CHANGING THE BORDERS OF THE FEDERAL TRUST OBLIGATION: THE URBAN INDIAN HEALTH CARE CRISIS

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INTRODUCTION

A. Urban Relocation

Lured by the promise of jobs, education, and economic security, an estimated 100,000 to 160,000 American Indians moved off reservations and into urban areas between 1953 and 1972[1] via the urban relocation efforts of Commissioner of Indian Affairs Dillon Myer.[2] Native Americans slowly but steadily migrated from rural reservations to urban areas between 1920 and 1950. World War II[3] and relocation policies developed by the federal Bureau of Indian Affairs (BIA) proved tremendous catalysts. The experimental BIA relocation program secured volunteers from reservations and provided them with bus tickets, $50 checks, and little else.[4] Rather than an escape from rural poverty, this misguided relocation program ultimately offered nothing more than an exchange of "one form of poverty for another."[5] As urban American Indians were isolated from their reservation counterparts, their connections to tribal cultures and histories withered

1. *Urban Indians and Health Care in America: Hearing on the FY 2004 President's Budget for Indian Programs before the S. Comm. on Indian Affairs*, 108th Cong. 4 (2003) [hereinafter *2004 Budget Hearings*] (testimony of Kay Culbertson, President, National Council of Urban Indian Health); Thomas W. Mitchell, *From Reconstruction to Deconstruction: Undermining Black Ownership, Political Independence, and Community Through Partition Sales of Tenancies in Common*, 95 NW. U. L. REV. 505, 531 n.155 (2001).

2. *'Urban Voices' Makes a Great Contribution*, INDIAN COUNTRY TODAY, Apr. 2, 2003, *at* www.indiancountry.com/?1049318409. Note that Myer was also the architect behind the Japanese-American internment camps during World War II. He served as Commissioner of Indian Affairs from 1950-1953. RICHARD DRINNON, KEEPER OF CONCENTRATION CAMPS: DILLON S. MYER AND AMERICAN RACISM 166 (1987).

3. During World War II, "65,000 Indians left reservations to join the armed forces or to work in war-related industries." Betty Pfefferbaum et al., *Learning How to Heal: An Analysis of the History, Policy, and Framework of Indian Health Care*, 20 AM. INDIAN L. REV. 365, 379 (1996) [hereinafter *How to Heal*].

4. Deborah Norman, *The Urban Indian Experience,* 28 ORAL. HIST. REV. No. 2, 169 (2001) (book review).

5. *Chicago's Urban Indians*, *at* www.wttw.com/chicagostories/urbanindian.html.

away under the forces of assimilation, in what is now considered to be a "massive attack on Indian identity."[6]

B. Urban Indian Health and Poverty

The United States government entered into hundreds of treaties with Native American tribes from 1787 to 1871. In almost all of these treaties, Native Americans gave up land in exchange for guarantees from the federal government[7] for, among other things, the creation of a permanent reservation for Indian tribes and the protection of the safety and well-being of tribal members.[8] The United States Supreme Court held that these promises created a trust relationship between the federal government and Native Americans.[9] In recognition of this trust relationship, Congress enacted wide-ranging pieces of legislation intended to benefit Native Americans.[10]

The federal government's statutory and trust obligations towards Native Americans notwithstanding, the inadequacy of federal funding for Indian programs is egregious. The U.S. Commission on Civil Rights recently concluded that federal funding has been insufficient in addressing urgent needs across the board—in health care, education, public safety, housing and rural development.[11] Furthermore, actions by the BIA ensure that Native Americans suffer not only from inadequate federal funding, but that extant federal funding is not equally accessible to urban Indians, despite the fact that they now make up more than 50% of the total American Indian population. For example, the Snyder Act of 1921 provides authorization for federal appropriations to fund social services such as general assistance, health care, child welfare, and employment assistance to a class of eligible benefi-

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6. Norman, *supra* note 4.

7. Brett Lee Shelton, *Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States*, Issue Brief (Henry J. Kaiser Family Foundation), February 2004, at 3, *at* http://www.kff.org/minorityhealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=31330.

8. *Hearing on H.R. 151 Before the House Comm. on Resources: to Elevate the Position of the Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health, and for Other Purposes; and H.R. 2440: Indian Health Care Improvement Act Amendments of 2003*, 108th Cong. (2003) [hereinafter *IHCIA Hearing*] (statement of Anthony Hunter, President, National Council of Urban Indian Health), *available at* http://resourcescommittee.house.gov/archives/108/testimony/anthonyhunter.htm.

9. Shelton, *supra* note 7, at 4.

10. *See* discussion *infra* Part I.B.

11. Mark Fogarty, *Civil Rights Report Rips Federal Indian Spending*, Indian Country Today, Aug. 12, 2003, *at* http://www.indiancountry.com/content.cfm?id=1060695448.

ciaries defined as "Indians throughout the United States."[12] However, the BIA has generally limited the Snyder Act's class of beneficiaries to American Indians living "on or near reservations," excluding urban Indians from these assistance programs.[13]

Indian health care is one specific area where federal programs designated for Indians do not serve urban Indians. American Indian health care is in a state of financial crisis, with urban Indians receiving a disproportionately small share of federal health care funds. To be precise, "[i]n FY 2003, Urban Indian Health Programs received 1.12% of the total Indian Health Service budget, although urban Indians . . . constituted 66% of the total American Indian population."[14]

The Indian Health Service (IHS) is the federal agency responsible for the provision or payment of health services for most American Indians.[15] Eligibility for IHS care depends largely upon membership in a federally-recognized tribe, and such recognition is generally predicated on treaty or federal statute.[16] IHS facilities, which include hospitals, health centers, and health stations, are primarily located on or near rural Indian reservations. The IHS funds 34 urban Indian programs, such as outreach and referral services, which are not authorized to receive the same funds or to provide the same services as rural IHS facilities.[17] The scope of services offered by these urban Indian programs is restricted to primary care, and the services, unlike those at the free non-urban IHS facilities, are provided on a sliding fee basis.[18]

IHS services—which can include hospital care, outpatient services, or contracted care from private sector health care providers—are provided free of charge to eligible American Indians and Alaska Natives.[19] However, there are limitations on eligibility for IHS services. Persons of "Indian descent" must belong "to the Indian com-

12. Snyder Act of 1921, 25 U.S.C. § 13 (2004). *See also* Heidi Frith-Smith & Heather Singleton, The L.A. County Am. Indian Children's Council, Urban American Indian Children in Los Angeles County: An Investigation of Available Data (June 2000) (on file with the New York University Journal of Legislation and Public Policy).

13. Frith-Smith & Singleton, *supra* note 12, at 9.

14. *2004 Budget Hearings*, *supra* note 1, at 7 (statement of Kay Culbertson, President, National Council of Urban Indian Health).

15. *See* discussion *infra*, Section I.B.1.

16. Andy Schneider & JoAnn Martinez, The Kaiser Comm'n on the Future of Medicaid, Native Americans and Medicaid: Coverage and Financing Issues 2 (Dec. 1997). There are an estimated 115,000 Indians who are members of non-recognized tribes; several hundred groups currently seek federal recognition.

17. *Id.*

18. Ralph Forquera, Henry J. Kaiser Family Foundation, Urban Indian Health 1, 12 (Nov. 2001).

19. *Id.* at 8.

munity served by the local facilities and program."[20] These eligibility rules effectively exclude most urban Indians, due to their distance from home reservations.[21] Although urban Indians can avail themselves of alternative health care programs, such as Medicaid and Medicare, they must qualify for those programs in order to receive care they would ordinarily receive from IHS solely based on their status as Indians. Furthermore, complete reliance on Medicaid and Medicare denies Indians the special services to which they are entitled by their former treaties, and thus the federal government's continuing trust obligation.

As the number of urban American Indians continues to grow, the already devastating scarcity of resources that plagues both urban and rural Indian health care will continue to leave urgent health care needs unmet. Indeed, IHS itself reports that the funding level for urban Indian programs is "estimated at 22% of the projected need for primary care services."[22] Although it is widely conceded that reservations in Indian Country[23] should receive the "lion's share"[24] of the IHS budget, the general scarcity of health care facilities and hospitals in rural areas creates an unacceptable disparity in the allocation of resources between urban and rural Indians. This disparity is even greater considering the increasing number of American Indians now living in urban centers. Despite the common misconception that urban Indians are in better health than their rural counterparts, recent data proves that urban Indian health problems are, unfortunately, just as dire as for those living on reservations.[25]

When the urban Indian health care program was first authorized in 1976, House Report 94-1026 recognized that "[i]t is, in part, because of the failure of former [f]ederal Indian policies . . . that thousands of Indians have sought a better way of life in the cities,"

20. *Id.*, citing 42 C.F.R. 36.12. To be considered a person of Indian descent, an individual must be "regarded as an Indian by the community in which he lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation, or other relevant factors."

21. FORQUERA, *supra* note 18, at 8.

22. INDIAN HEALTH SERVICE, URBAN INDIAN HEALTH PROGRAMS, *at* http://www.ihs.gov/NonMedicalPrograms/Urban/UIHP.asp (last modified June 12, 2002) [hereinafter *Urban Indian Health Programs*].

23. "Indian Country" designates all land within the boundaries of a reservation, all dependent Indian communities within the United States, Indian allotments held in trust or restricted title and tribal lands held in trust or restricted status by the United States. 18 U.S.C. §1151 (2004).

24. *IHCIA Hearing, supra* note 8, at 4 (statement of Anthony Hunter, President, National Council of Urban Indian Health).

