Engaging American Indian and Alaska Native Medicare Beneficiaries: Senior Medicare Patrol Toolkit

Prepared by International Association for Indigenous Aging

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Chapter 2: ITU Health Care Systems

The HHS provides health-related programs to AI/ANs through:
- The IHS;
- Reimbursement for health services provided directly to tribes, urban Indian health centers, and tribal health facilities through the Centers for Medicare and Medicaid Services’ (CMS) Medicare and Medicaid programs;
- The Health Resources and Services Administration;
- The Substance Abuse and Mental Health Services Administration; and
- The Administration for Children and Families.

Indian health care services should not simply be viewed as an extension of the mainstream health system in America. As previously discussed, the federal government’s responsibility for providing health services to AI/ANs dates back more than 200 years to the assumption of responsibility for Indian education, health care, and housing. Legal responsibility for AI/AN health traces back to many of the treaties enacted between 1776 and 1858. These treaties included medical care as partial compensation for the ceding of land and other resources. The provision of health services is a federal trust responsibility where, in exchange for land, and as compensation for their forced removal, the federal government has a legal responsibility to provide for the health and well-being of AI/ANs. It is part of the special government-to-government relationship between the United States and federally recognized tribes.

The IHS facilities, tribally operated “638” health programs, and urban Indian health programs provide general health care services for eligible AI/AN, and are known as the ITU health care system.

Congress passed the Indian Health Care Improvement Act of 1976. The goal was to raise “the status of health care for AI/ANs over a 7-year period to a level equal to that enjoyed by other American citizens.” More than 25 years later, this goal has not been achieved, while AI/AN health conditions and services remain substandard, as evidenced by the 2010 Census.

Indian Health History

Over the past 85 years, the federal government’s obligation to provide health care services to American Indians and Alaska Natives, explicit in some treaties, has been explicitly set forth in a series of federal laws, executive orders, and court decisions.

The responsibility to provide quality health care to AI/ANs is based on the Indian Commerce Clause of the U.S. Constitution, confirmed through treaties, federal law, and federal court decisions. The Indian Health Care Improvement Act (P.L. 94-437), along with the Snyder Act of 1921 (25 U.S.C. 13), form the statutory basis for the delivery of federally funded health care to AI/ANs.
The IHS delivery system was designed to be an integrated, community-based system that emphasizes prevention and public health. The IHS system delivers and purchases health care services and provides the infrastructure for health improvements by building health facilities and sanitation systems, as well as guaranteeing long-term improvement through the training, recruitment, and retention of health personnel. Inadequate resources create barriers for the IHS to fully achieve its mission.

To fully understand the unique ITU health care system today, it is necessary to understand the different acts passed by Congress that have shaped the current health care environment in Indian Country.

**Snyder Act of 1921.** Congress, for the first time, enacted legislation permanently authorizing appropriations for American Indian health care. The act authorized the BIA to expend federal funds and employ physicians “for the relief of distress and conservation of health.”

**Johnson O’Malley Act of 1934.** This act affirmed the federal government’s financial responsibility for Indian health services, authorizing the Secretary of the Interior to contract with state and local governments and private organizations to provide educational, medical, and other assistance to American Indians who no longer lived on the reservation.

**Transfer Act of 1954.** Health services for AI/ANs were transferred from the Interior Department to a newly created division of Indian health (retitled the Indian Health Service in 1955) under the U.S. Public Health Service in the Department of Health, Education, and Welfare. Primary motivation for the transfer was to improve the quality of medical services to American Indians through supervision by an agency with more administrative expertise and funding in health care.

**Indian Health Facilities Act of 1957.** This act authorized IHS to contribute to the construction costs of community hospitals in cases where such facilities could provide better access and care than would result from the direct construction of Indian facilities.

**Indian Sanitation Facilities and Services Act of 1959.** This act expanded the scope of IHS programs by authorizing the agency to provide sanitation facilities, including water supplies, drainage, and waste disposal, for American Indian homes, communities, and lands.

**Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638).** This act authorized IHS to turn over full administrative responsibility for IHS programs, through contracts, to tribes, upon request.

**Indian Health Care Improvement Act of 1976 (P.L. 94-437, IHCIA).** This act authorized a series of health programs based on a community health model, directed increased appropriations for such programs; included the first specific legislative acknowledgement of the special federal responsibility for American Indian health services, established urban Indian health programs,
and removed the prohibition of Medicaid and Medicare reimbursements to IHS and tribally operated facilities.

**Indian Health Care Improvement Act Amendments of 1992 (P.L. 102-573).** These amendments extended tribal self-governance to the IHS. Self-governance allows tribes to assume responsibility for resource management and service delivery, providing greater flexibility to design and develop programs that better meet the needs of their members, with no abrogation of the federal government’s trust responsibility.

**Affordable Care Act/Indian Health Care Improvement Act of 2010.** This act was enacted to improve the quality of health care and make it more accessible and affordable for all Americans—with special provisions for AI/AN populations—as well as permanently reauthorizing the IHCIA, which extends the current law and authorizes new programs and services within IHS.

This legislative history demonstrates AI/ANs long history of working with the federal government on health care systems through treaties and acts. Below are some quick facts related to the history of IHS.

- The first federal health assistance for AI/ANs dates back to 1832 when Congress appropriated $12,000 for a health program.
- By 1880, there were four AI/AN hospitals, which were run by the BIA. 35
- Forty years later, the Snyder Act of 1921 specifically authorized federal funds “for the relief of distress and conservation of health … [and] for the employment of … physicians” for Indian tribes throughout the United States. 36
- In 1954, the responsibility for health care delivery to AI/ANs was transferred from the Department of the Interior to the agency known today as the Department of Health and Human Services. 37
- In 1955, the HHS transferred the responsibility for health care delivery to IHS and, to this day, direct services are administered by IHS to tribes across the country.
Health Care Today

Indian Health Service
IHS is primarily responsible for providing care to AI/AN people who are members of federally recognized tribes. According to IHS, the agency provides care to an estimated 2.1 million AI/ANs, which encompasses about half of the 5.2 million people classified by the Census as AI/AN. The IHS directly operates 31 hospitals, 52 health centers, 2 school health centers, and 31 health stations throughout Indian Country.

Contract Health Services (CHS)
The CHS Program is for medical and dental care provided away from an IHS or tribal health care facility. The fund is used in situations where: 1) no IHS direct care facility exists, 2) the direct care element is incapable of providing the required emergency or specialty care, 3) the direct care element has an overflow of medical care workload, and 4) supplementation of alternate resources (i.e., Medicare or private insurance) is required to provide comprehensive care to eligible Indian people.

CHS funds are used to supplement and complement other health care resources available to eligible Indian people. CHS is not an entitlement program, and an IHS referral does not imply that the care will be paid for with IHS funds. If IHS is requested to pay, then a patient must meet the residency, notification, medical priority rating, and the use of alternate resources requirements.

The term Contract Health Services originated under BIA when medical health care services were contracted out to health care providers. In 1955, the Transfer Act moved health care from the BIA to the Department of Health Education & Welfare, establishing the IHS.

Because IHS programs are not fully funded, the CHS program must rely on specific regulations relating to eligibility, notification, residency, and the medical priority rating system. IHS is designated as the payer of last resort, meaning that all other available alternate resources, including IHS facilities, must first be used before payment is expected. These mechanisms allow IHS to stretch the limited CHS dollars, and are designed to extend services to more Indians. This renders the CHS program to authorize care at restricted levels and results in a rationed health care system.

Tribal Health Care
Indian tribes are recognized in law as sovereign entities with the power to govern their internal affairs. The legal authority of tribal governments to determine their own health care delivery systems, whether through IHS or tribally operated programs, must be honored.
The Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975 gave tribes the choice of whether to take over the administration and operation of health services from the U.S. Government or to remain with the government’s direct health system.

