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# URBAN INDIAN HEALTH

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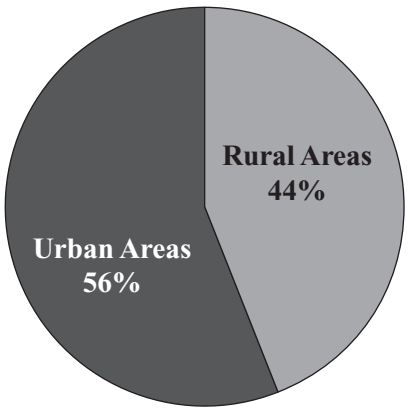
# Issue Brief: Urban Indian Health

Few people realize that the majority of American Indians and Alaska Natives in the United States are now living in American cities, not on reservations. Yet, Federal health care policy toward American Indians and Alaska Natives continues to focus largely on the needs of those living on reservations in rural areas—needs that, despite demonstrable progress since the creation of the Indian Health Service (I.H.S.) in 1955, remain substantial (Kauffman et al., 1997). The purpose of this Issue Brief is to describe the large and growing urban Indian population, their health status, and the major federal health programs (i.e., I.H.S. and Medicare) and federal-state programs (i.e., Medicaid and Child Health Insurance Program) that are available to improve Native Americans' access to needed health services.[1] In setting forth the circumstances of urban Indians, this Issue Brief does not intend to suggest that the health care needs of Indian people living in rural areas are in any way less compelling.

## A Growing Population of Urban Indians

In 1990, over *half* of the 2 million American Indians and Alaska Natives in the United States lived in urban areas (see Figure 1). In contrast, an estimated 430,000 Indians lived on 279 federal and state reservations *that* year, and another 40,000 lived in Alaska Native villages (Snipp, 1996).

**Figure 1**
**Distribution of American Indians and Alaska Natives by Geographic Region, 1990**




Total Population = 2 million

SOURCE: U.S. Census Bureau, 2001

[1] This Issue Brief uses the terms American Indian and Native American interchangeably. Also, unless otherwise indicated, both terms include the Alaska Native population.

Census data for 2000, although not directly comparable with 1990 data, show a similar pattern. In the 2000 Census, individuals could identify themselves by a single racial category or ancestry or by more than one such category (Grieco and Cassidy, 2001).[2] Using either Census 2000 category indicates that at most 36 percent (0.9–1 million) of American Indians and Alaska Natives currently live on reservations, or in other Census defined tribal areas (see Appendix 1).

Since data on urban and rural residency will not be published from the 2000 Census until May–June of 2002, this Issue Brief presents data on metropolitan areas to approximate the size of the Indian population living in urban areas.[3] Census 2000 data indicate that more than half (1.4 million or 57 percent) of the 2.5 million people who identify themselves solely as American Indian and Alaska Native live in metropolitan areas.[4] The proportion living in metropolitan areas is higher when considering individuals who identify themselves solely as American Indian and Alaska Native ***or*** as American Indian in combination with one or more racial category. Two-thirds (2.7 million or 66 percent) of the 4.1 million people who identify themselves solely or partially as American Indian and Alaska Native live in metropolitan areas.[5]

The 20 cities with the largest urban Indian populations in 2000, listed in order of the number of American Indians and Alaska Natives, are: New York, Los Angeles, Phoenix, Anchorage, Tulsa, Oklahoma City, Albuquerque, Tucson, Chicago, San Antonio, Houston, Minneapolis, San Diego, Denver, San Jose, Fresno, Mesa, Dallas, Seattle, and Portland (see Table 1). Considering the people who identified themselves as American Indian and Alaska Native in combination with one or more races yields the same group of 20 cities with one exception: Sacramento replaces Mesa.

