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A Report on Off-Reservation Native American Access to Healthcare in Albuquerque

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All errors and omissions in this report are the responsibility of the Center on Law and Poverty.

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1. Executive Summary

Over the course of two centuries, Native Americans ceded 550,000,000 acres of land to the federal government in exchange for certain promises, protections and services. Among these was guaranteed cradle-to-grave healthcare coverage, which should be the most comprehensive pre-paid healthcare plan in the country. Despite acknowledging this contractual obligation, however, the federal government has never fully delivered on it.

Currently, the federal Indian Health Service (IHS) is being systematically defunded and dismantled, with nothing set to take its place. The situation is acute for all Native Americans, the great majority of whom do not live on tribal lands. These so-called “Urban Indians” have been both recognized and ignored by the federal government. In the Indian Health Care Improvement Act of 1976, the federal government explicitly determined that Urban Indians have special access-to-healthcare needs. However, those needs are regularly and dangerously unmet, as evidenced by the fact that while approximately 65% of all Native Americans are considered Urban Indians (meaning they don’t live on or near their reservation or tribal lands), only about 1% of the IHS budget is designated for urban clinical facilities.

Albuquerque has one of the largest Native American populations in the country. Following the virtual shutdown of the federally run Albuquerque Indian Health Center in 2005, their lack of access to healthcare has become dire. There is a single primary care medical services clinic in Albuquerque that receives federal funding for Native American healthcare. (A second facility¹ receives federal funding, via a special congressional appropriation, to provide primary dental care to Native Americans under 25 who live in Albuquerque). The medical clinic, First Nations Community Healthsource, does not have the capacity to deal adequately with the healthcare needs of the tens of thousands of Native Americans living in Albuquerque. This community should have another option.

The University of New Mexico Hospital (UNMH) is bound by a 1952 contract to provide healthcare to Native Americans free of charge. This same contract binds the federal government to reimburse UNMH for its costs. Since the Albuquerque Indian Health Center closed its urgent care services, the healthcare promised by the 1952 contract has become critically important. Yet, to date, the federal government is not reimbursing UNMH for its costs and the Hospital is not providing full service treatment to Native Americans free of charge.

While it is unclear how the contract can or will be enforced, one thing is clear: the federal government is in breach of its contractual obligation to provide comprehensive healthcare to *all* Native Americans, and those living off-reservation are bearing the brunt of this failure. How to enforce that obligation, or find solutions in its absence, is the challenge Albuquerque’s Urban Indians face.

¹ The IHS Dental Clinic, housed at the Southwest Indian Polytechnic Institute (SIPI).

2. Healthcare Crisis for Urban Indians

Albuquerque's Urban Indian Community

Generally, Urban Indians are Indians who have left their tribal communities and are living in urban areas or other communities not 'on or near' tribal land.² The reasons for this massive migration away from Indian Country are many and varied, though a major factor was the federal government's forcible 'relocation' policies, instituted in the 1950s and carried on over a 20 year period.³ Indian Health Service (IHS) data indicates that Albuquerque has the highest percentage of Native Americans in its population of any American city (10.5%), with the third highest raw number of Native Americans.⁴

According to the IHS, in FY2003 there were 46,883 individuals representing as many as 407 tribes from across the country living in Albuquerque and listed as patients at the Albuquerque Indian Health Center.⁵ First Nations Community Healthsource which provides a variety of primary care services, primarily to Urban Indians, estimates there are between 45,000 and 51,000 Native people in Albuquerque representing more than 150 different tribes.

According to U.S. Census data, the median household income for Native Americans in Albuquerque in 1999 was \$23,440 and per capita income was \$8,679 compared to \$38,272 and \$20,884 for non-Indians.⁶ On average, at that time, 25.8% of Albuquerque's Native American population lived below poverty level, but there were neighborhoods in which as many as 64.6% of the population lived below poverty level.⁷

Native Americans made up 13.5% of the state's uninsured population in 2004, while consisting of 10% of the population as a whole.⁸ According to a more recent study by Mathematica Policy Research, Inc., using the U.S. Census definition of Native Americans who receive medical services exclusively from IHS as uninsured, less than a quarter of all New Mexico Native

² 'Urban Indian' and 'off-reservation Native American,' and any permutation of the two terms, are used interchangeably in this document. 'Urban Indian' is a legal term of art created by Congress when it passed the Indian Health Care Improvement Act in 1976; it is not typically used by Native Americans when self-identifying, and has no tribal or geographic resonance. Likewise, the terms Indian, American Indian, and Native American are used interchangeably (and are meant to be inclusive of Native Alaskans as well). There is no clear community preference, and no consistent term-of-art usage.

³ Also: "It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. Unfortunately, the same policies and programs that failed to provide Indians with an improved lifestyle on the reservation have also failed to provide [them] with the vital skills necessary to succeed in the cities." House Report 94-1026, p. 116, relating to PL 94-437 (April 9, 1976).

⁴ New York City and Los Angeles have higher raw numbers of Native Americans in their populations.

⁵ According to the IHS, Albuquerque's Native American population breaks down as follows: 54.8% are Navajo, 18.3% are members of the 19 Pueblos, 2.4% are from one of New Mexico's two Apache tribes, and 24.6% are affiliated with 385 different tribes from outside New Mexico.

⁶ These figures may not match up with IHS data as, according to the 2000 census, 28,857 Albuquerque residents self-identified as American Indian or Alaska Native, making up 5.2% of the total population. The econometric figures cited are based on this smaller population survey, not the more expansive IHS numbers.

⁷ Primarily Albuquerque's Southeast Heights neighborhood.

⁸ NM Human Services Department's "2004 Household Health Insurance Survey."