Tribes and tribal organizations, through contracts and compacts under the ISDEAA, operate almost 50% of the IHS system and provide health care in:

- 15 hospitals,
- 256 health centers,
- 9 school health centers, and
- 282 health stations (including 166 Alaska Native village clinics).

**Urban Indian Health Program**

The IHS Urban Indian Health Program supports contracts and grants to 34 urban health programs operating at 41 sites throughout the United States. These programs are funded under Title V of the Indian Health Care Improvement Act. Approximately 100,000 American Indians use 23 Title V urban Indian health programs. These populations are not generally able to access hospitals and health clinics, or contract health services administered by IHS and tribal health programs because they either do not meet IHS eligibility criteria or they reside outside of IHS and tribal service areas. Another 49,000 AI/ANs use 11 Title V programs in cities that are located in IHS or tribal service delivery areas.

Since 1972, IHS has gradually increased its support for health-related activities in off-reservation settings. The aim is to assist access to available health services, and also to develop direct health services when necessary. Though the Urban Indian Health Program still accounts for less than 1% of the total IHS budget.

In its 1992 amendments to the IHCIA, Congress specifically declared the policy of the Nation "in fulfillment of its special responsibilities and legal obligations to the American Indian people [is] to assure the highest possible health status for Indians and urban Indians, and to provide all resources necessary to affect that policy."

The types of services that are offered by the 34 programs vary from clinic to clinic. Activities range from the provision of outreach and referral services to the delivery of comprehensive ambulatory health care. Fifteen of the programs are designated as Federally Qualified Health Centers and provide services to Indians and non-Indians.

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5 IHCIA Title V directs the Department of Health and Humans Services Secretary to make contracts with or grants to Urban Indian Organizations for health projects to serve urban Indians, and sets requirement for the contracts and grants.
Services may include medical, dental, and community services; alcohol and drug abuse prevention, education, and treatment; AIDS and sexually transmitted disease education and prevention services (provided by all of the IHS Title V funded, off-reservation Indian health programs); mental health, nutrition education and counseling, pharmaceutical, health education, optometry, and social services; and home health care.

Dental care services, both preventative and restorative, are provided by many programs. Dental education and screenings for children and adults are provided in both clinic and community settings. When needed, referrals are made to specialists for orthodontics, periodontics, selected restorative procedures, and oral surgery.

Community outreach services are provided throughout the urban, off-reservation health programs, including patient and community education, patient advocacy, outreach and referral, and transportation. Outreach workers serve important functions as liaison between the off-reservation health program and the community, and work to make health services more available and accessible to those community members who need them.

Alcohol treatment services are provided at 10 off-reservation Indian sites. These programs were originally funded by the National Institute of Alcohol Abuse and Alcoholism (NIAAA). At least 28 additional NIAAA programs are in the process of being transferred to the Urban Indian Health Program.

Additional services at various off-reservation Indian health programs include health prevention activities, such as diabetes, maternal and child health, women's health, men's health, nutrition education and counseling for prenatal care and chronic health conditions, social services, community health nursing and home health care, and other health promotion and disease prevention activities.

Notes:

- The Urban Indian Health Program participates in line-item increases, as appropriated by Congress.

- The contracts and grants are awarded pursuant to a HHS/IHS class Justification for Other than Full and Open Competition (JOFOC) for Title V, Urban Indian Contracts. The applicable statutes are the Snyder Act of 1921 (25 U.S.C., 13) and Title V of the Indian Health Care Improvement Act (PL 94-437), as amended. The JOFOC is also pursuant to Federal Acquisition Regulation 6.302-5 and 41 U.S.C., 253 (c) (5), and the use of set asides under the Buy Indian Act, 25 U.S.C., 47. Full and open competition need not be provided for when a statute expressly authorizes or requires that the acquisition be made from specified sources, as identified by Title V and pursuant to the Buy Indian Act.
• The Urban Indian Health Program line item is distributed through contracts and grants to the individual urban Indian health programs. The distribution is based upon the historical base funding of these programs.

• The funding level is estimated at 22% of the projected need for primary care services, with less than 1% of IHS funding reaching urban Indian centers.

