Analysis with Expanded Definition

For purposes of the ACS survey, the Census Bureau uses two definitions of American Indian and Alaska Native. It counts “AI/AN alone” as “persons who [on the Census form] check only the box for American Indian or Alaska Native.” It also counts survey respondents who identify with another racial group, such as White or African-American, as well as AI/AN, as “AI/AN in combination with one or more races.” Some analysts rely on the broader definition of “AI/AN in combination.” Most prominently, the National Indian Health Board (NIHB) defines AI/AN as “a population classified as either AI/AN alone or in combination with Hispanic ethnicity and/or one or more other races.” The two definitions produce different results, which is noted in a recent report by the California Department of Public Health. Its findings use an expanded definition of AI/AN that allowed for multiple races and ethnicities, which more closely

aligns with both the legal and community held conceptions of AI/AN identity; it also addresses concerns of undercounting AI/AN births.

Using 2017 ACS 1-year estimates from IPUMS (data source noted above), we find that in addition to the 1.07 percent of “AI/AN alone” children in the U.S. with Medicaid coverage an additional 1.52 percent of “AI/AN in combination” children were enrolled in Medicaid nationally. Appendix Figure 7 below illustrates how these differences play out in the states discussed this paper. In Alaska, for example, 29 percent of the child Medicaid population is “AI/AN alone” and 13 percent of the child Medicaid population is “AI/AN in combination.” Together, “AI/AN alone” and “AI/AN in combination” children represent 42 percent of the Alaska child Medicaid population.

Figure 7: Comparison of Percent of State Child Medicaid Population Who are AI/AN Alone and AI/AN in Combination, 2017

State	Percent of the child Medicaid population that is AI/AN alone, 2017	Percent of the child Medicaid population that is AI/AN in combination, 2017
Alaska	29%	13%
Arizona	7%	3%
California*	0.4%	2%
Montana	15%	7%
New Mexico	14%	2%
North Carolina	2%	1%
North Dakota	21%	1%
Oklahoma	8%	10%
South Dakota	33%	3%
Texas*	0.2%	0.8%
Washington	2%	3%

* In cases where rounding a number down would result in a zero, we choose to round to the first decimal place

Source: Georgetown University Center for Children and Families analysis of the U.S. Census 2017 American Community Survey data using 1-year estimate from the Integrated Public Use Microdata Series (IPUMS).

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Appendix C: Data in the American Community Survey about Indian Health Service Coverage

The American Community Survey includes one question about whether or not respondents have Indian Health Service (IHS) coverage. The answers are self-reported and not cross-validated with IHS records. A May 2018 Census Bureau paper, “Reporting of Indian Health Service Coverage in the American Community Survey,” discusses the complexities of this self-reported data, indicating false negatives and false positives in connecting this variable with IHS administrative records.

Furthermore, there are substantial methodological issues with this survey question relating to construct validity—i.e., there is concern about the degree to which it actually measures what it purports to measure.

Our analysis of the IHS survey item from the ACS finds that nationally approximately 53.6 percent of all “AI/AN alone” children under 19 report having IHS, whereas 46.4 percent report not having IHS. A cross-referencing of the IHS item with coverage type indicates that among “AI/AN alone” children who are uninsured, 87 percent report having IHS coverage and 13 percent report not having IHS coverage. For the AI/AN alone children with employer-sponsored insurance, Medicaid, direct purchase coverage or other coverage type, between 30 and 55 percent, depending on coverage type, also report having IHS coverage.

These results make clear that IHS plays an important role as a source of coverage for AI/AN children, especially those without Medicaid/CHIP coverage.

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This issue brief is eighth in a series of papers from Georgetown University Center for Children and Families on the future of children’s health coverage. Other briefs in the series include:

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[How Medicaid and CHIP Can Support Student Success through Schools](#). Examines how Medicaid can help schools better serve children and families and how schools can help students get the health care they need.



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