Americans have full-year health insurance.⁹ First Nations Community Healthsource, Albuquerque's only Urban Indian health clinic, estimates that 70% of Albuquerque's Native American population is uninsured.¹⁰

In 2000, 18% of New Mexico's off-reservation community reported attaining a 4 year college degree or higher compared to 30.5% for all races.¹¹ The unemployment rate was 13.1%, compared to 5.7% for all races, and 56.1% of Native American households consisted of a single parent, compared to 35.2% for all races.¹²

Healthcare Challenges Facing Urban Indians in Albuquerque

The federal government has long recognized the problem of poor health among off-reservation Native Americans and, until recently, provided money to local healthcare facilities to provide primary healthcare services to Urban Indians, mainly through the IHS. This arrangement, however, has been deteriorating. Funding has been increasingly reduced, even as Urban Indian populations have grown, leaving these individuals with fewer and fewer options for care. For example, the Albuquerque Indian Health Center (AIHC), which at one time supplied urgent care to over 36,000 people per year, has been reduced to a shell of its former self, operating currently with less than a third of its previous staff. Since shuttering its urgent care facilities in 2005, no other entity has been able to fill the gap in healthcare access for Native Americans.

Because most federal healthcare dollars for Indians are distributed through tribes, Urban Indians often must return to their tribal homes to seek healthcare. However, tribal resources are generally inadequate. Tribes must ration the care they provide, giving priority to those who live on tribal territories. As a result, Urban Indians commonly cannot avail themselves of tribal care, either because their tribes cannot afford to care for them, or because their home tribes are too far away.¹³ As a result, most Urban Indians end up seeking care at the nearest public hospital or emergency room, or foregoing care altogether. In Albuquerque, this situation has led to dire results.

The off-reservation community in Albuquerque experiences higher rates of disease and death than other communities. For example, that community's diabetes rate is 67.6 per 100,000, compared to 13.5 for all races in the United States. Between 1990 and 1999, the rate of chronic liver diseases for Albuquerque's Native American population was 38.6 per 100,000, as compared to 14.8 for all races, and the diabetes death rate was 43.4 per 100,000, as compared to 23.6 for all races. The need for preventative and therapeutic care is great and largely unmet.

⁹ Almost 10% of New Mexico Native Americans are currently uninsured over the course of an entire year and 67% are uninsured for at least part of the year.

¹⁰ "White House Budget Puts Albuquerque Clinic at Risk," Kate Nash, *Albuquerque Tribune*, April 5, 2006.

¹¹ NMHSD 2004 Household Health Insurance Survey.

¹² *Id.*

¹³ Or because tribes, with the tacit support of the IHS, turn away tribal members who have not lived on the reservation within 180 days prior to seeking treatment there.

3. Federal Responsibility to Provide Native Americans with Healthcare

The federal trust responsibility for healthcare, enshrined in numerous treaties and agreements,¹⁴ is codified by the Snyder Act of 1921 and, subsequently, the Indian Health Care Improvement Act (IHCIA) of 1976. Currently, the Indian Health Service, which operates under the auspices of the federal Department of Health and Human Services, is charged with fulfilling this aspect of the trust obligation.¹⁵

Snyder Act

The Snyder Act gave Congress the authority to appropriate money for Indian healthcare.¹⁶ It specifically recognized that the federal trust responsibility includes healthcare concerns. The Act provides that the Bureau of Indian Affairs (BIA) under the direction of the Secretary of the Interior “shall direct, supervise, and expend” money that Congress appropriates “for the benefit, care, and assistance of the Indians throughout the U.S. for the following purposes” including “for the relief of distress and conservation of health.”¹⁷

Indian Health Care Improvement Act

The Indian Health Care Improvement Act of 1976 is a federal statute that transferred the responsibility of overseeing Indian healthcare concerns from the BIA to IHS. It also explicitly recognizes Urban Indians as a distinct group for the first time. The IHCIA states that “[i]t is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”¹⁸

The IHCIA specifically directs the Secretary of the Interior to expend funds allocated by Congress to the Indian Health Care Improvement Fund for the purpose of “meeting the health needs of Indians in an efficient and equitable manner.” But while the IHCIA authorized appropriations, it did not identify levels or goals for funding.¹⁹

A large portion of current IHS programs were either started or sustained through the use of IHCIA appropriations. As a result, the language of the IHCIA provides useful insight into Congress’ intent for IHS responsibilities and activities vis-à-vis Urban Indians.

Urban Indians, as distinct from Indians who live “on or near [a] reservation,” are defined by the IHCIA as any Indian who resides in an urban center.²⁰ An urban center is “any community

¹⁴ See generally: FELIX COHEN ET AL., COHEN’S HANDBOOK OF FEDERAL INDIAN LAW (2005).

¹⁵ The IHS was created in 1954, when responsibility for Native American healthcare was transferred from the Department of Interior to what was then the Department of Health, Education and Welfare.

¹⁶ 25 U.S.C. § 13 (1921).

¹⁷ *Id.*

¹⁸ Indian Health Care Improvement Act, 25 USC §1602(a) 2000

¹⁹ Rose Pfefferbaum, et. al, *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures and Practices*, 21 AM. INDIAN L. REV. 211, 216 (1997).

²⁰ 25 U.S.C. § 1603.

which has a sufficient Urban Indian population with unmet health needs to warrant assistance under Title V as determined by the Secretary.”²¹

Title V of the IHCA recognizes that Urban Indians have particular healthcare needs, and provides for certain programs in urban centers to “make health services more accessible to urban Indians.” Specifically, Title V established the Urban Indian Health Program, which is a vehicle for channeling appropriations directly to medical facilities that serve Urban Indian populations exclusively, bypassing other existing IHS funding streams.

The IHCA, including Title V, sunsetted in 2000, but Congress is currently in the process of reauthorizing it. Reauthorization will once again confirm and codify the federal responsibility to provide comprehensive healthcare to all Native Americans, and will reassert special recognition of the status and needs of Urban Indians. Even if successful, however, the reauthorization will not include an appropriation.

4. How the Federal Government Delivers Healthcare to Native Americans in Albuquerque

In order to understand how Native Americans in the Albuquerque area are supposed to receive healthcare, it is important first to understand the basic structure of the IHS, the Contract Health Service, programs designated specifically for Urban Indians, and a law that allows tribes to withdraw their share of funding from the IHS pool and administer their own healthcare programs directly. Also, and not incidental, all Indian healthcare programs are discretionary and funded at the will of Congress, effectively allowing the federal government to abrogate its trust responsibility by withholding funds.