## Who are Urban Indians?

Urban Indians are members of, or descendants of members of, one of the many Indian tribes or other organized groups of aboriginal inhabitants of the Americas who live in cities. The Indian Health Care Improvement Act defines the term "Urban Indian" to mean any individual who

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[2] The two major Census defined categories used in this report are: "race alone" and "race alone or in combination with one or more other races." The "race alone" refers to individuals who reported *only one* racial category. "Race alone or in combination with one or more other races" refers to persons who reported only one race *together* with those who reported that same race plus at least one other racial category. In this situation, it means a person indicating "American Indian and Alaska Native" and another Census race category, such as "White," "Black or African American," or "Asian." These two classifications are not mutually exclusive.

[3] "Metropolitan areas" and "urban areas" as used by the Census Bureau are not synonymous. The Census Bureau concept of a metropolitan area (MA) is "one of a large population nucleus, together with adjacent communities that have a high degree of economic and social integration with that core." Metropolitan areas comprise one or more entire counties, except in New England, where cities and towns are the basic geographic units. The Census Bureau defines an urban area as consisting of densely settled territory that contains 50,000 or more people.

[4] Of the 2,475,956 American Indians and Alaska Natives who identified only one racial category, 1,421,132 or 57.4 percent, lived inside metropolitan areas in 2000.

[5] Of the 4,119,301 individuals who identified themselves solely as American Indian and Alaska Native, or as American Indian and Alaska Native in combination with one or more other races (categorized by the Census as "race alone or in combination with other races"), 2,698,724 or 65.5 percent lived inside metropolitan areas.

"resides in an urban center"[6] … and "meets one or more of the four criteria" for qualifying as an "Indian" under the Act.[7]

The migration of Indians from the reservations to American cities occurred throughout the past century and is expected to continue. As shown in Figure 2, the proportion of Indians living in what the Census Bureau defines as "urbanized areas" grew from 45 percent in 1970 to 56 percent in 1990 (U.S. Census Bureau, 2001, personal communication). Historically, this migration reflected federal government "relocation" policies in effect during the 1950's. Over 160,000 American Indians and Alaska Natives were forcibly moved from their reservations into cities to promote assimilation into the dominant U.S. society (Kauffman et al., 2000; Hall, 2001). A failed social experiment, this mandatory "relocation" policy was discontinued 30 years ago. Migration from reservations to cities continues, even though, as they make this transition, Indians frequently lose access to health care and other benefits granted them when living on reservations. Contemporary migration reflects the search for employment, education, and housing opportunities in light of the high unemployment rates, limited educational systems, and housing shortages on some reservations.[8]

Urban Indians are a highly diverse population. In any given city, the urban Indian population is likely to include members (or descendants of members) of many different tribes, including tribes recognized by the federal government and tribes that are not. These individuals may or may not have cultural, religious, or historical ties. They tend to be dispersed throughout metropolitan areas rather than residing in "urban Indian neighborhoods." As a result, urban Indians may share less of a sense of community than Indians living on reservations, which frequently are dominated by one or perhaps a few major tribal groups. It is also common for urban Indians to travel back to their home reservations for periodic visits to family or friends as a way of maintaining their cultural connections.

## The Health Status of Urban Indians

American Indians and Alaska Natives experience significant disparities compared to whites for many health indicators. Rates for infant mortality among Native Americans are nearly one and a half times those of whites and age-adjusted death rates of Indians in the I.H.S. service areas (i.e., Indians residing "on or near" reservations) were at least twice as high as U.S rates for alcoholism, tuberculosis, diabetes, and accidents in 1992–1994 (USDHHS, 1997). Also, cancer mortality rates for American Indians increased between 1980 and 1997, while decreasing for whites

[6]An "urban center" is defined in Section 4(g) of the Act as "any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under Title V, as determined by the Secretary."

[7]This definition is presented in Section 4(f) of the Act, P.L. 94-437. The criteria for Native people ancestry as set forth in Section 4(c) of the Act, are: "(1) irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary [of HHS]."

[8]Despite a widespread misperception, many reservations do not have the resources associated with successful gaming operations or other forms of economic development.