• Eighteen additional cities have been identified as having an urban Indian population large enough to support an urban Indian health program.

### Health System Funding

“Don’t get sick after June,” has been incredibly effective [in] describing the problem of what it means for a health care delivery system to run out of money.  
-- Dr. Yvette Roubideaux, Indian Health Service Director

The need for additional funding is particularly well supported by advocates for Native American health care, who have developed a variety of measurements to verify the inadequacy of present funding levels. Over the years, they have made the following arguments to the President and Congress when requesting additional funding:

• Annual per-capita health expenditures for Native Americans are only 60% of the amount spent on other Americans under mainstream health plans.

• Annual per-capita expenditures fall below the level for every other federal medical program and standard.

• Annual increases in IHS funding have failed to account for medical inflation rates and increases in population.

• Annual increases in IHS funding are less than those for other HHS components.

• Annual increases have effectively been reduced to reflect increased collection efforts despite express congressional intent that appropriations not be reduced.

### Background

As the primary health care provider for Native Americans, IHS receives the vast majority of funds appropriated for that purpose. For FY 2015, the President’s budget request included $4.27 billion for IHS, just 5.5% of a $77.1 billion HHS discretionary budget and an even smaller 0.4% of the overall HHS budget of $1 trillion. 41

While other HHS components and programs provide limited health-related services for Native Americans, their Native American expenditures are equal to approximately 0.5% of IHS spending on
Native Americans, which is less than $20 million. The FY 2015 budget request includes a $200 million increase from FY 2014. To some extent, at least in the allocation of additional funds, the increase reflects priorities established through tribal consultation, including increases to cover pay raises and inflation, thereby protecting the current level of services and providing greater funding for preventive services.

Another HHS agency, CMS, directly funds health care services for AI/ANs who are enrolled in Medicaid, Medicare, or the state-administered Children’s Health Insurance Program when their care is provided through IHS or tribal facilities. When IHS budget appropriations are combined with collections from CMS and private third-party insurers, the total composes the program-level funding for IHS and provides a better picture of the overall federal government spending on Native American health care. Even with program-level funding boosted by third-party collections, the end result is a rationed system. The IHS acknowledges this reality in its budget justification, explaining that its system “explicitly rations care, deferring and denying payment for medical services that are thought to be of lower priority.”

To what degree rationing is a problem is discussed in detail in the Contract Health Services section.

Casinos Don’t Equal Health Care for All

It is necessary to address the myth surrounding the gaming industry in Indian Country, its contribution to the continued shortfalls in federal funding, and the resulting system of rationed care. Because the Native gaming industry has grown to encompass 220 tribes, 377 facilities, and more than $16 billion per year in revenue, a perception exists that Indians have been given everything they need and that federal “handouts” are no longer necessary. This perception is inaccurate on several levels. First, it ignores the federal trust obligation discussed earlier in this report. Second, it overstates the magnitude and impact of gaming profits. A report prepared for the American Indian Program Council provides a clearer picture of the impact of casinos in Indian Country:

- Only half of all tribes have casinos.
- Thirty-nine casinos produced the majority of casino-generated income.
- More specifically, 39% of casinos accounted for 66% of revenue.
- Casinos in five states, with more than half the total Native American population, accounted for less than 3% of all casino revenue.
- Casinos in three states, with only 3% of the Native American population, accounted for more than 44% of all casino revenue.
- Dozens of casinos barely break even because of inadequate sizes or locations.

The overall effect is that only a relatively small number of tribes have been very successful enough to establish health care systems independent of federal aid. For most tribes, gaming has brought increased administrative, legal, and lobbying expenses, along with impressive gains for non-Indian investors and state governments that have taken as much as 16% of revenue. After other expenses are covered, a small percentage of the successful tribes appropriately apply some portion of their
increased revenue to health care. Nevertheless, the vast majority of tribes and Native people must continue to rely on the inadequate funds appropriated to the IHS.

### Per Capita IHS Expenditures Compared with Other Federal Per Capita Health Care Expenditures

Figure 2. 2009–2010 Indian health expenditures per capita compared with other federal per capita health care expenditures.