25. James May, *Urban Indians Suffer Health Problems at Higher Rates*, INDIAN COUNTRY TODAY, Apr. 21, 2004, *at* http://www.indiancountry.com/?1082573954.

and that "the same policies and programs that failed to provide Indians with an improved lifestyle on the reservations have also failed to provide [them] with the vital skills necessary to succeed in the cities."[26] The plight of urban Indians has not improved since the expansion of the IHS program to urban Indians in 1976, and given the increasing number of Indians residing in urban areas,[27] the federal government must modify the IHS program to render it more fully responsive to the health care needs of these American Indians. As Congress recognized when it first authorized the urban Indian health programs, the federal government's trust obligation to Native Americans does not end at the borders of the Indian reservations.

C. Changing Trends in Indian Health Care

Inadequate funding has plagued federal programs for Indian health care since their inception in 1832.[28] Despite congressional recognition of the desperate state of federal Indian health care services, Congress remains unwilling to allocate the funds necessary to meet the extraordinary demand for services.[29] However, beneath the persistent lack of financial resources is an emerging policy trend that threatens to *structurally* undermine—and perhaps ultimately eliminate—the federal government's obligation to finance American Indian health care. This Note argues that the trend towards greater tribal self-governance and self-determination opens the door for the federal government to retreat from its historical trust obligation to American Indians. Furthermore, as resource allocation is increasingly left to the discretion of individual tribes, health care services for off-reservation urban American Indians may be worse than they are under the current system. Tribes will be forced to make the ethically and politically difficult choice between allocating funds for Indian Country or for off-reservation tribal members.

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26. FORQUERA, *supra* note 18, at 9.

27. *Id*. at 1.

28. Congress authorized the first appropriation for Indian health care in 1832 for the purchase and administration of smallpox vaccine. As a precursor to the IHS, treaties in 1836 began providing for medical supplies and physician services as partial consideration for tribal land cessions to the federal government. Shelton, *supra* note 7, at 3, 5. It was not until 1904, when Indian health was in a state of crisis, that the federal government first paid some "systemic attention" to Indian health care. *How to Heal*, *supra* note 3, at 374.

29. On March 12, 2004, the U.S. Senate rejected an amendment to increase the Indian Health Service budget by $3.44 billion. As it exists, the Indian Health Service budget makes up only one-half of one percent of the Department of Health and Human Services overall budget. *Senator Daschle on Indian Health Service*, INDIANZ.COM, Mar. 12, 2004, *at* http://www.indianz.com/News/archive/000662.asp.

Part I of this Note will outline the present federal health care scheme that exists for American Indians, based on both the traditional trust relationship between the United States and American Indians and the statutory recognition of the trust duty. Part II will describe the differences between health care services available for urban Indians and those available to Indians residing on tribal reservations. Part III will examine the growing trend of tribal self-governance and analyze its tension with federal trust obligations. Part IV will consider the implications of the Bush Administration's "One-HHS" departmental consolidation initiative, and Part V will explore possible solutions that may offer more protection for the health and future of urban American Indians.

I.
THE EXISTING FEDERAL INDIAN HEALTH CARE SCHEME

A. *Federal Trust Doctrine*

The unique trust relationship between American Indians and the federal government derives from rights established when tribal land was relinquished by certain tribes[30] through treaties with the U.S. government in exchange for services and other protections.[31] The Supreme Court's decision in *Cherokee Nation v. Georgia*,[32] authored by Chief Justice Marshall, characterized the relationship between Indians and the U.S. as "unlike that of any other two people in existence."[33] In declaring Indians "denominated domestic dependent nations" and therefore not "foreign nations" within the meaning of Article III, section 2 of the U.S. Constitution, Marshall described Indians as being "in a state of pupilage. Their relation to the United States resembles that of a ward to his guardian."[34] Marshall's use of the wardship analogy is inapt: unlike traditional guardians, the U.S. holds title to the lands of the "ward." Additionally, the legal designation of a ward indi-

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30. Tribes that did not sign treaties with the U.S. are not federally recognized by Congress and therefore cannot be beneficiaries of any social services such as Indian health care. JILL MARSDEN, TURNING POINT PROGRAM, ISSUES AFFECTING PUBLIC HEALTH DELIVERY SYSTEMS IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES 3 (Dec. 1998), *available at* http://www.turningpointprogram.org/Pages/marsden.pdf.

31. U.S. COMM'N ON CIVIL RIGHTS, A QUIET CRISIS: FEDERAL FUNDING AND UNMET NEEDS IN INDIAN COUNTRY at 3 (July 2003), *available at* http://www.usccr.gov/pubs/na0703/na0204.pdf [hereinafter A QUIET CRISIS].

32. 30 U.S. 1 (1831).

33. *Id.* at 16.

34. *Id.* at 17.

cates a lack of legal capacity—a concept completely at odds with the notion of Indian tribes as self-governing, sovereign entities.[35]

1. *Violation of Trust:* Cobell v. Norton

The contrived nature of the "trustee and ward" description was recently scrutinized in *Cobell v. Norton,*[36] a class-action challenging federal mismanagement of Indian trust funds. The federal government routinely places proceeds generated from the Indian lands into a trust which is to be paid out to Indian holders of individual trust accounts. The U.S. Department of the Interior (DOI) was charged with management of the funds. The U.S. government, as trustee of the Individual Indian Money (IIM) trust, was alleged to have mismanaged Indian accounts to the tune of $176 billion.[37] Presiding Judge Royce Lamberth noted that "[s]uch behavior certainly would not be tolerated from private sector trustees."[38] Further, this malfeasance is inexcusable, "[f]or the beneficiaries of this trust did not voluntarily choose to have their lands taken from them; they did not willingly relinquish pervasive control of their money to the United States. The United States imposed this trust on the Indian people."[39]

The situation has failed to improve since Judge Lamberth's ruling. On April 5, 2004, court-appointed Special Master Alan L. Balaran resigned from the case, citing the DOI's repeated attempts to stonewall his investigation of their reform efforts as major impediments to any significant progress.[40] Balaran describes the DOI's "systemic failure to properly monitor the activities of energy companies leasing minerals on individual Indian lands," the consequences of which could cost those companies millions of dollars.[41] Balaran's letter concludes that there are "[b]illions of dollars at stake," and that it "is past time to get systems in place that will enable the Departments of the Interior

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35. Lynn H. Slade, *The Federal Trust Responsibility In a Self-Determination Era*, May 1999, *at* http://www.modrall.com/articles/article_26.html (citing Restatement (Second) Trusts § 7, Comment (a) (1959)).

36. Cobell v. Babbitt, 91 F. Supp. 2d 1 (D.D.C. 1999). When the lawsuit was filed in 1996, Bruce E. Babbitt was Secretary of the Interior. In January 2001, Gale A. Norton became Secretary of the Interior and the caption of the case changed from *Cobell v. Babbitt* to *Cobell v. Norton.*

37. Andrew Metz, *A Betrayal of Trust: Land Lease Deal with the U.S. is a Trail of Broken Promises*, NEWSDAY, Aug. 31, 2003.

38. Cobell, *supra* note 36, at 6.

39. *Id*.

40. Letter from Alan L. Balaran, Special Master, to Hon. Royce C. Lamberth, United States District Court for the District of Columbia, 1 (Apr. 5, 2004), *at* http://www.dcd.uscourts.gov/96-1285bg.pdf.

41. *Id.* at 2.

and Treasury to track trust data accurately in the future, as well as render an honest and reliable accounting in the present."[42] Judge Lamberth has ordered the DOI to "make a full and accurate historical accounting of all individual Indian trust accounts."[43] Yet despite the extremity of the mismanagement found in the *Cobell* case, the federal government still retains title over these Indian lands. As Chief Justice Marshall observed in 1831, this imposition of the trust relationship upon American Indians is unlike any other legal relationship.

2. *Scope of Trust*

The scope of the trust doctrine is difficult to define. As one scholar writes, "[a]sserting the existence of the trust relationship between Indian tribes and the federal government is far easier than defining its contours."[44] The ambiguity of the trust relationship has its roots in its original articulation by Chief Justice Marshall. While in *Cherokee Nation*, Marshall analogized the relationship of the Indian tribes to the federal government to that of "ward to his guardian,"[45] one year later, in *Worcester v. Georgia*,[46] Marshall analogized that same relationship to one of "feudatory and tributary states of Europe."[47] The first characterization connotes a state of subjugation while the second "treats tribes as sovereign entities allying themselves to a stronger power."[48] This second formulation casts the relationship as one of government-to-government.

To the extent that the wardship analogy still persists, it has become "rehabilitated as a trustee-beneficiary relationship."[49] While the government-to-government interpretation of the trust doctrine has become predominant since the late twentieth century, the concept of a trustee-beneficiary manifests itself in federal court rulings where tribes, as beneficiaries, are "entitled to hold their federal trustee accountable."[50] In this way, the "precise legal contours" of the trust doctrine "remain unchartered and its various interpretations inconsistent

42. *Id*. at 3.
43. *Daschle: Provide Justice to Indian Trust Account Holders*, INDIAN COUNTRY TODAY, Mar. 26, 2004, *at* http://www.indiancountry.com/content.cfm?id=1080319728.
44. Nell Jessup Newton, *Symposium: The Indian Trust Doctrine After the 2002-2003 Supreme Court Term*, 39 TULSA L. REV. 237, 237 (2003).
45. *Id.*
46. 31 U.S. 515 (1832).
47. Newton, *supra* note 44, at 237.
48. *Id.*
49. *Id*. at 239.
50. *Id.*

with one another," despite the central role it plays in Indian law.[51] "Three components define the trust relationship: land, self-governance, and social services."[52] Thus, the concept of trust has tremendous variation. For example, in *Cobell*, there are literal apportionments of land from which individual American Indians are entitled to earn royalties.[53] But with social services, there is nothing so concrete upon which to rely, and thus the federal trust "obligation is ill-defined with respect to specific rights and responsibilities."[54] In the social service context, the government's trust responsibility has been construed as insufficient, in and of itself, to form the basis of a claim or to constitute a legal entitlement.[55] Although the federal trust obligation is often invoked in statements to and by Congress, the empty promises that have resulted from budgetary restrictions suggest that the trust relationship is nothing but a sham.