## Table 1
## 20 Cities with Largest Urban Indian Population, Among Cities with Populations of 100,000 or More[1], 2000

| | | American Indian and Alaska Native (alone)[2] | American Indian and Alaska Native (alone or in combination)[2] |
|---|---|---|---|
| **United States** | | **2,475,956** | **4,119,301** |
| **Population inside Metropolitan Areas** | | **1,421,132** | **2,698,724** |
| **Population outside Metropolitan Areas** | | **1,054,824** | **1,420,577** |
| **Cities with largest urban Indian population** | | | |
| **Rank** | **City** | | |
| 1 | New York City, NY (all 5 boroughs) | 41,289 | 87,241 |
| 2 | Los Angeles, CA | 29,412 | 53,092 |
| 3 | Phoenix, AZ | 26,696 | 35,093 |
| 4 | Anchorage, AK | 18,941 | 26,995 |
| 5 | Tulsa, OK | 18,551 | 30,227 |
| 6 | Oklahoma City, OK | 17,743 | 29,001 |
| 7 | Albuquerque, NM | 17,444 | 22,047 |
| 8 | Tucson, AZ | 11,038 | 15,358 |
| 9 | Chicago, IL | 10,290 | 20,898 |
| 10 | San Antonio, TX | 9,584 | 15,224 |
| 11 | Houston, TX | 8,568 | 15,743 |
| 12 | Minneapolis, MN | 8,378 | 12,683 |
| 13 | San Diego, CA | 7,543 | 16,178 |
| 14 | Denver, CO | 7,290 | 12,187 |
| 15 | San Jose, CA | 6,865 | 13,228 |
| 16 | Fresno, CA | 6,763 | 11,239 |
| 17 | Mesa, AZ | 6,572 | 9,175 |
| 18 | Dallas, TX | 6,472 | 11,334 |
| 19 | Seattle, WA | 5,659 | 11,869 |
| 20 | Portland, OR | 5,587 | 12,125 |
| **20 Cities Subtotal[3]** | | **270,685** | **460,937** |

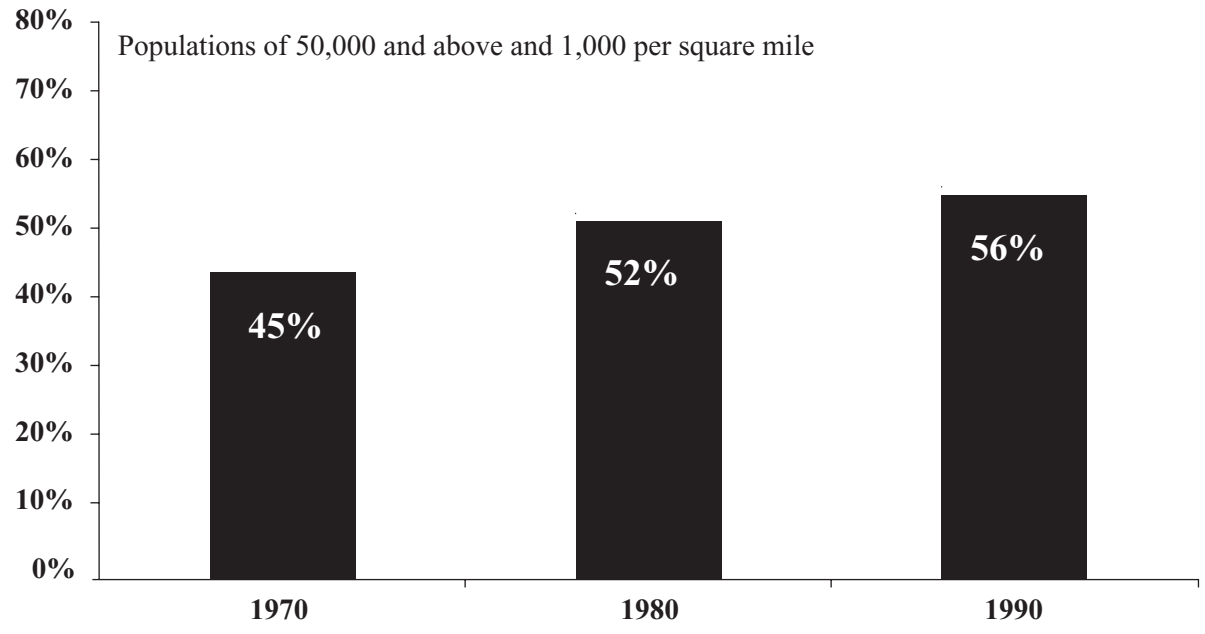
[1]In the United States, there are 245 places with 100,000 or more populations. These places include 234 incorporated places (232 cities, 1 municipality, and 1 town), 4 city-county consolidations with the county name included as part of the place name.