Indian Health Service

The IHS is charged with providing a comprehensive healthcare service delivery system for approximately 1.8 million of the nation’s estimated 4.1 million American Indians and Alaska Natives.²² However, it is funded at only 54% of the level necessary to provide full services in the 35 states in which it operates.²³ While funding for IHS has increased every year, studies have found that the IHS budget has failed to even keep pace with inflation and population growth.²⁴ Between 1990 and 2005, total IHS appropriations increased approximately 5.8% on

²¹ *Id.*

²² This figure includes both respondents who identified themselves solely as Native American/Alaska Native **and** those who identified themselves as both NA/AN and a second ethnicity.

²³ 2005 IHS facts on Indian Health Disparities. When IHS was created in 1954, it was structured around reservation areas, mostly in the West, where most Native Americans lived at the time. By the late '50s - early '60s the federal relocation program had begun. Native Americans that were relocated were covered under private insurance for 6 months after the move. After that, they were on their own---unless they were relocated to a community with a local IHS facility like Albuquerque or Phoenix. Currently, many Native Americans live in geographic areas not served by IHS.

²⁴ Caryn Trombino, *Increasing Access to Health Care: Methods to Address the National Crisis: Changing the Borders of the Federal Trust Obligation: The Urban Indian Health Care Crisis*, 8 N.Y.U. J LEGIS. & PUB. POL’Y 129 (2005), note 2, at 142. In addition to direct federal funding, IHS receives income from third party payors, including private insurers, Medicare and Medicaid.

average. However, the bulk of those increases were eaten up by mandatory pay raises for the nearly 14,500 federal employees that make up the delivery system.²⁵

IHS provides care directly to members of federally recognized tribes as well as their children. Formal tribal enrollment is not required to establish eligibility.²⁶ Enrollment *can* be used to establish eligibility, but other acceptable evidence includes participation in tribal affairs or residence on tax exempt property.²⁷ IHS will also provide care to non-eligible women, pregnant with the children of eligible men.²⁸

Direct health services, excluding those provided through facilities operated by tribes, are administered through a decentralized system of 12 Service Area offices and 155 IHS and tribally managed Service Units. Any member or descendant of a federally recognized tribe is entitled to available care at any IHS direct service facility, regardless of where the facility is located; no eligible Native American can be denied because of their place of residence.²⁹

Service Areas are typically funded based on their ‘user population,’ which counts the number of potential users as determined by tribal enrollment figures, rather than by ‘active users’ which would track the number of individual patients seen annually in a Service Area and allocate funds accordingly. The use of the less accurate ‘user pop’ method creates even further disparities across the system by not distributing resources based on actual need. Each tribe elects which funding formula to use; the likelihood of receiving more funding under the ‘user pop’ formula frequently results in the choice of that option.

Service Units provide care within defined geographic areas typically centered around a reservation or, in Alaska, a population concentration. The base of operations for a service unit is typically a small hospital or health center. IHS does not always provide ancillary and specialty services, including laboratory and X-ray services, obstetrics/gynecology services, or outpatient mental health; nor do IHS facilities offer catastrophic healthcare services.

In New Mexico there are two IHS ‘Service Areas:’ Albuquerque and Navajo. The Albuquerque Service Area includes counties throughout central New Mexico and also includes parts of Texas and Colorado. Within this service area there are eight ‘Service Units,’ including the Albuquerque Service Unit, which is responsible for serving the healthcare needs of over 30,000 Urban Indians as well as the tribal land-based Native Americans in the area.³⁰

Chronic under-funding has resulted in these unfortunate statistics: in 2005 the federal government spent \$3,945 per capita for federal prisoners, as compared to \$2,130 per capita for

²⁵ Furthermore, rescissions mandated by the federal Deficit Reduction Act amounted to 1.5% in 2006, effectively wiping out any operational appropriations increase.

²⁶ 42 C.F.R. § 136.12(a)(1). All persons of “Native American descent who belong to the Native American community” are eligible for direct services.

²⁷ 42 C.F.R. § 136.12(a)(2).

²⁸ 25 U.S.C. § 1680c(c).

²⁹ <http://www.ihs.gov/NonMedicalPrograms/Urban/Overview.asp>

³⁰ Albuquerque is one of only three U.S. metropolitan areas to have an IHS direct care facility. The other two are Anchorage and Phoenix.

the 1.4 million Native Americans serviced by IHS.³¹ In 2003, the federal government expended \$2,007 per Native American client, compared to \$4,487 for Medicaid clients and \$7,145 for Medicare clients.³² In that same year, the overall per capita expenditure for healthcare in the United States was \$5,952.³³ An under-funded IHS routinely reduces programs and services, which increases the number of patients that must seek care outside the IHS system through Contract Health Services (CHS).³⁴

Contract Health Services

Services not provided through IHS direct care facilities may be provided to eligible patients through contracts with non-IHS caregivers. Because many Indian communities are isolated, IHS and tribal healthcare programs make extensive use of contracts with other hospitals and specialists to supplement direct services. These contract health costs comprise about a quarter of the total cost of clinical services provided by IHS. Insufficient funding, however, has resulted in the failure to provide services for all but the most life threatening conditions,³⁵ and requests for CHS services are denied to approximately 67% of eligible Urban Indians who apply.³⁶

IHS has sought to reduce contract health costs by limiting its obligation to provide contract healthcare to Indians not living near their reservations.³⁷ If a Native American does not live on a reservation but does live within a Contract Health Service Delivery Area (CHSDA) that serves his or her reservation, and he or she maintains close social and economic ties with his or her tribe, then he or she remains eligible for contract health services.³⁸ The vast majority of Urban Indians are, as a result, not eligible for Contract Health Services.

In most cases a CHSDA consists of the county or counties in which a reservation is located, as well as any counties it borders.³⁹ The Albuquerque CHSDA includes only Sandia, Isleta and Laguna pueblos, as well as the Navajo Nation through its settlement at Tohajilee.⁴⁰ Albuquerque residents from any other tribe are ineligible for CHS services. Since the closing of the urgent care unit at the Albuquerque Indian Health Center in 2005, most Albuquerque area CHS dollars are now being spent for urgent care at non-IHS facilities. However, all CHS-eligible

³¹ 2005 IHS Expenditures per capita compared to other federal health expenditure benchmarks

³² Congressional Research Service report prepared for Sen. Jeff Bingaman March 16, 2007

³³ Ibid.