3. *Trust Responsibility to Provide Indian Health Care*

The notion of a federal trust obligation to provide social services arises from the U.S. government's forced relocation policies of the late 1870s which deprived Indians of their traditional economy and made them dependent upon the federal government. Under these policies, "the BIA became the provider of basic necessities and thus successfully placed Indians in a state of coerced dependency."[56] Federally-provided social services, such as Indian health care, are said to derive from this dependency.

There have been legislative attempts to cast Indian health services as a legal entitlement, pursuant to a *constitutional* trust responsibility. U.S. Representative Frank Pallone, vice chair of the Native American Caucus, wants to make the IHS an entitlement program like Medicare or Social Security.[57] The Supreme Court "failed to articulate the source of the fiduciary duties owed by the government, whether and how the United States and the Indian tribes manifested an

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51. Note, *Rethinking the Trust Doctrine in Federal Indian Law*, 98 HARV. L. REV. 422, 422 (1984).

52. A QUIET CRISIS, *supra* note 31, at 3.

53. Cobell, *supra* note 36, at 9-11.

54. Rose L. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices*, 21 AM. INDIAN L. REV. 211, 219 (1997) [hereinafter *Providing for the Health Care Needs*].

55. *Id.*

56. Cobell, *supra* note 36, at 7.

57. Sen. Tom Daschle & Rep. Nancy Pelosi, News Conference on Minority Health Disparities Legislation (Oct. 21, 2003), *in* FEDERAL DOC. CLEARING HOUSE, INC. (on file with the New York University Journal of Legislation and Public Policy) [hereinafter *Daschle News Conference*].

intent to create a trust relationship, and how the United States intended to fulfill its role as guardian of the tribes."[58] The Supreme Court's enunciation of the trust doctrine never indicated "whether the purpose of the 'trust' was to protect tribal property, to buttress the tribes' political and social structures, to achieve some combination of these, or to do something else entirely."[59] However, several pieces of federal legislation have reaffirmed the implied federal obligation to provide Indian health care, as discussed below.

B. The Statutory Scheme

Although Congress did make limited appropriations for Indian health care in the 19th century, the Snyder Act of 1921 was the federal government's first broad formulation of Indian health care policy.[60] In 1912, President Taft sent a summary to Congress that detailed the results of several surveys showing the severity of health and sanitary conditions on Indian reservations.[61] Eleven years later, Taft's actions resulted in the enactment of the Snyder Act. The Act gave Congress the authority to appropriate money "for the benefit, care and assistance of the Indians *throughout* the United States. . .[f]or relief of distress and conservation of health."[62] Although the Act did provide basic authorization for federal involvement in Indian health, authorization was limited to discretionary programs; the Act did not extend to entitlement to specific services, and failed to identify levels or goals for funding.[63]

In 1928, the non-governmental Institute for Government Research released The Problem of Indian Administration, popularly known as the Merriam Report, which looked at health services for Indians in comparison with health services for the general population.[64] The Merriam Report aimed to identify the factors that would aid American Indians in meeting a minimum standard of health.[65] Although the Merriman Report and federal policy reflected assimilationist philosophies, the federal provision for American-Indian health care

58. Note, *Privatization of Federal Indian Schools: A Legal Uncertainty*, 116 HARV. L. REV. 1455, 1463 (2003).

59. Note, *Rethinking the Trust Doctrine*, *supra* note 51, at 425.

60. *Providing for the Health Care Needs*, *supra* note 54, at 215.

61. Shelton, *supra* note 7, at 7.

62. *2004 Budget Hearings*, *supra* note 1, at 2 (testimony of Kay Culbertson, President, National Council of Urban Indian Health) (citing 25 U.S.C. § 13).

63. *How to Heal*, *supra* note 3, at 376–77.

64. Shelton, *supra* note 7, at 8.

65. *Id.*

serves to illustrate the unique relationship between the federal government and the American Indian nations.

1. *The Transfer Act*

Working with the BIA, public health medical officers provided health services for American Indians with the appropriations provided by the Snyder Act. By 1954, the state of Indian health care under the BIA was so abysmal that Congress passed the Transfer Act[66] to shift responsibility for Indian health to the Public Health Service (PHS), and by 1955 the Indian Health Service was created as a special branch of the PHS responsible for administering American-Indian health care programs.[67] Today the IHS is an agency of the U.S. Department of Health and Human Services (HHS).

2. *The Indian Health Care Improvement Act*

The Indian Health Care Improvement Act (IHCIA),[68] passed in 1976, "represents the first legislative statement of a goal for federal Indian health programs and a requirement for the provision of resources."[69] In addition to providing authority for expanded IHS programs, the IHCIA went far beyond the scope of the Snyder Act to provide additional guidance for comprehensive developments such as the recruitment of health care professionals, a scholarship program for Indian students pursuing work in health professions, and the repair and construction of health care facilities.[70] Notably, Title V of the Act established services for urban Indian individuals.[71] The IHCIA not only provided for more urban health centers, but also amended the Social Security Act "to permit reimbursement by Medicare and Medicaid for covered services provided by the IHS."[72] However, it is im-

66. Transfer Act, ch. 658, 68 Stat. 674 (1954) (codified as amended at 42 U.S.C. §§ 2001-2005 (1998)).

67. NATIONAL INDIAN HEALTH BOARD, REASONS TO SUPPORT REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT H.R. 2440 AND S. 556, *at* http://www.nihb.org/docs/ihcia_reasons_to_support.pdf.

68. Pub. L. No. 94-437, 90 Stat. 1400 (codified in scattered sections of 25 U.S.C.).

69. *How to Heal*, *supra* note 3, at 385-86.

70. *See How to Heal*, *supra* note 3, at 386; *Hearing on the Indian Health Care Improvement Act Reauthorization of 2003*, 108th Cong. (2003), *available at* 2003 WL 1822041 (F.D.C.H.) [hereinafter *Reauthorization Hearing*] (statement of Dr. Charles Grim, Interim Director, Indian Health Services).

71. *See* Shelton, *supra* note 7.

72. *How to Heal*, *supra* note 3, at 386. The Social Security Act, § 1800 reads "(a) hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization. . .shall be eligible for payments under this title."

portant to note that Title V programs represent only a small proportion of the IHS budget, and are not direct delivery services, but have traditionally been contracted out.[73]

3. Indian Self-Determination Act

The Indian Self-Determination Act of 1975 (ISDA) emerged out of a belief that the federal domination of American-Indian service programs hindered the advancement of American-Indian interests.[74] The ISDA enabled tribes to take over the management of their own health care programs through federal contracts and with continued federal oversight.[75] This contractual program is designated as "Self-Determination" under Title I of the ISDA, whereas Title III establishes "Self-Governance" programs which permit tribes to enter into compacts that give tribes even greater independence from federal oversight.[76] Tribes negotiating for Title I contracts or Title III compacts undergo planning and budget/program negotiations with the IHS and/or the BIA, and ultimately draft a formal agreement with a detailed annual funding agreement.[77] However, in the case of Title III compacts, such agreements "may include 100% of the tribal share of programs/services hitherto operated by IHS. . . ."[78] In the Year 2003 Profile, the IHS reported that 265 tribes (out of the more than 560 tribes which are federally recognized) and tribal organizations contracted under Title I, and that tribes administered 52% of the IHS fiscal year 2002 appropriation through either self-determination contracts or self-governance compacts.[79]

Congress amended the ISDA in 2000 to authorize a permanent self-governance program in the IHS and require the development of implementation regulations.[80] With good reason, tribes have long felt that federal policy makers fundamentally misunderstand the issues and realities that define American Indian life. Self-determination has increased "the involvement of American Indian people in planning, priority setting and fashioning delivery systems. . . ."[81]

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73. Marsden, *supra* note 30, at 4.
74. *How to Heal*, *supra* note 3, at 384.
75. THE ASSOCIATION OF AMERICAN INDIAN PHYSICIANS, POLICY PAGE (2001), *at* http://www.aaip.com/policy/AAIP_Policy_Page.html.
76. *Id*.
77. Marsden, *supra* note 30, at 6.
78. Marsden, *supra* note 30, at 6.
79. INDIAN HEALTH SERVICES, YEAR 2003 PROFILE (Mar. 2003), *at* http://info.ihs.gov/Infrastructure/Infrastructure6.pdf.
80. INDIAN HEALTH SERVICES, TRIBAL SELF-DETERMINATION (Feb. 2001), *at* http://info.ihs.gov/TreatiesLaws/Treaties2.pdf.
81. Marsden, *supra* note 30, at 1.

Yet, despite its seeming popularity, not all tribes have rushed to implement administrative self-determination. The response has been mixed, with some tribes transitioning rapidly into self-governance and others more hesitant, in recognition of their lack of experience in the delivery of health care services.[82] Some tribal leaders fear that contracting or compacting may lead to "termination by appropriation," wherein it would be possible for the federal government to deny responsibility for all aspects of the programs other than funding and subsequently to cut funding.[83] As tribes have already witnessed with the IHS, it is easy for Congress to cut funding for federal programs.