*Note: FEHB=Federal Employee Health Benefits; IHS=Indian Health Service.*

Source: National Tribal Budget Formulation Workgroup. 48

### Relationship of Medicare to ITUs

Amendments to two landmark federal acts—the ISDEAA of 1975 and the IHCIA of 1976—provided new health care delivery options for IHS and tribes. Among other things, the IHCIA included authorization to collect from Medicare, Medicaid, and other third-party insurers for services provided at IHS or tribal facilities. Under the ISDEAA, many tribes assumed roles previously carried out by the federal government. According to IHS, tribes currently administer more than half of IHS resources through contracts and compacts. IHS administers the remaining resources and manages facilities where tribes have elected not to contract or compact their health programs. 49
Why Do Elders Need Medicare?

IHS is not health insurance or an entitlement program, and it limits the types of services it covers. Because IHS funding appropriations historically fall short, health care funding often runs out before the end of the year. CMS funding helps supplement the health care programs, which, in turn, help provide greater access to care for elders and can enhance those services and resources.

Medicare and Medicaid payments can be used to offset IHS and tribal health care expenses without a reduction in appropriated funding. The law specifically dictates those reimbursements must then be spent only on health care. Funding by these two programs is a significant source of revenue for tribes and IHS.

Elders can also use Medicare to pay for Medicare-approved services outside of the IHS system. There are certain services that aren’t routinely paid for by the ITU system that may be covered by Medicare, including:

- Skilled Nursing Facility Care (Part A);
- Hospice Care (Part A);
- Dialysis (Part B);
- Acute In-patient Mental Health Programs (Part A);
- Mental Health services outside of the IHS System (Part B); and
- Certain DME, such as beds, scooters, lifts (Part B).

Conversely, some tribes may pay for services not provided by Medicare, such as vision, dental, and hearing services.

Tribes and Medicare

Under the IHCIA, tribes have the authority to pay for Medicare premiums for their tribal members. And, as previously noted, tribes may opt to provide additional services to their members beyond what Medicare covers. Each tribal health entity establishes its priorities, service design, and service line.

Payment of premiums and the provision of additional services is not a practice of all tribes, but it is an option. The benefit to the tribes is knowing that all tribal members have health coverage and that it could bring additional revenue to the tribe from third-party billing. However, there is the obvious challenge of affordability, among others.

AI/AN Medicare Enrollees

It is a challenge to routinely and accurately identify and classify all AI/ANs receiving, or who are eligible for, Medicare. Medicare, Census, and IHS data often contain significant discrepancies. In a study of 33 of the most AI/AN populated states, an average of 10% of all AI/ANs reported having Medicare coverage, ranging from 6% to 15%. See Figure 2 below for state-by-state percentages. 50
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Figure 2: Percentage of AI/ANs Enrolled in Medicare by State

The US Census’ 2008 to 2010 American Community Survey estimated that approximately 446,000 AI/ANs had Medicare coverage. However, Medicare’s database only identified 385,000 beneficiaries in that same timeframe. When matched with an IHS dataset, the IHS data only uncovered 331,674 beneficiaries. Remaining Medicare enrollees were identified through the Social Security Administration or the Medicare Beneficiary Survey. Differences arise largely as a result of Medicare’s inability to identify a large portion of self-declared AI/ANs, alongside classifying them in other racial, other, or unknown group categories. 51

Population growth has significant implications for Medicare enrollment numbers. According to 2010 Census data, the AI/AN population alone, or in-combination, grew by 27% from 2000. During that same time frame, the total population grew at only 9.7%. 52 Census population projections forecast that the percentage of AI/AN-only who are 65 and older will more than double in the next two decades—a faster growth rate than the both the total population and most other races, including those of Hispanic origin. 53

Barriers to Medicare Enrollment

A number of known barriers to enrolling elders in Medicare exist. In some areas, like North Dakota and South Dakota, due to devastatingly poor prevailing socioeconomic conditions, work history requirements keep elders from being eligible. Other barriers include:

- Beliefs that IHS covers all medical needs so they don’t feel that they need the service;
Beliefs that, because they are Native American, they are entitled to free care and shouldn’t have to enroll in, or be concerned about, health care insurance or billing;

- Complexity of the health care system;
- Lack of knowledge and awareness about how to enroll;
- Lack of knowledge about health insurance;
- Confusion over the parts of Medicare, coverage options, deductibles, etc.;
- Difficulty signing up: no internet access and limited information and resources available to help in the community; and
- Costs of the programs.