³⁴ It must also be noted that IHS has been persistently criticized for spending too much of its budget – in both its local and national offices – on administrative salaries and costs, and not enough on the provision of direct medical services.

³⁵ IHS uses the criteria that a condition must be a “life and limb” emergency to qualify for CHS approval; see: <http://www.ihs.gov/NonMedicalPrograms/Urban/Overview.asp>

³⁶ This translates to 280,000 “active users,” meaning those who reside within the Contract Health Service Delivery Area of their own home Service Unit, who are denied CHS services. See: <http://www.ihs.gov/NonMedicalPrograms/Urban/Overview.asp>

³⁷ 42 C.F.R. § 136.23.

³⁸ 42 C.F.R. § 136.23(a).

³⁹ U.S. Government Accountability Office, *supra* note 8, at 11.

⁴⁰ In another odd twist, even though Laguna Pueblo members can go to the AIHC and receive Contract Health Services in Albuquerque due to the Pueblo’s physical contiguity with Bernalillo County, the funds allotted to care for Laguna tribal members actually go to fund the Acoma-Cañoncito-Laguna Service Unit, which has its own hospital.

Albuquerque Native Americans are not guaranteed access to treatment through CHS: since funds are insufficient to cover the volume of eligible CHS demands, priorities for service are determined based on relative medical need,⁴¹ and only the most serious cases are receiving consideration. Even these needs are not fully met, as more than two-thirds of urgent care needs are currently denied by CHS.⁴²

If the entire state of New Mexico was a CHSDA, as is the case with Oklahoma, all Native Americans from New Mexico tribes would be eligible for contract care. But for New Mexico to become a statewide CHSDA, a tribe would have to petition the IHS. This has not happened.

Urban Indian Healthcare Program

The Urban Indian Health Program (UIHP), established by the Indian Health Care Improvement Act,⁴³ provides funding for 34 urban Indian clinics in 19 states with a potential user base of around 1,000,000 off-reservation Native Americans.⁴⁴ In 2004, these clinics provided healthcare access to around 78,000 Native Americans.⁴⁵ The program is severely under-funded: the entire UIHP budget hovers around \$34 million, which is approximately 1% of the total budget for the Indian Health Service -- despite the fact that the off-reservation Native American community has grown to comprise over 65% of the total number of Native Americans in the US.⁴⁶

Unlike IHS and tribal clinics, where services are free to all eligible Native Americans, federally subsidized Urban Indian programs provide services on a sliding fee scale, and the scope of the services is restricted to primary care.⁴⁷ Any referrals for specialty care, diagnostic services, hospitalization, etc., are made with the understanding that the patient will be responsible for the costs of those services.

In Albuquerque there is only one facility that receives funding through the UIHP: First Nations Community Healthsource.⁴⁸ First Nations, established in 1972, provides primary care, dental care and behavioral healthcare to approximately 1120 patients per month with a current budget of around \$2.4 million. It receives approximately \$380,000 per year in UIHP funds.⁴⁹ Many of its patients are not Native American. In 2006, First Nations treated 5769 primary care patients, 3163 of whom were Native American.⁵⁰

⁴¹ 42 C.F.R. § 136.23(e).

⁴² http://info.ihs.gov/Files/CHS_06_Profile-Jan2006.pdf.

⁴³ More specifically, by Title V of that act; the Urban Indian Health Program is often referred to as "Title V."

⁴⁴ Urban Indian Health Institute, Seattle Indian Health Board: www.uihi.org.

⁴⁵ *Id.*

⁴⁶ 2000 U.S. Census

⁴⁷ Henry J. Kaiser Family Foundation Report "Urban Indian Health," p. 12, prepared by Ralph Forquera, MPH, of the Seattle Indian Health Board (November, 2001).

⁴⁸ A second facility, the Albuquerque Indian Dental Clinic at the Southwestern Indian Polytechnic Institute, also receives approximately \$500,000 per year from IHS -- but not from UIHP -- to treat Native Americans up to age 25 who live in Albuquerque.

⁴⁹ First Nations also receives an additional \$500,000 appropriation annually from IHS, but not through the Urban Indian Health Program fund.

⁵⁰ The exact figures for dental and behavioral health patients treated were not available as this report went to press.

Federal funding for Urban Indian Healthcare clinics has been under assault by the current administration. In each of the last several years, President Bush has attempted to zero out all IHS funding for the 34 non-profit Urban Indian clinics. To date, that funding has always been restored, though at an extremely low level given the population base it is meant to serve

Public Law 638

Since the passage of PL 93-638, the Indian Self Determination Act and Education Assistance Act of 1975, tribal governments have had the opportunity to contract directly for their own programs and services, including healthcare services, with the federal government.⁵¹ These are generally referred to as “638 contracts,” and permit tribes to administer a full spectrum of services, including both direct and contract healthcare services, facilities construction, community health representatives programs, mental health and drug abuse services and health education initiatives.

Tribes may withdraw up to 100% of their tribal share of the IHS funding in their service area.⁵² Nationally, in FY 2006, tribes controlled approximately \$1.8 billion, or 55 percent of IHS's total budget, through 638 contracts.⁵³

These healthcare centers are required to provide care to any person who is otherwise eligible for IHS services.⁵⁴ Currently, according to anecdotal evidence, local 638 clinics are taking new patients **only** if they are members of the tribe operating the facility, in contravention of federal law.⁵⁵

Albuquerque Service Unit

The Albuquerque Service Unit of the IHS is severely under-funded, and has had to cut back substantially on the services it provides. The most recent blow was the 2005 closing of the AIHC urgent care unit, which had been treating between 100 and 200 patients daily.⁵⁶ One significant reason for the lack of resources lies in the way in which IHS calculates and distributes its funding of local healthcare providers.

When the IHS was created, most Native Americans still lived on or near their tribal lands. Its purpose was to provide healthcare in remote areas where no other options existed. Federal healthcare dollars were therefore allocated based on a tribe's enrollment numbers, and allocated to the service areas where those tribes are located – or to the tribes directly – based on those numbers. Even though in the intervening years many Native Americans have migrated for various reasons from their tribal lands, that formula continues to guide IHS spending.

⁵¹ Though with continued federal oversight. See: 25 U.S.C. § 450.