C. The Indian Health Care System

1. Indian Health Statistics

Notwithstanding the lofty goals set forth by the IHCIA, grossly inadequate funding is an intractable impediment to meaningful progress for the health of the Indian nations. The government spends $5,000 per capita every year for health care for the general population, $3,803 for federal prisoners, and yet only $1,914 per capita for Indian health care.[84] The death rate of Indians from various diseases, as compared to the rest of the population, is 52% higher for pneumonia and influenza, 318% higher for diabetes, 650% higher for tuberculosis, and 670% higher for alcoholism.[85] The U.S. Commission on Civil Rights reports that, compared to other racial or ethnic groups, Indians experience a higher rate of disease occurrence, and life expectancy shorter by nearly six years. Further, approximately 13% of all Native American deaths occur under the age of 25, a rate triple that of the general U.S. population.[86] Given these statistics, it is indisputable that the government is falling far below its goal of providing American Indians with health care at "the highest level,"[87] or even at a level on par with the rest of the nation.

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82. *How to Heal*, *supra* note 3, at 388.

83. Shelton, *supra* note 7, at 10–11.

84. *Sen. Daschle: The Time Has Come to Improve Health Care in Indian Country*, Indian Country Today, Oct. 24, 2003, *at* http://www.indiancountry.com/content.cfm?id=1067005237.

85. *Daschle News Conference*, *supra* note 57.

86. A Quiet Crisis, *supra* note 31, at 34.

87. *2004 Budget Hearings*, *supra* note 1 (statement of Charles W. Grim, Interim Director Indian Health Service).

2. *IHS Budget Stagnation*

On March 11, 2004, in a floor speech preceding a Senate vote on an amendment to increase the budget for the IHS by $3.44 billion, Senator Tom Daschle observed that the IHS budget "makes up only one-half of one percent of the HHS budget. That means that the health system with the sickest people and the greatest need gets the smallest increases."[88] The Senate rejected the amendment, approving only an increase of $292 million, despite the fact that the provision of adequate clinical services for eligible Indians[89] alone would require an increase of $9.079 billion.[90]

In 2004, President Bush's enacted budget for the IHS was $2.9 billion, which was a 2.5% increase over the budget for 2003.[91] The President's budget request for 2005 is $3 billion, a 1.6% increase.[92] As Don Kashevaroff, president of the Alaska Native Tribal Health Consortium, points out, the 1.6% "increase" is far outpaced by the rate of inflation.[93] Calling inflation "the deadly enemy," Kashevaroff argues that "[t]he rising cost of health care wipes out any gains in the IHS budget."[94] Concerns about inflation are echoed elsewhere. One study asserts that "the IHS budget has failed to keep pace with medi-

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88. *Senator Daschle on Indian Health Service*, INDIANZ.COM, Mar. 12, 2004, *at* http://www.indianz.com/News/archive/000662.asp (text from floor speech by Senator Tom Daschle).

89. An individual's enrollment as a member of a federally recognized tribe is the most common standard applied for eligibility for health services from the IHS. According to the IHS Manual,

> A person may be regarded as within the scope of the Indian health program if he. . .A. Is of Indian and/or Alaska Native descent. . .B. Is an Indian of Canadian or Mexican origin, recognized by any Indian tribe or group as a member of an Indian community served by the Indian Health program; or C. Is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through post partum (usually 6 weeks); or D. Is a non-Indian member of an eligible Indian's household and. . .services are necessary to control a public health hazard. . . .

INDIAN HEALTH SERVICE, INDIAN HEALTH MANUAL, ELIGIBILITY REQUIREMENTS FOR HEALTH SERVICES FROM THE INDIAN HEALTH SERVICE, *at* http://www.ihs.gov/GeneralWeb/HelpCenter/CustomerServices/elig.asp (last modified Mar. 7, 2002).

90. *Daschle Asks Bush to Increase Funding for IHS*, INDIANZ.COM, Dec. 18, 2003, *at* http://www.indianz.com/News/archives/003077.asp. Senator Daschle maintains that the IHS would need at least $9.079 billion if it is expected to provide clinical services to all eligible Native Americans.

91. Jerry Reynolds, *Shortfalls in Bush Budget Request*, INDIAN COUNTRY TODAY, Feb. 13, 2004, *at* http://www.indiancountry.com/content.cfm?id=1076686908.

92. *Id.*

93. *Proposed Boost in IHS Budget Rejected by Senate*, INDIANZ.COM, Mar. 12, 2004, *at* http://www.indianz.com/News/archive/000663.asp.

94. *Id.*

cal cost inflation and population growth."[95] A director for the National Council of Urban Indian Health testified that although congressional "appropriations have increased, these increases have not allowed for medical inflation increases, general inflation increases, salary increases or population growth."[96]

3. IHS Service Structure

The IHS provides services for 1.6 million American Indians and Alaska Natives residing on or near reservations.[97] Direct health services, excluding those operated by tribes, are administered through a decentralized system of twelve Area Offices and 155 IHS and tribally managed service units.[98] IHS services are intended by Congress to be residual to the services of other providers.[99] Alternative sources of health care, such as Medicare, Medicaid, and private insurance, are to be used first, with IHS as a service provider and/or payor of last resort.[100] Even though the IHS has never had the funds necessary to provide services comparable to traditional private employee health care, it has developed a comprehensive service delivery system, including preventative care, curative care, rehabilitative services, and environmental services.[101] However, the level of health services varies from reservation to reservation. A typical base of operations for service units includes a small hospital or health center, with service type and level determined by individual Area Offices.[102] Although many commentators agree that IHS does an impressive job given their limited resources, IHS facilities are nevertheless overcrowded and underfunded.[103] Only 19 of the 49 IHS and tribal hospitals across the U.S. have surgery programs; Indians seeking specialized treatment must sometimes travel great distances for vital health care.[104]

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95. Marsden, *supra* note 30, at 5.

96. *Indian Health Care Improvement Act: Joint Hearing on S. 556 and H.R. 2440 Before the Comm. on S. Indian Affairs and the House Resources Comm.*, 108th Cong. 108–41 (2003) [hereinafter *Hearing on S. Indian Affairs*] (statement of Kay Culbertson, Executive Director, Denver Indian Health and Family Services).

97. INDIAN HEALTH SERVICE, YEAR 2003 PROFILE, *supra* note 79.

98. *Id.*

99. *Providing for the Health Care Needs*, *supra* note 54, at 225.

100. *Providing for the Health Care Needs*, *supra* note 54, at 225.

101. Marsden, *supra* note 30, at 4–5.

102. *Providing for the Health Care Needs*, *supra* note 54, at 232.

103. U.S. Commission of Civil Rights Chairwoman Mary Frances Berry commented that "no matter how hard IHS tries, their needs haven't been given a preferred position within the budget on the part of the national government." *Minority Health: Civil Rights Commission Discusses Indian Health Care*, 96 MANAGED CARE WEEKLY DIGEST, Nov. 10, 2003, *available at* 2003 WL 8940090.

104. *Id.*

The Congressional findings that preface the IHCIA state that "[f]ederal health services to maintain and improve the health of the Indians are . . . *required* by the Federal Government's historical and unique legal relationship with, and resulting *responsibility* to, the American Indian people."[105] The findings further identify a "major national goal. . .to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level. . ."[106] The IHCIA, at the very least, codifies the federal government's obligation to ensure sufficient health care facilities are available for American Indians. Yet, as noted above, American Indians continue to suffer a higher disease occurrence rate than any other racial or ethnic group in America.[107] The current availability of specialized treatment for rural Indians fails to satisfy the high burden set by the IHCIA.

IHS also provides funds for contract health service programs (CHS), through which health care is purchased from private health care providers.[108] If a tribe has no direct care services it will use CHS to purchase all of its services. Otherwise, tribes will use CHS to purchase specialty services and inpatient care.[109] As discussed further in Part II, urban Indians are not eligible for CHS.

4. *Economies of Scale*

When tribes opt under the ISDA to take their share of funds, the funds available for IHS as a whole (and for any tribes that have not opted to self-govern) are consequently reduced. These funds were "previously used by IHS for administration, technical assistance and coordination, epidemiology and surveillance at the service unit, area office and headquarters levels."[110] In an article co-written by former IHS director Dr. Everett R. Rhoades, the authors argue that removal of tribal shares from the IHS resource pool creates serious market inefficiencies—essentially, self-governance constitutes movement away from "economies of scale," which exist when "a larger operation results in a lower per unit cost of production."[111] In other words, the health care system is most efficient, of the highest quality, and best

105. 25 U.S.C. § 1601(a).
106. 25 U.S.C. § 1601(b).
107. A Quiet Crisis, *supra* note 31, at 34.
108. Indian Health Service, Health Care Away from Home Reservation, *at* http://www.ihs.gov/generalweb/helpcenter/customerservices/chsda.asp (last modified Sept. 13, 2001).
109. Marsden, *supra* note 30, at 5.
110. *Id.*
111. *Providing for the Health Care Needs*, *supra* note 54, at 238.

able to keep pace with technological change when it relies on economies of scale. Dr. Rhoades and his colleagues argue that, operating with its full resources during the pre-tribal compact and contract era, the IHS had been able to utilize its very limited resources efficiently by integrating services both regionally and nationally.[112] Given the fact that Indian Country mostly consists of isolated rural areas and reservations, the IHS's national or regional pooling of resources can achieve much more efficiency than any single local entity would be able to sustain. Isolated geographic locations "require cooperation among service providers rather than increased competitive pressures that may result" when tribes opt for self-governance compacts.[113]