[2]"Race alone" refers to individuals who reported only one racial category. "Race alone or in combination with one ore more other races" refers to persons who reported only one race together with those who reported that same race plus at least one other racial category. In this situation, it means a person indicating "American Indian and Alaska Native" and another Census race category, such as "White," "Black or African American," or "Asian." These two classifications are not mutually exclusive.

[3]Included within Population inside Metropolitan Areas category.

SOURCE: U.S. Census, 2000

**Figure 2**
**Proportion of U.S. Indian Population in Urban Areas, 1970, 1980, 1990**




SOURCE: U.S. Census Bureau, 2001

(USDHHS, 2000).[9] Disparities for diabetes are particularly striking—with the prevalence rate among Indian people being three times higher than the rate for white, non-Hispanics (USDHHS 2001). Despite the poorer health of Indian people, 1 in 3 Native Americans were uninsured in 1999, and more than one-third of uninsured Native Americans report that they do not have a regular source of medical care (The Kaiser Commission on Medicaid and the Uninsured, 2000).[10]

The poorer health status of American Indians and Alaska Natives, compared to other Americans, has been well documented (Young, 1996). Much less is known about the health of urban Indians. The few empirical and population-based studies that exist suggest that health indices are similar for Indian people who reside on or near reservations and those in urban areas.[11] One study, published in the *Journal of the American Medical Association,* analyzed births, deaths, and communicable diseases in 1 metropolitan and 7 rural counties in Washington State between 1981 and 1990. This study found that, compared with urban whites, urban Indians had higher rates of low-birthweight infants, higher rates of infant mortality, higher rates of injury-and alcohol-related deaths, and higher rates of tuberculosis and sexually transmitted diseases (Grossman et al., 1994). Another article, published in Cancer, suggests that urban Indians experience health risks later in life related to earlier years of living on the reservation (Burhansstipanov, 2000). For

[9]Between 1980 and 1997, age-adjusted death rates for malignant neoplasms increased from 82–96 per 100,000 American Indian males and from 62–74 per 100,000 American Indian females. Similar trends were observed for respiratory cancer and breast cancer.

[10]The uninsured estimate also includes those reporting only I.H.S. eligibility for health services.

[11]A review of the Native Health Research Database sponsored by the I.H.S. and the University of New Mexico (see www.hsc.unm.edu/nhrd) identified 186 reports, journal articles, and newspaper articles published since 1966 that contained the textword "urban." At least 42 of these citations focused on urban Indian health or health care use, based on the title.

example, the article notes that many tribal nations are concerned that exposure to environmental pollutants (such as nuclear wastes) may be associated with the early development of breast carcinomas in women in their 30s or early 40s.

Several factors confound the study of urban Indians and their health status. The principal problem is the lack of a clear, uniform definition of urban Indians that local and state health officials can use in identifying the population. Another factor that complicates monitoring of health indices is the dispersion of urban Indians throughout metropolitan areas. A further difficulty is that residential mobility among urban Indians is extremely high, especially among low-income individuals and families. These factors combine to make identifying the population and collecting accurate health status data difficult.