⁵² Trombino, *supra*, at 139.

⁵³ FY 2006 Budget in Brief: Indian Health Service, *available at* <http://www.hhs.gov/budget/06budget/indian.html>.

⁵⁴ 42 C.F.R. § 136.12. Tribes providing healthcare under PL 638 may independently decide to extend services to individuals not otherwise eligible for care (for example, non-Indians).

⁵⁵ There have been reports that this policy is in direct response to the actual or anticipated flood of new patients from Albuquerque seeking treatment following the closure of the IHS urgent care facility in 2005.

⁵⁶ “Bush Won't Bail Out Urban Indian Health Center,” *Albuquerque Tribune*, Monday, January 31, 2005

The money doesn't follow the patient; it goes to the wherever that patient is tribally enrolled. So Native Americans from tribes outside of the Albuquerque Service Unit who live in the Albuquerque area – and make up 75% of the local Native population – are not accounted for when the Albuquerque Service Unit is funded. As a result, services for the entire Albuquerque Urban Indian community must be funded by allocations intended to serve only the tribes located in the Albuquerque area, which happen to be three of the smaller tribes in New Mexico: Sandia, Santa Ana, and Zia Pueblos.⁵⁷

In FY2005, federal allocations to the Albuquerque Service Unit for direct medical services amounted to just \$542 per capita, because of the need to serve those Native Americans not officially accounted for on the local tribal rolls. This figure is well shy of the national IHS per capita spending average of \$2,130.⁵⁸ In order to fund local Urban Indian healthcare services at even that low level, the Albuquerque Service Unit would need an annual budget of around \$58 million. It has always operated with much less and, due to recent events, that amount has plummeted.

More and more local tribes have recently contracted with IHS under PL 638.⁵⁹ The good news is that these tribes were then able to spend an average of \$3,136 on treatment for their people.⁶⁰ However, as a result of these funds leaving the IHS direct service pool, the Albuquerque Service Unit was left with \$10 million in tribal allocations, in addition to about \$4 million a year from Title V funding. This created a substantial operational shortfall, as, in 2005, AIHC needed \$15 million to operate at 'full' capacity.⁶¹

The devastating impact of these funding shortfalls in the Albuquerque area is significant and widespread. In 2006, a resident at the University of New Mexico Hospital, Dr. Dan Waldman, completed some preliminary research into the effects of the closure of urgent care services at AIHC. Based on interviews with 110 participants, 83.8% of whom live in Albuquerque, he learned that:

- 56.9% of the respondents self-identified as Navajo (remember, the Albuquerque Service Unit gets NO funding based on appropriations for Navajos).

⁵⁷ Because of complex federal policy restraints, there is no process for reimbursement -- and the Albuquerque Indian Health Center receives no funding -- from the Navajo Area for the treatment of Albuquerque Native Americans, despite the fact that by some estimates Navajos make up around half of the Albuquerque Indian population. Moreover, Isleta Pueblo, which would otherwise be included, has withdrawn all of its funding share from the Albuquerque Service Unit, see FN 41.

⁵⁸ Based on 1.4 million tribal users nationwide.

⁵⁹ The Alamo Chapter of the Navajo Nation recently assumed full control of all operations of the Alamo Navajo Health Center. In 2005, Isleta Pueblo took all of the \$6.5 million it is afforded in the IHS annual budget, leaving none to go to Albuquerque Indian Health Center. Jemez Pueblo took \$4.7 million, or nearly its entire \$5 million share, that same year. Sandia Pueblo took only a few thousand dollars of its \$820,000 allotment; and Santa Ana and Zia pueblos took none of the \$2.7 million to which they are entitled.

⁶⁰ Again, the reason for the relatively high expenditure numbers among these 638 tribes is the formula that allocates funds based on tribal enrollment numbers, not on the numbers of tribal members who actually live in the Pueblo or on the reservation.

⁶¹ *Id.* Moreover, IHS does not consider 'full capacity' to be the equivalent of full funding for every patient; rather, it operates on the presumption that when 'full funded' it will be funded at 60% of actual need.

- 57% had no health insurance, 19% had private insurance, 1% were enrolled in the UNM Care charity plan, and 23% had Medicaid or Medicare.
- Since the closure of urgent care services at AIHC in 2005, respondents sought urgent care services at non-IHS facilities an average of 4 times.
- 61.6% of respondents answered that they had not sought medical care at least once in a situation where they would have previously gone to AIHC's urgent care.
- 45.5% of respondents stated that the single greatest barrier in seeking walk-in services was lack of insurance or increased costs.
- 22.8% of respondents stated they owe more than \$500 for walk-in care received since the AIHC urgent care closure.

Finally, the Commonwealth Fund recently issued its *Scorecard on Health System Performance, 2007*. In this report, it ranked each state according to a number of different dimensions of their healthcare systems. Unfortunately, New Mexico ranked dead last in the category of "Access." This ranking was based on metrics involving the entire state population. When considering the extreme vulnerability of off-reservation Native Americans within the evident shortcomings of New Mexico's healthcare delivery system, it becomes logical to extrapolate that New Mexico's Urban Indian population has the worst access to healthcare of any community in the United States.

5. UNMH and the 1952 Contract

History

What we now know as the UNM Hospital began in 1949, when Congress authorized the Secretary of the Department of Interior to transfer 5.33 acres of BIA-controlled federal land to Bernalillo County for the construction and operation of a hospital by the county. The intention was to build a hospital for the approximately 18,000 Pueblo Indians living on surrounding reservations.⁶² At the time, however, William W. Zimmerman, Acting Commissioner of the Bureau of Indian Affairs testified that "the hospital would be open to Indians from many parts of the Southwest, and for that matter, to Indians from any part of the United States, and would not be limited under this bill to Pueblo Indians."⁶³ The costs of care and treatment of all eligible Indians would be reimbursed by the federal government, pursuant to predetermined formulas.