5. *Downsizing the IHS*

Another perceived downside to the self-governance trend is that, as tribal shares are removed and the IHS is necessarily downsized, direct services for tribes remaining with the IHS are systematically diminished. This decreases a tribe's incentive to stay with IHS; otherwise non-self-governing tribes are pressured to protect themselves by opting for self-governance, regardless of the effect on their health care, which in turn pressures still other tribes to leave the IHS.[114] Thus, the fragmentation of the IHS delivery system results in a significant downsizing of the entire IHS administrative structure.[115] The downscaling of the IHS is no secret; IHS itself reports that it "will continue to downsize relative to the continued increase in self-determination activity and the transfer of IHS resources to tribal governments."[116]

D. *Conclusion*

The slow but steady movement towards the elimination of the IHS—combined with congressional failure to allocate more resources for either form of Indian health care—signals a retreat from the federal trust obligation towards Indian health care. Dr. Rhoades and his co-authors surmise that some tribes "fear that self-determination and self-governance will lead to the dissolution of the IHS and, with it, dissolution of federal responsibility for Indian health care."[117] In the seven years since the publication of Dr. Rhoades' article, such dissolu-

112. *Id.*
113. *Id.*
114. *Id.*
115. Marsden, *supra* note 30, at 5.
116. INDIAN HEALTH SERVICE, TRIBAL SELF-DETERMINATION, *supra* note 80.
117. *Providing for the Health Care Needs*, *supra* note 54, at 239.

tion is visible. Although compacts with local and tribal agencies can lead to services greater and more efficient than the IHS delivery system, it is necessary to keep a watchful eye on the backward creeping of the federal government's fulfillment of its trust obligation. Tribes have not yet received the funding necessary to improve—and oftentimes simply maintain—their health care systems, and congressional funding has even failed to keep up with the rate of inflation.

The Bush administration has already moved to collapse the IHS into the greater organizational structure of the HHS in the "One-department" or "One-HHS" initiative, which will be explored more thoroughly in Part IV of this Note. To the extent that the IHS is reduced and heath care is administered by tribes themselves, urban Indian heath care will suffer a tremendous blow. The interests of urban Indians will necessarily be in conflict with on-reservation Indians with respect to the allocation of dangerously scarce resources.

II.
The Urban Indian Health Care System

Like their reservation counterparts, urban American Indians suffer enormous health disparities as compared to the general population.[118] The Seattle Indian Health Board's Urban Indian Health Initiative describes the current state of urban Indian health as "a national crisis."[119] Urban Indians have significant problems regarding access to care, with urban Indian health care centers receiving only 1.12% of the total IHS budget despite the fact that 66% of American Indians reside in urban areas,[120] and 25% of such Indians were living in poverty in the year 2000.[121]

A. *The IHS and Urban Indian Projects*

The IHS provides financial assistance to 34 urban projects across America, with services ranging from community health to comprehensive primary health care.[122] When these national non-profit projects receive contracts or grants from the IHS, the funding comes from Title V of the IHCIA.[123] These contracts and grants meet only 22% of

118. Lornet Turnbull, *Urban Indians Face Health Disparities, Study Finds*, The Seattle Times, Mar. 18, 2004, at B1.
119. *Id.*
120. *2004 Budget Hearings*, *supra* note 1, at 7 (testimony of Kay Culbertson, President, National Council of Urban Indian Health).
121. Turnbull, *supra* note 118.
122. Indian Health Service, Year 2003 Profile, *supra* note 79.
123. Pub. L. 100–713, 102 Stat. 4820. *See* Katherine McIntire Peters, *Urban Challenge*, Gov't Executive, Dec. 2000, at 27.

urban programs' needs, and the programs must seek other forms of funding to supplement the finances provided by the IHS.[124] One program, for example, has a patchwork of 60 different funding sources.[125]

1. Inadequacies in Funding

The National Council of Urban Indian Health (NCUIH) reports that due to inadequate funding urban programs can serve only 95,767 of the estimated 605,000 eligible urban Indians.[126] Still, there are 18 other cities with an urban Indian population large enough to warrant an Urban Indian Health Program.[127] In its testimony before Congress on the President's 2004 Budget Request, the NCUIH recommended a $6 million increase to the President's proposal, briging the proposal amount to $35,947,000.[128] Conceding that this would not meet the total need of $1.5 billion, the requested increase would enable the Urban Indian Health Program to provide direct medical services in several urban areas, as opposed to the primarily outreach and referral services it currently offers.[129]

2. Service and Facilities

Services offered by different Urban Indian Health programs vary widely. Some offer only guidance and referrals, while those with better funding deliver comprehensive ambulatory health care.[130] Specialized services require referral providers. Some programs offer dental care, and most offer educational programs and outreach services for alcohol treatment, AIDS and STD prevention, and family and group counseling. Inadequate funding limits the breadth and quality of care available. In his testimony before the Senate Committee on Indian Affairs, Ron Morton, the Executive Director of the San Diego American Indian Health Center, described the outdated and nearly dilapi-

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124. *"A Partnership For a New Millennium: Addressing the Unmet Health Care Needs in Indian Country": Oversight Hearing Before the S. Comm. on Indian Affairs*, 105th Cong. (1998) [hereinafter *Partnership Hearing*] (statement by Ron Morton, Executive Director, San Diego American Indian Health Center), *available at* http://indian.senate.gov/1998hrgs/0521_rm2.htm.

125. *Hearing on S. Indian Affairs*, *supra* note 96 (statement of Kay Culbertson, Executive Director, Denver Indian Health and Family Services).

126. *2004 Budget Hearings*, *supra* note 1, at 7 (testimony of Kay Culbertson, President, National Council of Urban Indian Health).

127. *Urban Indian Health Programs*, *supra* note 22.

128. *2004 Budget Hearings*, *supra* note 1, at 8 (testimony of Kay Culbertson, President, National Council of Urban Indian Health).

129. *Id.*

130. *Urban Indian Health Programs*, *supra* note 22.

dated facility from which his clinic operates.[131] After speaking of leaky ceilings, the four-by-eight foot pharmacy, and old electrical wiring, Morton described how the lack of funding to the programs made even obsolete machines welcome.[132] Morton went on to report that urban Indian health programs have never received funding for facilities improvement, adolescent substance abuse treatment, contract support costs, or environmental health, despite the fact that there are provisions for these funds in the IHS budget.[133]

Under the IHS scheme, Indians living away from their reservations for more than 6 months lose their free contract health care.[134] For free emergency health care from an IHS or tribal hospital, urban Indians must travel great distances to return to their reservations.[135] IHS urban projects may refer Indians to an IHS hospital if one is located in the area, but urban projects do not provide hospital care directly.[136] Urban Indians are often unaware of their entitlement to emergency treatment under the Emergency Medical Treatment and Active Labor Act (EMTALA). Many Indians, particularly the elderly, are simply not comfortable seeking health care from non-Indian providers. They will often forego treatment if culturally-appropriate care is unavailable.[137]

3. *Medicaid and Reimbursement Rates*

Many Indians who move into urban areas typically do not sign up for health care benefits such as Medicaid even when eligible.[138] Some Indians feel that it is the federal government's obligation to provide them with Indian-specific care and so they "should not have to enroll

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131. *Partnership Hearing*, *supra* note 124, at 1 (statement by Ron Morton, Executive Director, San Diego American Indian Health Center).

132. *Id.* at 2.

133. *Id.*

134. Allison Farrell, *Report: Indian Health Care is Suffering*, MISSOULIAN, Oct. 30, 2003, at B1. Tribal or non-urban IHS providers can use contract health service programs (CHS) to purchase specialty services and inpatient care from private health care providers.

135. *See id.*

136. *Providing for the Health Care Needs*, *supra* note 54, at 223.

137. Levanne R. Hendrix, *Health and Health Care of American Indian and Alaska Native Elders*, ETHNOGERIATRIC CURRICULUM MODULE, *at* http://www.stanford.edu/group/ethnoger/americanindian.html ("Culturally appropriate interventions depend upon the elder's individual tribal affiliation, level of traditional beliefs, and acculturation to Western biomedical health care system. Many older AI/AN exhibit a basic distrust of the Western health care system. . . .").

138. Brian Stockes, *Urban Indian Health Care Concerns Voiced*, INDIAN COUNTRY TODAY, Aug. 21, 2001, *at* http://IndianCountry.com/?133.

in health care programs for the general population."[139] Some refuse to undergo the Medicaid application process, feeling that it is too intrusive.[140] Others are misinformed about the nature of coverage through Medicare or Medicaid—many have been told incorrectly that they are only entitled to apply to IHS for health care services.[141] Still other obstacles include the expense, time, and skill necessary to complete proper documentation as it is demanded by various Medicaid enrollment forms, and the varying costs of co-payment requirements, which in some cases results in the application of liens on patients' property when they cannot afford to pay their medical bills.[142]

Despite these barriers, Medicaid "has become an increasingly important financial resource for urban Indian health providers of direct clinical services."[143] Unlike the limited funds available to IHS, Medicaid is an open-ended entitlement program and has become increasingly essential to funding for many IHS, tribal, and urban programs.[144] Medicaid provides financial incentives for states to encourage the use of IHS and tribal health facilities because the federal government provides a matching rate of 100% for services provided by Tribes or non-urban IHS facilities.[145] The 100% reimbursement rate is in contrast to the 57% average that the federal government typically pays to cover a given state's Medicaid costs.[146] Not only does the 100% reimbursement rate remove "any financial disincentive a state might otherwise face in paying for covered services provided to Native American Medicaid beneficiaries. . . because a state doesn't have to commit any of its own funds," but the matching rate "also provides a financial incentive for states to encourage Native American beneficiaries to use IHS and tribal providers."[147] Unfortunately, services provided by urban Indian programs do not receive the same 100% reimbursement rate. The effect of this rule leaves "urban Indian health programs in a

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139. FORQUERA, *supra* note 18, at 13.