## The Federal Role in Indian Health Care

The federal government has a trust responsibility, based on treaty obligations and federal statutes, to provide health care to members of federally recognized Indian tribes. The Indian Health Service (I.H.S.) within the Department of Health and Human Services (DHHS) has the mission of discharging this trust responsibility on behalf of the federal government. However, because the hospitals and clinics run by the I.H.S. (or by tribes under contract with the I.H.S.) are located primarily on reservations in rural areas, most urban Indians who are members of federally-recognized tribes do not have access to services through I.H.S. (or tribally-run) facilities. Moreover, many urban Indians are not enrolled members of federally-recognized tribes, and I.H.S. generally does not consider these individuals as eligible for services provided by its hospitals and clinics (or those run by tribes under contract with the I.H.S.). The I.H.S. does, however, administer a program of grants and contracts to nonprofit urban Indian organizations that provide outpatient health care and referral services to urban Indians.

The current I.H.S. policy toward urban Indians has roots in the creation of the agency in 1954, when responsibility for Indian health was transferred from the Department of Interior to the Department of Health and Human Services (then the Department of Health, Education and Welfare). The original I.H.S. mission was the construction and operation of hospitals and clinics on Indian reservations and "the conservation of the health of Indians," who during this period of history resided largely on reservations and in rural areas. As the urban Indian population increased, in part due to government relocation programs, the need for health services for urban Indians also became apparent.[12] Several cities, particularly designated relocation sites, independently developed health services for urban Indians. I.H.S., with funds from the Office of

[12] The National Council of Urban Indian Health identifies 8 Federal government policies as leading to the emergence of an urban Indian population: "(1) the BIA relocation program, which relocated 160,000 Indians to cities between 1953 and 1962… ; (2) the failure of Federal economic policies on reservations which has forced many Indians to become economic refugees in the cities; (3) the Federal policy of 'terminating' tribes in the 1950s and 1960s, many of which have not yet been restored to recognition; (4) the marginalization of tribal communities such that they exist but are not federally recognized; (5) Indian service in the U.S. military, which brought Indians into the urban environment; (6) the General Allotment Act, which resulted in many Indians losing their lands and having to move to nearby cities and towns; (7) court-sanctioned adoption of Indian children by non-Indian families; and (8) Federal boarding schools for Indians." See Hall, 2000.

Economic Opportunity, provided its first direct support for urban Indian health clinics in 1972 in Minneapolis, Rapid City, and Seattle (Bergman et al., 1999).

In 1970, President Nixon in a landmark policy statement to Congress announced self-determination as the basis for relations between the federal government and Indians. In this speech, he acknowledged changing Indian demographics and the need to help urban Indians.[13] The support of the Nixon White House for Indian causes did much to ensure the success of Congressional legislation in 1975 intended to encourage Indian participation in the planning and management of health services (Kaufman et al., 1997). The Congress, in 1976, passed the Indian Health Care Improvement Act (P.L. 94-437), which sought to improve the health status of Indians through a comprehensive approach. This Act included the creation of the urban Indian health program under Title V (Bergman et al., 1999).

States generally have taken the view that the health care needs of American Indians and Alaska Natives are the responsibility of the federal government because it has a trust responsibility to provide health care to members of federally recognized tribes. However, Indian people, including urban Indians, are also citizens of the states in which they reside. They are entitled to the same health care benefits to which any other citizen of the state is entitled. Thus, an urban Indian who meets the eligibility criteria for a state's Medicaid program or a state's Children's Health Insurance Program (S-CHIP) may enroll and have payment made for covered services at state (and federal) expense.

## Urban Indians and the Indian Health Service

The agency through which the federal government seeks to carry out its trust responsibility is the Indian Health Service (I.H.S.), a largely rural health care delivery system. With a budget of $2.6 billion in FY 2001, the I.H.S. reports that it provides, directly or indirectly, a range of health care services to approximately 1.5 million American Indians and Alaska Natives who belong to 556 federally recognized tribes in 35 states.[14] Few I.H.S. facilities, whether operated by the agency itself or by tribes, are located in urban areas. Notable exceptions are the three I.H.S. medical centers located in the urban areas of Anchorage, Alaska; Albuquerque, New Mexico; and Phoenix, Arizona.