On January 18, 1952, Bernalillo County signed a contract with the United States, 'acting by and through the Commissioner of Indian Affairs for the operation and maintenance' of the hospital. The final construction cost of the hospital of \$3.25 million was shared by the two parties to the contract; \$1.5 million from the BIA, \$1.75 million from Bernalillo County. In 1954, the Bernalillo County Indian Hospital was opened with the mission of serving Indians and indigents (whose costs are provided for by the county mill levy). According to the contract, the hospital was obligated to reserve at least 100 beds for Pueblo Indian patients. Subsequent Amendments in 1956 and 1957 reiterated the primacy of the contract's intention to "assure that adequate medical treatment for qualified Indians is properly provided."

⁶² Testimony before Subcommittee of the Committee on Interior and Insular Affairs on August 19, 1949.

⁶³ *Id.*

The term “Indian” was explicitly used in the contract to mean all Native Americans, not just those from tribes in the Albuquerque area or even New Mexico.⁶⁴ There was no distinction made between Pueblo and non-Pueblo Indians, let alone between residents and non-residents of either Bernalillo County or the State of New Mexico.⁶⁵ In other words, any member of any federally recognized tribe from anywhere in the United States was eligible for federally-reimbursed care at the Bernalillo County Indian Hospital.⁶⁶

In 1968, the name of the hospital was changed to Bernalillo County Medical Center. In 1969, UNM assumed operation of the hospital as a teaching hospital. In 1978, UNM assumed full control of the hospital under a 20-year lease with the county, which was renewed in 1999. In each amendment and extension, UNM and Bernalillo County have explicitly agreed to honor the responsibilities to Native Americans identified in the original federal contract. IHS has consistently signed off on amendments and extensions, and in 1978 it made the All Indian Pueblo Council (AIPC) a Native American representative party to the contract, able to participate in negotiations and consultations and eligible to receive all reporting previously owed to IHS.⁶⁷ In 1987, the facility was renamed the University of New Mexico Hospital (UNMH).

However, in the course of amending and expanding on the original contract, some curious changes have been made. For example, language in a 1999 amendment indicates that the hospital was built on land conveyed to Bernalillo County by the federal government “for the purpose of providing a site for a hospital for the County that would **also** serve Native Americans **of New Mexico**” (emphasis added).⁶⁸ This statement is a blatant misrepresentation of the facts.

What is now UNMH was **originally conceived** as an Indian Hospital; the original federal contract made no mention of indigent care, and; the hospital was explicitly named the ‘Bernalillo County Indian Hospital.’ It was never intended that the hospital would provide treatment solely to Native Americans from New Mexico tribes. Though seemingly innocuous, this kind of language shift can have serious consequences as the contract is interpreted now and in the future – especially in light of the new pressures faced by UNMH to treat Native Americans in the wake of the closure of urgent care services at AIHC.

Current State of Affairs

Though the contract and lease agreement have been amended several times, the gist of the original 1952 federal contract remains the same: the hospital is obligated to provide high quality

⁶⁴ “Indian” was defined in the 1952 contract’s ‘definition of terms’ section as “a person qualified, as determined by the Secretary [of the Interior], to receive medical, surgical and hospital care and service through or from the Bureau of Indian Affairs[.]” In Section Four of the contract the term is used more expansively to refer to “any person of Indian blood.”

⁶⁵ The drafters of and signatories to the contract were well aware of such distinctions, as evidenced by the priority for Pueblo Indians of access to the 100 beds set aside for Indian use, and the specific requirement that “at least one Pueblo Indian” shall be appointed by the County to the Board of Trustees.

⁶⁶ Section 24 states unequivocally that “[t]his contract shall be perpetually binding upon the County, the Trustees and their successors, and any authorized successor operator of the hospital.”

⁶⁷ The All Indian Pueblo Council is a consortium representing all 19 New Mexico Pueblo tribes. It does not represent the Navajo Nation, the Mescalero Apache or the Jicarilla Apache.

⁶⁸ Agreement Regarding Consent to Lease Agreement, 1999, Section I, paragraph C.

healthcare services to Indian people and the federal government is obligated to pay for them. It is important to keep in mind that, prior to the closing of the IHS urgent care facility in Albuquerque in 2005, most Native Americans were unaware of the federal contract and their right to seek treatment at UNMH because, given the existence of a local IHS direct care facility, they had little need or inclination to go to UNMH for medical care.

In 2003, UNMH sought an extension of its lease with Bernalillo County in order to qualify for a federal mortgage it needed to build a new wing. This lease extension required IHS approval, which was ultimately granted. However, the negotiations took place once again without any Urban Indian input, with detrimental results. In the resulting 2004 lease extension agreement, several new policies were introduced which were very questionable in the context of the intent of the original contract.

For example, the UNMH payment policy for uninsured patients explicitly states that Native Americans will be treated the same as other Bernalillo County residents when presenting themselves for care. This language was intended to ensure that Native Americans are not turned away from UNMH and sent instead to the IHS for treatment, as had apparently happened in the past. However, that policy language also seems to have the effect of equating Native Americans with other patients in a way that is contrary to the intentions of the contract, insofar as it can be read to indicate that UNMH no longer has to provide Native Americans with healthcare free of charge.

Finally, another new policy -- regarding the UNMH charity care program (UNM Care) -- also appears to eliminate any responsibility to provide free care to Native Americans *unless* they are indigent and live in Bernalillo County. UNMH will now enroll *indigent* Native American residents of Bernalillo County in UNM Care, not charge them a co-pay (as is required of other UNM Care participants) and absorb the costs, rather than charging IHS. When it comes to providing healthcare to Native Americans in Albuquerque, or paying for it to be provided elsewhere, IHS has managed to extricate itself from all its responsibilities.

There is a problem with the premise of the new UNMH approach to providing healthcare for Native Americans through its UNM Care program: the original contract never singled out either indigence or Bernalillo County residence as criteria for care of Native Americans. Nor did the 1952 contract ever contemplate that any Native American would be ever charged anything for medical care at the hospital; those costs were always meant to be paid by the federal government, which seems to have left the equation entirely.⁶⁹

This new interpretation of the fiscal responsibility for Native American healthcare incurs new costs for Bernalillo County and the state of New Mexico. Moreover, restricting access to those locally-funded charity care dollars to Native Americans who are residents of Bernalillo County raises other questions. What are out-of-county Native Americans who now rely on UNMH to provide care supposed to do? If they are unable to access the charity care dollars, is the federal

⁶⁹ Two other changes resulting from the 2004 agreement are the creation of two new positions within UNMH to facilitate intake and billing for Native Americans and to liaise with the tribes regarding contracting under PL 638, and the reiteration of the mandatory nature of meeting and reporting requirements between UNMH and IHS/AIPC; prior to the new agreement, neither requirement had been met.

government picking up their tab? Or are they being billed, contrary to the intent of the original contract? And why, given the explicit nature of the original contract, is UNMH not in fact an 'IHS Facility' for billing and scope of treatment purposes?