**Medicare Payments for Elders**

Difficulties identifying AI/ANs enrolled in Medicare, as well as the complexities of the ITU systems of care, make quantifying the amount of funds spent on AI/AN Medicare beneficiaries extremely challenging.

Essentially, all AI/ANs enrolled in Medicare (who can be identified) have Part A (Hospital Insurance), and about 90% have both Part A and Part B. This is surprising, given the common perception that many tribal elders with access to IHS or tribal facilities feel that paying premiums for care is inappropriate due to the federal trust responsibility. However, some state Medicaid programs pay the Medicare Part B premiums for all IHS AI/ANs. There are also tribes who pay premiums for their elders to ensure that they have access to needed care throughout the year. 54

According to the IHS budget proposal for 2015, payments from CMS to IHS and tribal facilities for 2014 will total just over $1 billion, including approximately $217 million for Medicare. 55 This is a significant increase from approximately $735 million in total 2010 reimbursements. It is important to note that these estimates fail to account for all collections by IHS-funded facilities, as tribal facilities are not required to report reimbursements.

According to Crouch et al (2012), Medicare payments for hospitalizations not covered by managed care, for IHS AI/ANs alone, totaled $604 million in 2009 (the latest dataset available for analysis at the time). Medicare hospital payments typically constitute the largest category of benefit payments—roughly twice as much as payments for physician and other professional services. Medicare prescription drug data were not available at the time of the report. Based upon these estimates, somewhere in the neighborhood of $1 billion may be paid by Medicare annually for AI/AN care.
Billing Entities

A number of entities are involved in the ITU billing process.

- The Medicare Administrative Contractor for IHS is currently Novitas Solutions, Inc. (formerly Trailblazer Health Enterprises, LLC).

- Tribes, federally qualified health centers, rural health centers, and other non-IHS entities may have other fiscal intermediaries or carriers, can use the Medicare Administrative Contractor designated for their state for Medicare claims, or can elect to file claims through Novitas.

- Blue Cross and Blue Shield of New Mexico currently serves as the fiscal intermediary for the federal IHS Contract Health Services program and 11 tribal programs.
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7 Senator Ben Nighthorse Campbell, chair, and Senator Daniel K. Inouye, vice chair, Senate Committee on Indian Affairs, letter to the Senate Committee on the Budget, Feb. 29, 2000, as reported in Concurrent Resolution on the Budget, FY 2001, Report of the Committee on the Budget, United States Senate, Mar. 31, 2000, p. 188 (hereafter cited as Senators Campbell and Inouye, letter to the Senate Committee on the Budget, Feb. 29, 2000).


10 Ibid. p.4. The states with the largest Native American populations, in descending order, are California, Oklahoma, Arizona, Texas, New Mexico, New York, Washington, North Carolina, Michigan, Alaska, and Florida. The census identifies the four geographical regions as Northeast, Midwest, South, and West. Ibid.

11 In 1997, the Office of Management and Budget definition of American Indian or Alaska Native included the original peoples of North and South America, including Central America. Census Bureau,AI/AN Population: 2000, p. 8.


15 Urban Indian Health Institute 2004


20 Ibid


42 USCCR, A Quiet Crisis, Tables 2 and 3 of Chapter 3 (citing the Budget of the United States Government, Fiscal Year 2004, Historical Tables, Table 5.4, pp. 103–04).

43 Ibid

44 Ibid., p. IHS–27.


47 *Ibid.* See also Brosnan, J.