There are three principal ways in which the I.H.S. delivers or pays for the delivery of services. First, it uses its own hospitals, outpatient health centers, and smaller health stations and its 14,800 employees to deliver services directly. Secondly, it contracts (or compacts) with tribes under the Indian Self-Determination and Education Assistance Act (P.L. 93-638, as amended) to operate its hospitals, health centers, or health stations themselves (Bauman et al., 1999). As of 2001, over half (53 percent) of the I.H.S. budget for medical care was managed by tribes (USDHHS, 2002). Finally, the I.H.S. purchases services not available through its own facilities

[13]See section 7, Helping Urban Indians, President Nixon's Special Message to the Congress on Indian Affairs issued July 8, 1970.
[14]I.H.S., www.ihs.gov/NonMedicalPrograms/Profiles/profileDelivery.asp.

from non-tribal, private sector hospitals and health practitioners; these "contract health service" purchases accounted for about 17 percent of the agency's FY 2001 budget.

I.H.S. services are provided free of charge to eligible American Indians and Alaska Natives. Eligibility for services delivered by I.H.S. facilities does not extend to *all* American Indians and Alaska Natives. Instead, it is limited to "persons of Indian descent belonging to the Indian community served by the local facilities and program." These include an individual "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."[15] Eligibility for "contract health services" purchased from non-I.H.S. providers is even more restrictive.[16]

These I.H.S. eligibility rules limit the I.H.S. service population to about 1.5 million of the 2.5 million–4.1 million individuals who identify themselves solely or partially as American Indian and Alaska Native. The effect of these eligibility rules is to exclude most urban Indians from services provided through I.H.S. or tribally-run facilities or purchased from non-tribal, private sector providers through the "contract health services" program. One exception to this general rule is found in Oklahoma, where tribal members and descendants living in Oklahoma City and Tulsa are eligible for I.H.S. services (Kauffman, 1999). Yet despite the eligibility restrictions that apply to all other I.H.S. or tribally-run facilities, it is indisputable that, at current funding levels, I.H.S. lacks the resources necessary to enable it and the contracting tribes to offer the equivalent of a "mainstream" benefits package to the 1.5 million American Indians and Alaska Natives that qualify.[17]

## The Urban Indian Health Program

Although urban Indians generally lack access to care at I.H.S. or tribal facilities, the I.H.S. does administer a program targeted at urban Indians. The I.H.S. views its service delivery system as having three elements: the traditional I.H.S. hospitals and clinics ("I"); the tribally-operated hospitals and clinics ("T"); and the urban Indian health programs ("U"). This "I/T/U" concept reflects a recognition by I.H.S. that the management of urban Indian programs is an integral component of its organizational mission, albeit a minor one. As shown in Figure 3, about 46 percent of I.H.S. resources are allocated to I.H.S. facilities, 53 percent to tribally-operated facilities, and only 1 percent to urban Indian programs. Despite the change in demographics of the American Indian population, funding for urban Indian health has remained at about 1 percent of I.H.S.'s annual appropriation since 1979 (see Table 2).