Furthermore, the designation of AIPC as the Native American entity of record for negotiating and reporting purposes raises other problems. For example, AIPC is now invited to a contract-mandated annual meeting to discuss implementation of the contract's elements. No Urban Indians are invited to attend this meeting. But the majority of the off-reservation Native Americans living in the Albuquerque metro area (the vast majority of whom are Navajo) are not members of the Pueblo tribes and, therefore, are not in any way represented by AIPC. AIPC has no real incentive to advocate on their behalf.

In the process of amending the contract, IHS has, with AIPC support, become the payor of last resort for Native American care. This was the result of some smooth lawyering on the part of the IHS, which managed to leverage UNMH's need for a swift new lease agreement into a substantial diminution of its own fiscal responsibilities. It seems more than coincidental that merely one year after this agreement shifting the financial burden from IHS to UNMH was completed, IHS essentially shut down its own local facility, thereby leaving Albuquerque's Native American community with no option for free care other than UNMH. Yet UNMH did little to publicize its availability to the local Native American community, and limited its provision of free care to those it considered charity cases rather than to all Native Americans, as required by the contract.⁷⁰ Although UNMH has recently created a paid staff position whose purpose is to liaise with local tribes, it has done little to establish formal relations with the community to which it is most likely – and most obligated – to provide service: Albuquerque's Urban Indians.

According to UNMH, Native American patient encounters⁷¹ from FY 2004 to FY 2006 averaged around 1,100 emergency room visits, 1,800 inpatient encounters and 6,200 outpatient visits. Native Americans made up from 5.1% to 5.6% of the total number of patients seen at UNMH, though they constituted between 11.8% and 12.6% of all UNMH emergency room visits. Those numbers can only be expected to rise. But it is still not clear who is supposed to pay for that treatment, now that the federal government seems removed from the equation. Increasingly, that burden appears to be falling on the very people the hospital was initially constructed to provide free service to – Native Americans.

On the heels of a statewide "Healthcare Summit" called by New Mexico's Governor, UNMH has committed to creating a "storefront" for its Office of Native American Services, to be staffed primarily by Native Americans and charged with centralizing information about patient services, billing, etc., in a prominent point-of-entry location by the fall of 2007. But the hospital has stopped well short of enacting a policy that simply states, as mandated by the contract, "Native Americans treated at UNMH will not be billed for their care."

⁷⁰ UNMH has also recently adopted a new language access policy for Native Americans, as the result of a lawsuit brought by the NM Center on Law and Poverty on behalf of several local Native American advocacy organizations.

⁷¹ The population of Native American patients treated at UNMH is derived from patient records where the patients chose to self-declare their race as Native-American; such data, therefore, is not conclusive.

6. Possible Solutions

Incremental efforts are underway to address the healthcare access needs of Urban Indians in Albuquerque. Positive developments include the coalescence of a number of Urban Indian advocates into a group with a concerted focus on Urban Indian healthcare, whose efforts have resulted in some small improvements at UNMH. But the central concern – how to make the federal government live up to its contractual obligation to provide comprehensive healthcare to all Native Americans – remains largely unaddressed. So decisions must be made whether to try to hold the federal government to its commitment, or look elsewhere to address these urgent problems. Or, do both. Here are some of the possible courses of action that could help increase access to healthcare by Albuquerque’s Urban Indians:

Advocate for Full Federal Funding for Native American Healthcare Services

There appears to be a concerted effort in Washington to de-fund the IHS. Even if the IHCA is reauthorized, it will take a separate bill to fund the programs therein. Native American healthcare is a federal responsibility; New Mexico’s federal delegation must advocate strongly and unequivocally for the level of funding necessary to adequately meet that responsibility.

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Increase Enrollment of Urban Indians in Existing Healthcare Coverage Programs

Medicaid is a federal program that provides comprehensive healthcare to eligible individuals, mostly low-income women and children.⁷² Another program, the State Coverage Initiative (SCI), provides extensive medical coverage to men between 19-64 years old living at or below 200% of FPL. Enrolling in these programs is a somewhat controversial proposition within the Native American advocacy community, some of whom object to what they see as the ‘medicaidization’ of Indian healthcare.⁷³ They argue that the federal government is tacitly pursuing a strategy to diminish and ultimately eliminate the Indian Health Service, which they see as an abrogation of the federal obligation to provide comprehensive cradle-to-grave medical coverage to all Native Americans. But for Urban Indian mothers and children -- and men between 19-64 years old in Albuquerque -- who cannot afford their own insurance, there may be few other immediate options.

The New Mexico Human Services Department (HSD) claims that, as of April 2007, there are 75,550 Native Americans enrolled in Medicaid, representing 18% of the state’s total Medicaid enrollment. This is touted as one of the highest Native American Medicaid enrollment rates in the country. HSD has made a public commitment to increase those enrollment numbers, through its New MexiKids program and – in an expansion of coverage for men between the ages of 19 and 64 – the State Coverage Insurance program (SCI).

Another available program is the UNMH charity care program, UNM Care, which is available to all residents of Bernalillo County who qualify.⁷⁴ UNM Care provides comprehensive health coverage to all who qualify, establishing a ‘medical home’ for all clients and assigning them a primary care physician. Moreover, UNM Care is the only one of the programs noted here that does not require a co-pay from Native Americans (non-Native enrollees do have a co-pay requirement). While UNM Care has the potential to provide healthcare coverage at no cost to thousands of Urban Indians, to date, the program has had extremely low numbers of Native

⁷² Medicare, which provide healthcare for seniors, presents another difficulty beyond any cultural disinclination to enroll in a non-IHS federal program: there are a number of Urban Indian seniors who, having lived most of their lives on a reservation, never worked at a job subject to Social Security withholding, which is a prerequisite for qualifying for Medicare.