140. *Id.*

141. *Id.*

142. U.S. COMM'N ON CIVIL RIGHTS, STAFF DRAFT, BROKEN PROMISES: EVALUATING THE NATIVE AMERICAN HEALTH CARE SYSTEM 118 (July 2004), *at* http://www.usccr.gov/pubs/nahealth/nabroken.pdf. Although some states specifically exempt American Indians from co-payment requirements, most do not, and this type of cost sharing impedes enrollment in public programs.

143. FORQUERA, *supra* note 18, at 13.

144. SCHNEIDER & MARTINEZ, *supra* note 16, at ii.

145. *Id.*

146. *Id.*

147. *Id.*

Medicaid provider category that is less favorable from the states' standpoint."[148]

In their most recent evaluation of Native American health care, the U.S. Commission on Civil Rights emphasized the importance of restructuring the reimbursement rate such that it is linked to the individual patient rather than the IHS facility from which the patient receives care.[149] Because states are only fully reimbursed when Native Americans receive health services at approved IHS facilities, multiple sources of Indian health care are excluded from full reimbursement: contracted health care, long-term care, home care, and urban Indian care.[150] Under the present scheme, a state's financial incentive to enroll Indian patients in Medicaid depends entirely on the type of facility from which the patient seeks care and necessarily excludes vital sources of health care.[151]

Medicaid is, nevertheless, often the only health care on which many urban Indians can rely. In Montana, for example, almost 39% of Indians are dependent on Medicaid, while only 8% of the rest of the state population relies on the program.[152] At the Denver Indian Health and Family Services (DIHFS), only 8% of the patients are employed full time and of those patients only 1.5% have private health insurance.[153] Ninety-two percent of the patients have no insurance, including Medicare, Medicaid, or S-CHIP.[154] Vividly illustrating the shortfalls of the current system, the director of DIHFS noted that an uninsured urban tribal member has three options in the event of a catastrophic illness or disaster: a) seek care at one's home reservation—potentially facing a waiting period of up to 6 months until CHS eligibility kicks back in, b) apply for Medicaid and other indigent care insurance, or c) do nothing.[155]

As many state Medicaid programs are shifting from fee-for-service to managed care organizations (MCOs) or primary care case management organizations (PCCMs),[156] urban Indian facilities face significant challenges as they lack the financial resources or the expertise to become Medicaid MCOs. When urban Indian facilities cannot

148. *Id.* at 9.
149. U.S. Comm'n on Civil Rights, Broken Promises, *supra* note 142.
150. *Id.* at 112.
151. *Id.*
152. Farrell, *supra* note 134.
153. *Hearing on S. Indian Affairs*, *supra* note 96 (statement of Kay Culbertson, Executive Director, Denver Indian Health and Family Services).
154. *Id.*
155. *Id.*
156. Schneider & Martinez, *supra* note 16, at iii.

reorganize as MCOs, they can either subcontract with a Medicaid MCO in their service area or remain unaffiliated with any MCO.[157] Both these options would seriously affect patient volume and Medicaid revenues.[158] While the only practical option may be to subcontract with one or more Medicaid MCOs or PCCMs, there is no assurance that urban Indian health programs will be able to affiliate on terms that are favorable to their organization.[159] If urban Indian programs received the 100% reimbursement rate that other IHS and tribal providers receive, then they would stand a greater chance of successively qualifying as MCOs or PCCMs. The likely result of these structural changes to Medicaid is to force Medicaid-eligible Indians to enroll in an MCO or PCCM that is not affiliated with the IHS or a tribe. Consequently, an urban Indian's ability to choose a culturally-appropriate provider would be either greatly reduced or eliminated.

Finally, urban organizations are not protected by the Federal Tort Claims Act.[160] Providers of urban Indian health care must therefore bear the high cost of malpractice insurance, creating a major barrier in efforts to become direct medical service providers.[161] Proposals for further improvements in the urban Indian health care network have been included in the most recent reauthorization draft of the IHCIA, which will be discussed in Part V.

III.
Implications of the Movement Towards Self-Determination and Governance

Despite its drawbacks, the trend toward greater tribal self-determination and self-governance is a desirable development. As the *Cobell* litigation shows, there are times when the United States, as trustee, has egregiously wronged American Indians. To many, the terminology of the trust doctrine itself—"ward and guardian"—reinforces an identity of post-colonial inferiority. Respect for the autonomy of Indian tribes seems to imply that "some mechanism. . .be implemented in order to determine whether Native Americans desiring to manage their affairs are competent and capable of doing so."[162] Indian health care, however, is far more complicated than a simple

157. Forquera, *supra* note 18, at 14.
158. *Id.*
159. Schneider & Martinez, *supra* note 16, at 14.
160. *Hearing on S. Indian Affairs*, *supra* note 96 (statement of Kay Culbertson, Executive Director, Denver Indian Health and Family Services).
161. *Id.*
162. Jeremy R. Fitzpatrick, Note, *The Competent Ward*, 28 Am. Indian L. Rev. 189, 195 (2003).

question of autonomy versus dependency. Undoubtedly, many tribes have accepted the opportunity to implement a self-determined or self-governed health system, believing that they can create a system superior to IHS service. It is also clear that the secondary effects of tribal self-determination, such as the "increased employment of tribal members, through tribal preferences for hiring and promoting tribal members into tribal administrative and staff positions,"[163] help bring leadership skills, educational advancement, and economic enhancement to much of Indian Country. However, the ISDA's version of self-governance is not a satisfactory path to self-determination.[164]

A. *Limitations of the ISDA*

According to the IHS Office of Tribal Self-Governance (OTSG), "Self-Governance is fundamentally designed to provide Tribal governments with more control and decision-making authority over the Federal financial resources provided for the benefit of Indian people."[165] This system is explicitly predicated on the provision of federal financial resources. OTSG asserts that when administration and management authority is in tribal hands, federal funds will be more efficiently employed.[166] While the rhetoric sounds appealing, the reality remains that tribes attempting self-governance and self-determination are hamstrung by statutory limitations and the unremitting inadequacy of financial resources.[167]

In 1998, 94% of tribal leaders and health system directors reported plans to enter into self-determination or self-governance agreements with the IHS.[168] For the transition to work, increased federal funding was critical. It must be understood that "tribal self-governance in the provision of health care does nothing, in and of itself, to increase and enhance the very limited pool of health care resources."[169] What's more, tribal provision of health care "may also result in increased costs of production as tribes compete within and among themselves for these limited resources."[170]

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163. Raymond Cross, *Tribes As Rich Nations*, 79 OR. L. REV. 893, 930 (2000).
164. *Id.* at 931.
165. INDIAN HEALTH SERVICE, OFFICE OF TRIBAL SELF-GOVERNANCE, PURPOSE AND METHOD OF OPERATION, *at* http://www.ihs.gov/NonMedicalPrograms/SelfGovernance/index.asp.
166. *Id.*
167. Cross, *supra* note 163, at 931.
168. *Hearing on Fiscal 2005 Budget: Indian Affairs*, 108th Cong., (Feb. 11, 2004) [hereinafter *Fiscal 2005 Budget*] (statement of Sally Smith, Chairman, National Indian Health Board).
169. *Providing for the Health Care Needs*, *supra* note 54, at 238-39.
170. *Id.* at 239.

In the budget request for 2005, tribes asked for an additional $100 million to meet the current contract support cost shortfall, as well as a $20 million increase to sustain the tribal management of IHS programs.[171] Alarmingly, in the FY 2003 budget, the OTSG funding was reduced 50%, without notice to tribes. The enacted budget for 2004 and the proposed budget for 2005 both leave funding at the 2003 budget level.[172]

A report released by the U.S. Commission on Civil Rights concludes that for tribes who have taken over health care from the IHS "funding has not been enough to support the associated expenses, particularly for the many tribes already experiencing budget constraints."[173] The Civil Rights Commission estimates that existing contracts require an additional $150 million just to compensate for the current insufficiency.[174]

1. Breach of Self-Determination Contract

In *Thompson v. Cherokee Nation of Oklahoma*,[175] the Federal Circuit Court of Appeals ruled that the HHS breached contracts with the Cherokee Nation "by failing to pay the full indirect costs of administering federal programs."[176] Although the contracts require HHS to pay the indirect costs incurred in connection with program operations, HHS did not pay the amounts in full, blaming the failure on insufficient funds.[177] Tribes have argued, from the introduction of the federal Indian self-determination policy, that "indirect cost shortfalls have undermined the policy by forcing tribes to use scarce funds to pay the administrative burden of federal programs."[178] The court in *Thompson* agreed.

Writing for the Federal Circuit in *Thompson*, Judge Timothy Dyk stated that "the consistent failure of federal agencies to fully fund tribal indirect costs has resulted in financial mismanagement problems for tribes as they struggle to pay for [a variety of] administrative requirements."[179] Acknowledging that tribal funds are "needed for com-

171. *Fiscal 2005 Budget*, *supra* note 168.
172. *Id.*
173. A Quiet Crisis, *supra* note 31, at 45.
174. *Id.*
175. 334 F.3d 1075 (Fed. Cir. 2003).
176. *Id*. at 1079.
177. *Id.*
178. Jerry Reynolds, *Health Care Funding Victory for the Cherokee Nation*, Indian Country Today, Jul. 29, 2003, *at* http://www.indiancountry.com/content.cfm?id=1059507618.
179. *Thompson*, 334 F.3d at 1080.

munity and economic development" in Indian Country, the court emphasized that "tribes are operating federal programs and carrying out federal responsibilities when they operate self-determination contracts [and should therefore] not be forced to use their own financial resources to subsidize federal programs."[180]

In its defense the HHS argued that due to appropriations there were no available funds to pay the contracts' indirect costs.[181] The court, however, ruled that absent an express statutory cap, the Secretary possesses authority to reprogram and therefore make funds available to meet contractual obligations.[182] While this decision was a victory for the Cherokee Nation of Oklahoma (the tribe was awarded $7.5 million), it clearly identifies an escape valve for Congress. In the future, the congressional appropriations committee need only create an express statutory cap on HHS funding to ensure that tribes continue to "subsidize" federal programs from their own pocketbooks.