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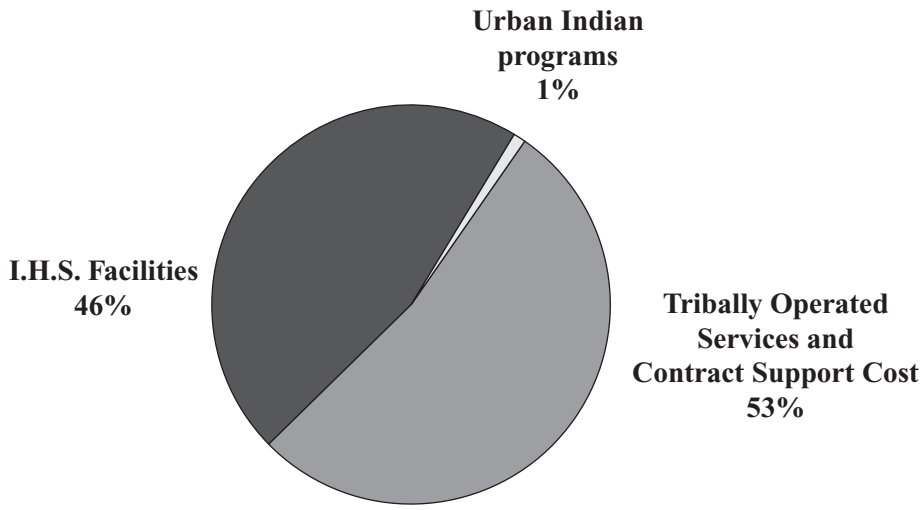
[15] 42 C.F.R. 36.12. Exceptions are made for individuals in need of emergency medical care, for non-Indian family members, and for non-Indian women pregnant with an Indian child.

[16] To qualify for contract health services, an individual must not only be I.H.S.-eligible but must reside in a "contract health service delivery area (CHSDA)" designated by the I.H.S., 42 C.F.R. 36.23.

[17] The I.H.S. estimates that its appropriations are sufficient to fund 50 percent of the actuarial cost (estimated at $3,221 per person in 2001) of the "benchmark" Federal Employees Health Benefits Program (FEHBP) benefits package for American Indians and Alaska Natives eligible for its services. An additional $1.7 billion would be needed in FY 2001 to enable it to fund an equivalent benefits package for its eligible population (www.ihs.gov/NonMedicalPrograms/Lnf/conIHCIH.htm). These estimates do not take into account the unmet needs of urban Indians or other American Indians or Alaska Natives whom the I.H.S. does not include in its eligible population of approximately 1.5 million.

**Figure 3**
**Indian Health Service Budget Allocations:**




Total Budget = 2.6 billion

SOURCE: DHHS Budget, 2001

The urban Indian program was first authorized in 1976, more than 20 years after the establishment of the I.H.S., in Title V of the Indian Health Care Improvement Act (P.L. 94-437).[18] As Kauffman (1999) notes, Title V "represented a significant departure for the Indian Health Service, which had previously not included Indians living outside I.H.S. service areas within the scope of the program." The Congressional rationale for the program (House Report 94-1026) was in part to address the problems resulting from misguided Federal policies towards American Indians and Alaska Natives: "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."[19]

The purpose of the Title V program is to make outpatient health services accessible to urban Indians, either directly or by referral. These services are provided through non-profit organizations, controlled by urban Indians, that receive funds under contract with the I.H.S. Urban Indian

[18]This was not the first federal program specific to urban Indians. Congress began recognizing the needs of urban Indians in the late 1960s. In 1969, Congress appropriated $321,000 to establish a clinic in Rapid City, South Dakota to help Indians from surrounding reservations that were moving to that town. Prior to the enactment of the Indian Health Care Improvement Act, several larger cities had begun to develop health services for urban Indians, particularly those 8 cities originally designated as relocation sites for the federal government's Indian termination policy of the 1950s (Chicago, Dallas, Los Angeles, Minneapolis, San Francisco, Seattle, and Tulsa), and several independently operating urban Indian clinics were already well established. Most received funds from the Office of Economic Opportunity (OEO) program and other federal anti-poverty programs.

[19]House Rept. 94-1026 relating to P.L. 94-437 (April 9, 1976), p. 116.