⁷³ According to research done by the Urban Indian Health Institute (<http://www.uihi.org>), barriers to Medicaid enrollment among Native Americans range from a lack of understanding of the enrollment process to transportation difficulties to literacy and language obstacles. One particular factor is a fear of negative consequences as a result of having to divulge personal information regarding land holdings, assets, vehicle information and bank accounts. Anecdotally, there is fear about the state seizing such property once it is divulged.

⁷⁴ Applicants who earn up to 235% of the Federal Poverty Level are eligible to enroll.

American participants, due primarily to a lack of successful outreach.⁷⁵ UNMH has promised to increase its outreach and enrollment efforts targeting Native Americans.

Require UNMH to Promulgate and Implement a Specific Policy for Native Americans

The Governor of New Mexico convened a day-long conclave in December of 2005 to address the way UNMH has been fulfilling its public health mission. Regarding the UNMH obligation to Native Americans, the Summit clearly acknowledged a ‘special commitment’ and a ‘special obligation’ to provide healthcare to Native Americans, without ever clarifying what they were. In the Summit’s formal report, the only recommendation regarding Native American healthcare at UNMH was that the hospital “fulfill the intent of the 1952 contract regarding priority service at UNMH for Native Americans.” These generalities have been the norm for UNMH in explaining its role as a provider of health care to Native Americans. Hopefully, in the near future, there will be a policy defining exactly what UNMH’s commitment and obligation to Native Americans pursuant to the contract are, and how they will be fulfilled.

To help motivate such an outcome, advocates can look to the Community Affairs Advisory Council (CAAC) of the UNMH Office of Community Affairs. The CAAC is a citizen group charged with providing advice to the UNMH administration about its policies and procedures from a consumer perspective. One of the Council’s stated priorities is examining and advocating for improved healthcare access for Native Americans. In this capacity, the Council recently created a sub-committee to investigate and report in detail the history and current status of access to healthcare by Native Americans living in Bernalillo County, and examine current UNMH policies addressing those issues (especially in the context of recommendations that came out of Governor Bill Richardson’s Healthcare Summit, which was held in July of 2006).

The mandate of the sub-committee is to educate CAAC, so that it may then make informed recommendations to the Vice President of the University of New Mexico Health Sciences Center. The sub-committee is expected to ask UNMH to explicitly clarify – or create, if necessary – its policy regarding Native Americans in light of its obligation under the 1952 contract to provide comprehensive healthcare services for which the federal government would be financially liable, and to detail how such a policy will be monitored and enforced going forward.⁷⁶

Enforce the 1952 Contract

There is an argument to be made that any diminishment in the duty of the hospital that is now UNMH to provide healthcare to all Native Americans free of charge, with costs to be reimbursed by the federal government, is a breach of that contract. Amendments to the contract permitting such diminishments that were agreed to by the federal government in its role as trustee for Native Americans – who are, after all, the actual third party beneficiaries to the contract – may not be valid insofar as they negatively impact the ability of Native Americans to receive the care (at no cost) that the original contract provided for.

⁷⁵ UNM reports that the total number of Native Americans enrolled in UNM Care in FY 2004 was 24 out of a total number of 14,268 enrollees; it rose to 95 out of 14,194 in FY 06.

⁷⁶ The sub-committee is slated to make its report to CAAC by the fall of 2007.

Though amendments and related lease agreements have put UNMH in the position of having agreed to a lesser federal role in covering the costs of treatment to Native Americans, with the closing of the AIHC in 2005 UNMH may now find itself fiscally unable to absorb the costs of treatment for Native Americans who can no longer go to an IHS direct care facility. As a result, UNMH is in a difficult position, having agreed to the various contractual terms that now place it in such a financially precarious position. As a signatory, UNMH is in no position to now challenge those terms, but it could certainly benefit from a lawsuit brought by other Native American individuals and/or entities which would seek payment from the federal government to UNMH to cover the healthcare costs of Native Americans entitled to cost-free treatment at the successor to the Bernalillo County Indian Hospital, as mandated by the contract.

Charter a Council – City or County

Building on the success of Urban Indian healthcare advocates in other regions, an ad hoc group of Urban Indian healthcare advocates in Albuquerque has begun to explore models for creating a formally chartered council (or other entity) which would be recognized by either the city, the county, or the state as a quasi-governmental agency which could provide a conduit for funding, health planning, policy development, and service expansion. One potential model is the Bernalillo County Community Health Council (BCCHC), which was created by state statute.

Recommendations Proposed by the Native Healthcare Council of New Mexico

- Designate a portion of SCI money provided to UNM to prioritize enrollment of Native people living in the Albuquerque area.
- Designate a portion of Mill Levy funds provided to UNM to prioritize and pay for healthcare services to Native people living in Albuquerque, specifically to establish a medical home through the UNM Care program.
- Facilitate agreements between the Navajo Area Indian Health Service and the Albuquerque Area Indian Health Service to provide funding for Navajo tribal members residing in Bernalillo County.
- Encourage tribes to purchase private insurance for tribal members living off the reservation and include tribes in the State insurance pool.

7. Conclusion

The healthcare crisis facing the Native community in Bernalillo County is the result of the convergence of three factors: federal policy, historical changes to the local public hospital, and changing demographics within the Native community. Policy changes and continuous funding shortfalls have eroded the federal trust responsibility to provide health care services. Changes to the unique lease agreement between Bernalillo County, IHS and the UNM Hospital have transformed a hospital built specifically to care for Native people into a teaching and research institution with no clear policy towards Native Americans. Changing demographics and stagnant federal funding allocation formulas have failed to meet the needs of a mobile Native population,

resulting in minimal federal dollars to pay for healthcare services. The closing of urgent care services at the Albuquerque Indian Health Center has caused significant challenges for otherwise uninsured Native Americans in Albuquerque in need of medical services. This problem cannot go on unaddressed, and will take a community-wide effort to begin to address substantively. We hope this report will help to clarify the history, the status, and the potential for change regarding what is blossoming into a crisis at this very moment.

If you would like more information about the issues addressed in this report, please contact the NM Center on Law and Poverty at (505) 255-2840 or through our website: www.nmpovertylaw.org.