On March 22, 2004, the U.S. Supreme Court granted certiorari to hear the dispute.[183] The Court will resolve a circuit split since the Federal Circuit's ruling conflicts with an earlier 10th Circuit Court of Appeals ruling that declined to hold the HHS liable for the funding shortages.[184]

2. *Eliminating the BIA*

Several features of the ISDA (and its implementation) appear to have opened the door for the federal government to eventually cease, or at least substantially reduce, financial support for Indian health care, using tribal self-governance as their ticket out. Sensing this subtle, multi-fronted assault on the federal government's trust obligation, many tribes have undertaken the task of strengthening that trust obligation. Prompted by a November 2001 Bush proposal to create a new agency to handle Indian trust assets, tribal leaders rushed to protect the existence of the BIA.[185] Calling the BIA their "ugly baby" in need of fixing, tribal leaders argued that without the BIA "there was no trust responsibility."[186] Since November 2001, several major trust duties have been transferred out of the BIA and into the Office of Special

180. *Id.* at 1080-81.
181. *Cases and Recent Developments*, 13 FED. CIR. B. J. 295, 305 (2003).
182. Reynolds, *supra* note 178.
183. *Supreme Court to Resolve Self-Determination Dispute*, INDIANZ.COM, Mar. 23, 2004, *at* http://www.indianz.com/News/archive/000820.asp.
184. *Id.*
185. Editorial, *Indian Country's Ugly Baby*, INDIANZ.COM, Nov. 05, 2003, *at* http://www.indianz.com/News/archives/002380.asp.
186. *Id*.

Trustee (OST), headed by Ross Swimmer.[187] Records, probate, data cleanup, and trust systems, all pertaining to the undervaluation of Indian lands, were given to the OST. The removal of programs from the BIA to OST and elsewhere prevents tribes from exercising greater control over their affairs because DOI "officials are unwilling to compact and contract for programs outside the BIA."[188] Tribes want to be able to contract and compact for appraisal services. Swimmer determined that the OST will retain the budget for the Office of Appraisal, but asserted that "tribes will still have the ability to contract and compact with OST for the appraisal function."[189]

Many tribes and tribal advocates, however, express growing concern over the expansion of the OST. An editorial published by Indianz.com, a major forum and source of news for Indian Country, went so far as to surmise that the White House is "conspiring with Congress to undermine the trust relationship."[190] Senator Tim Johnson, a member of the Senate Indian Affairs Committee, recently requested that the General Accounting Office (GAO) investigate the management and administrative system of the OST.[191] Reports from the GAO and independent accounting firms disagree on the amounts owed to tribal and individual Indian beneficiaries, with one audit showing that the OST is holding back at least $121 million from individual Indians, in contrast with the $62 million previously reported.[192]

Johnson's letter also challenged the OST's recent expansion, which has resulted in an increase of 54% in the agency's budget during the last two years, despite cuts in funds for reservation-level programs at the BIA.[193] Members of the Administration, including Secretary of the Interior Gale Norton, prefer to portray these initiatives as pro-tribal sovereignty and therefore something that they had expected tribes to endorse eagerly.[194]

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187. *Id.*

188. *Id.*

189. *Swimmer to Retain Control of Indian Appraisals*, INDIANZ.COM, Apr. 06, 2004, *at* http://www.indianz.com/News/archive/001587.asp.

190. *See* Editorial, *supra* note 185.

191. *Johnson Seeks Investigation Into OST Expansion*, INDIANZ.COM, May 07, 2004, *at* http://www.indianz.com/News/2004/001660.asp.

192. *Id.*

193. *Id.*

194. "The spirited defense [of the BIA] befuddled the Republicans, who thought they were doing Indians a favor." Editorial, *supra* note 185.

B. *What Tribal-Self Governance Means for Urban Indian Interests*

The position of urban Indian health care could not be more vulnerable. If the gradual shift towards tribal self-determination continues, it is unclear what will happen to the already-weak Urban Indian Health Program within the IHS. It seems likely that tribes will be responsible for providing aid and resources to urban Indians. If this is so, urban Indian health care may face an even more severe reduction in funding.

Urban Indians, particularly those who have lived in cities for generations, often develop "pan-Tribal" communities. Ties with respective tribes tend to wither with time and distance. Many urban Indians struggle with their identity, "never having been completely accepted by the tribes and finding no place in the Whiteman's world."[195] The relationship between tribal leaders and their urban counterparts varies widely from tribe to tribe. Professor Rennard Strickland, founder of the Center for the Study of American Indian Law and Policy at the University of Oregon, observes that "substantial differences exist in tribal attitudes towards their on and off-reservation compatriots."[196] Some tribes go to great lengths to reach out to urban Indians, some do not. The decision or ability to do so may depend heavily on the kind of resources to which each tribe has access. Hence, if tribes are left scrambling for money due to unforeseen shortfalls in the changeover from IHS to self-determined health programs—as were the Cherokees in the indirect cost contract litigation—not only will the reservation health care program suffer, but off-reservation urban Indians could potentially risk losing all their federal funding.

This is precisely the situation that confronts two urban clinics in Tulsa and Oklahoma City, both designated "federal demonstration projects."[197] Unlike other urban Indian clinics, these two non-profits are considered IHS service units for financial allocation, and therefore receive annual funding through the IHS.[198] In stark contrast to most urban Indian health clinics, the Tulsa center has "a staff of 74, and provides a full spectrum of direct care. The center has its own x-ray, mammography and pharmaceutical services [and in 1999] it moved

195. *Partnership Hearing*, *supra* note 124, at 1 (statement by Ron Morton, Executive Director, San Diego American Indian Health Center).

196. Telephone Interview with Rennard Strickland, Phillip Knight Professor of Law, University of Oregon School of Law (Mar. 14, 2004).

197. Jerry Reynolds, *Health Bill Hearing Raises Doubts*, INDIAN COUNTRY TODAY, Jul. 18, 2003, *at* http://www.indiancountry.com/content.cfm?id=1058546581.

198. *Id.*

into an impressive new 27,000-square foot facility."[199] The new house bill reauthorizing the Indian Health Care Improvement Act, H.R. 2440, would subject urban clinics, including these two demonstration projects, to the ISDA and, subsequently, tribal health care contracting and compacting processes.[200] Urban clinics could therefore be "absorbed into tribal budgeting processes."[201] This fate is particularly harmful to the two federal demonstration projects as they could potentially lose all of their IHS funding. Without the current statutory protection of the Tulsa center, the Creek and Cherokee tribes of Oklahoma could pull their share of the clinic's funding. Recognizing that "there just isn't enough money to go around," negotiations with tribes can be very difficult for the clinic.[202] While the tribes agree that the clinics offer excellent services, monetary restrictions could very easily result in the closure of urban clinics, such as the one in Tulsa.[203]

Representatives from the two centers are working hard to maintain their statutory protection in the reauthorization of the IHCIA—a protection preserved in the Senate version of the bill, S.556.[204] Unlike these demonstration projects, the other 34 urban programs lack such protection. As illustrated in Part II, urban Indian clinics already receive far less funding and are capable of delivering far fewer services than other IHS facilities. Permanent statutory protection must be extended to all urban Indian clinics to ensure that, like the two demonstration projects, tribes will not be permitted to "reach beyond their service boundaries to siphon away resources of other effective programs in order to bolster tribal health budgets."[205] It is imperative that the limited funds currently available to urban Indian health clinics be insulated from tribal self-governance and self-determination projects, so as to protect urban clinic funding from encroachment. The scarcity of resources is certainly a threat to the health of all American Indians, but when nearly 70% of the Indian population resides in cities, the existence of urban Indian health projects cannot depend on the discretion of tribes, whose interests will surely be in conflict.

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199. Peters, *supra* note 123.
200. Reynolds, *supra* note 197.
201. *Id.*
202. Peters, *supra* note 123.
203. *Id.*
204. *See generally*, *A Bill to Reauthorize the Indian Health Care Improvement Act: Hearing on S. 556 Before the S. Comm. on Indian Affairs*, 108th Cong. 10 (2003) [hereinafter *Hearing on S. 556*] (statement of Everett R. Rhoades, Vice-President of the Central Oklahoma American Indian Health Council, Inc.), *available at* http://www.senate.gov/~scia/2003hrgs/071603hrg/rhoades.PDF.
205. *Id.*

IV.
"ONE-HHS": DEPARTMENTAL CONSOLIDATION AND THE HIS

Signaling what may be another oblique assault on the federal government's obligation to Indians, Bush's proposed reorganization of the IHS[206] is perceived by many tribal leaders and Indian advocates to hold disastrous consequences for Indian health care. The effort was first outlined in the 2003 budget and entails the consolidation of 40 HHS offices into just four.[207] The four areas targeted for consolidation are public and legislative affairs, information technology, facilities construction, and human resources (HR).[208] The facilities construction and HR moves are expected to have a significant impact on Indian Country, as funding for the construction of new IHS clinics and hospitals will share the same pool of money as other HHS projects.[209] The HR move will have more immediate and obvious repercussions, as dozens of IHS jobs will be eliminated and more than 200 employees relocated.[210] The employees will be removed from their locations in Indian Country and relocated to an office outside Washington, D.C.[211] Tribes fear that this move will put the office "completely out of touch with the day-to-day realities and characteristics of IHS such as Indian preference, different budget sources, tribal shares, [and] tribal sovereignty."[212] The Tribal Self-Governance Advisory Committee points out that "a Beltway-based HR office will [not] be able to comprehend, let alone respond adequately to, the unique personnel requirements of [the IHS]."[213] Pre-consolidation, the IHS is the second-largest division at the IHS with about 15,000 employees.[214] No specific target date for consolidation was specified, although the HR and facilities changes will be implemented sometime during the fiscal year 2004.[215]

206. Jerry Reynolds, *HHS Consolidation Surfaces at Senate Health Care Hearing*, INDIAN COUNTRY TODAY, Apr. 07, 2003, *at* http://www.indiancountry.com/content.cfm?id=1049741307.
207. *Bush Management Initiative Impacts IHS Employees*, INDIANZ.COM, Feb. 07, 2003, *at* http://www.indianz.com/News/show.asp?ID=2003/02/07/ihs.
208. *Id.*
209. *Id.*
210. *Bush Initiative to Be Scrutinized by Congress*, INDIANZ.COM, Feb. 18, 2003, *at* http://www.indianz.com/News/show.asp?ID=2003/02/18/ihs.
211. *Id.*
212. *Id.*
213. *Reauthorization Hearing*, *supra* note 70, at 6 (statement of Don Kashevaroff, Representative, Tribal Self-Governance Advisory Committee).
214. *Bush Initiative to Be Scrutinized by Congress*, *supra* note 210.
215. *Id.*

Julia Davis-Wheeler, chairperson of the National Indian Health Board in Denver, believes that downsizing the IHS "is just a catastrophe for us."[216] The Administration, however, predicts "management savings" of $31 million, and that "One-HHS" will "ensure coordinated, seamless, and results-oriented management across all Operating and Staff Divisions of the Department."[217] Bush appointee Dr. Charles Grim, Director of the IHS, claims that the One Department Initiative will have great benefits for the Department's Native American constituents, allowing the HHS to "speak with one, consistent voice. . . . [T]he revised premise within HHS is that all agencies bear responsibility for the government's responsibility and obligation to the Native people of this country."[218] Don Kashevaroff, testifying on behalf of the tribes participating in the IHS Self-Governance program, noted that "[u]nlike the other HHS operating divisions, the operations of the IHS are widely dispersed throughout the United States, primarily in small communities and remote, isolated, rural areas."[219] Regardless of the HHS' commitment to Indian communities, Kashevaroff argues that "[e]-mail and telephone encounters cannot replace" the current system.[220] Congressman Frank Pallone, vice-chair of the House Native American Caucus, believes the plan will result in "less attention paid to Indian affairs," and notes that "more and more there's this withering of the federal obligation. There's no question that's what's going on, whether they admit it or not."[221]

V.
Solutions for Better Indian Health Care

The story of Indian health care has largely been a story of inadequate funding. Without more budgetary appropriations, it will be difficult to achieve any positive change in Indian health care. Certain structural changes, however, can and should be made to health care delivery to American Indians both on and off reservation.

216. Reynolds, *HHS Consolidation Surfaces*, *supra* note 206.

217. *One HHS: 10 Department-wide Management Objectives* (Office of Human Resources), *at* http://www1.od.nih.gov/ohrm/programs/PerfMgmt/AttJRevisedOne HHSProg MgmtObjectives.pdf.

218. *Reauthorization Hearing*, *supra* note 70, at 8–9 (statement of Dr. Charles Grim).

219. *Id.* at 5 (statement of Don Kashevaroff).

220. *Id.*

221. Jerry Reynolds, *Pallone Sees Tribal Action Translating Itself at Political Level*, Indian Country Today, Jul. 28, 2003, *at* http://www.indiancountry.com/cpntent.cfm?id=?1059415069.

The Reauthorization of the Indian Health Care Improvement Act (IHCIA) has been postponed or stalled in Congress since 2000. After the Act was reintroduced in March of 2003, hearings for the Reauthorization were held in July 2003 and, most recently, Secretary Tommy Thompson endorsed the Act in a hearing before the Senate Committee on Indian Affairs in July 2004.[222] Despite Thompson's expressed support for the Reauthorization, there has been no further movement toward enactment as of mid-September. The current Congressional session is scheduled to adjourn in early October 2004.

In 1999, the IHS director convened a National Steering Committee (NSC) to develop a report on IHCIA recommendations. The NSC is composed of one elected tribal representative and one alternate from each of the twelve IHS Areas, a representative from the National Indian Health Board, a representative from the National Council on Urban Indian Health, and the Tribal Self-Governance Advisory Committee.[223] Although the NSC heard from many tribal leaders who supported authorizing Indian health care as an entitlement program, the Committee was unsure how to proceed with such a mighty undertaking.[224] As a compromise, the NSC included in Title VIII of the draft bill a provision that would create a Tribal/Congressional Commission to evaluate entitlement issues and make recommendations to Congress.[225] Now that the Health Care Equality and Accountability Act has been introduced, it is unclear whether this Commission on an Indian Entitlement will remain in the revised version of the bill.

The proposed Reauthorization bill contains several improvements for urban Indian health delivery. Title IV of IHCIA authorized urban health programs to recover reasonable charges for services provided to individuals who have private or public medical insurance. The urban Indian health organization is currently deemed an "out-of-network provider" for health insurance, Managed Care organizations, Medicare

222. *Reauthorization Hearing*, *supra* note 70, at 1 (statement of Tommy G. Thompson, Secretary, Department of Health and Human Services).

223. *Hearing on S. 556*, *supra* note 204 at 4 (statement of Rachel Joseph, Co-Chair, National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act), *at* http://www.senate.gov/~scia/2003hrgs/071603hrg/joseph.PDF.

224. While the NSC agrees that the Federal government has a trust responsibility to provide Indian health services and facilities, it recognizes that there are many unanswered questions regarding what constitutes an entitlement; what criteria should be applied to define the entitlement class; whether the entitlement flows to tribes or individual Indian people; and, what benefits should be included in an entitlement package.

Id. at 7.

225. *Id.*

and Medicaid, and a change in this status is key to reimbursement.[226] Section 509 authorizes grants which would allow urban projects to lease, purchase, renovate, construct, or expand facilities to be used as satellite clinics.[227] Section 516 authorizes the development and construction of two residential treatment centers for urban Indian youth who suffer from mental health and substance abuse problems.[228]

Like the two urban demonstration projects in Oklahoma, funding for all urban Indian clinics should be kept in a pool separate from that open to Tribal self-governance and self-determination programs. Urban projects are currently able to offer only a fraction of the services that Tribal and IHS programs can provide for free. Furthermore, the two urban demonstration projects in Oklahoma have proved a tremendous success. Not only should their protection be preserved in the Reauthorization of the IHCIA, but the time has come for more urban clinics to receive the funding and legal status that these two demonstration projects currently enjoy.

Lastly, if the currently existing Urban Indian Health Programs are to survive the ongoing changes in states' Medicaid programs, they must at least receive 100% reimbursement rates, as do other IHS clinics, hospitals, and tribal programs. Urban programs have the potential to expand state Medicaid funding, and their continued survival is needed to ensure that the federal government does not fully abandon its obligation to provide Indian-specific health care to individual Indians living off-reservation.

Conclusion

Until and unless they are able to converge as a united political voice, urban American Indians must remain a protected interest of the IHS. Congress must not allow the current funding designated for urban Indian health projects to be commandeered by self-governing tribes. Tribal self-governance and self-determination are good programs that can potentially reach levels of success that the IHS has historically struggled to reach. However, without adequate funding they will face the same roadblock currently impeding the IHS.[229]

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226. *Hearing on S. Indian Affairs*, *supra* note 96 (statement of Kay Culbertson, Executive Director, Denver Indian Health and Family Services).

227. *Id.*

228. *Id.*

229. Bush Administration official Michael O'Grady, Assistant Secretary of the HHS, recently told tribal leaders in Montana that they "need not look for any additional funding for health care in the future," and that they must "look for ways to do more with less." David Melmer, *More Bad News About Health Care Funding*, Indian

The federal government's trust obligation must also be observed with vigilance. We have seen how tribes were shortchanged on indirect costs when attempting to run their self-governed health programs. Structural changes in the IHS, as part of the Administration's "One-HHS" initiative, can potentially result in continued downsizing of the IHS and less attention overall to the needs of Indian health.

On the other hand, if the Reauthorization of the IHCIA is finally approved, the astonishing health disparity that afflicts American Indians may begin to improve gradually. In the meantime, Indian health advocates should ensure that all eligible urban Indians are registered to receive Medicaid and/or Medicare despite their shortcomings. While health care provided through Medicaid is not the ideal,[230] it is a mistake to overlook this important source of health care funding, particularly given the unpromising prospect of any significant increases to the IHS budget. The most immediate step that should be taken is to fully reimburse states for Indian Medicaid expenses, regardless of whether health care was delivered through an approved IHS facility. For the last half-century, increasing numbers of Native Americans have lived far beyond the borders of reservations. Their heritage and status as American Indians remains unchanged, as does the federal government's obligation to fulfill the promises made to their tribal ancestors.

COUNTRY TODAY, Sept. 10, 2004, *at* http://www.indiancountry.com/content.cfm?id=1094827872.

230. Federal budget proposals have, in the past, used the amount collected from public insurance programs to artificially inflate the amount of federal dollars appropriated for Indian health care. This practice contributes to low participation rates in Medicare and Medicaid because many American Indians fear that participation in these programs will lead to the gradual elimination of the IHS. U.S. COMM'N ON CIVIL RIGHTS, BROKEN PROMISES, *supra* note 149.