**Table 2**
## Comparison of Urban Indian Funding to Total Indian Health Service Funding, 1979–2001 (in thousands)

| Year | Total I.H.S. Budget | Total Urban Budget | Percentage Urban |
|---|---|---|---|
| 1979 | $492,193 | $7,270 | 1.48% |
| 1980 | $546,569 | $8,000 | 1.46% |
| 1981 | $606,709 | $8,900 | 1.47% |
| 1982 | $599,645* | $8,160 | 1.36% |
| 1983 | $679,216 | $7,385 | 1.08% |
| 1984 | $778,812 | $9,000 | 1.15% |
| 1985 | $890,567 | $9,800 | 1.10% |
| 1986 | $820,979 | $9,644 | 1.17% |
| 1987 | $867,704 | $9,000 | 1.00% |
| 1988 | $943,297 | $9,624 | 1.02% |
| 1989 | $1,020,106 | $9,962 | 0.09% |
| 1990 | $1,178,337 | $13,049 | 1.11% |
| 1991 | $1,353,167 | $15,687 | 1.16% |
| 1992 | $1,431,603 | $17,195 | 1.20% |
| 1993 | $1,524,992 | $20,965 | 1.37% |
| 1994 | $1,646,088 | $22,834 | 1.39% |
| 1995 | $1,707,092 | $23,349 | 1.37% |
| 1996 | $1,760,842 | $23,360 | 1.33% |
| 1997 | $2,057,000 | $24,800 | 1.20% |
| 1998 | $2,098,612 | $25,379 | 1.20% |
| 1999 | $2,118,349 | $26,382 | 1.25% |
| 2000 | $2,390,728 | $27,813 | 1.16% |
| 2001 | $2,604,562 | $29,909 | 1.15% |

*Congress adjusted the I.H.S. budget excluding some reimbursable positions that had been previously counted.

SOURCES: Indian Health Service, Health Service Appropriation History, 1983–1999, 03/12/99; Indian Health Service, History of Appropriations 1911–1982, 01/09/82; FY 2001 Approved I.H.S. Budget.

organizations commonly supplement these I.H.S. dollars with revenues from other sources, such as Medicaid and Medicare payments, private insurance reimbursements, and support from localities and private foundations. As of FY 2001, the I.H.S. spent $29.9 million appropriated under Title V to help fund 34 Indian health contractors in 20 states and two I.H.S. urban service sites in Oklahoma. Table 3 illustrates the distribution of these programs nationally. The majority of these programs provide medical services; the remainder offer only referral services or other services, such as alcohol and substance abuse treatment. These programs serve an estimated 130,000 urban Indians (author's review of I.H.S. Urban Indian Program Statistics, 1999).

## Table 3
## Urban Health Programs, Fiscal Year 01[1]

| I.H.S. Service Area | Location | Medical Services | Largely Referral |
|---|---|---|---|
| Aberdeen | Pierre, SD | X | |
| | Lincoln, NE | X | |
| Alaska | No title V programs | | |
| Albuquerque | Denver, CO | X | X |
| Bemidji | Albuquerque, NM | X | |
| | Minneapolis, MN | X | |
| | Detroit, MI | X | |
| | Green Bay, WI | X | |
| | Milwaukee, WI | X | |
| | Chicago, IL | X | |
| Billings | Billings, MT | X | |
| | Butte, MT | X | |
| | Great Falls, MT | X | |
| | Helena, MT | X | |
| | Missoula, MT | X | |
| California | Bakersfield, CA | X | |
| | Fresno, CA | | X |
| | Los Angeles, CA | | X |
| | Sacramento, CA | X | |
| | San Diego, CA | X | |
| | San Francisco, CA | X | |
| | San Jose, CA | X | |
| | Santa Barbara, CA | X | |
| Nashville | Boston, MA | | X |
| | New York, NY | | X |
| Navajo | Flagstaff, AZ | X | |
| Oklahoma | Oklahoma City, OK[2] | X | |
| | Tulsa, OK[2] | X | |
| | Wichita, KS | X | |
| | Dallas, TX | | X |
| Phoenix | Phoenix, AZ | | X |
| | Reno, NV | | X |
| | Salt Lake City, UT | X | |
| Portland | Portland, OR | X | |
| | Seattle, WA | X | |
| | Spokane, WA | X | |
| Tucson | Tucson, AZ | | X |

[1]These programs are supported through grants and contracts to nonprofit urban Indian organizations. They are authorized through Title V of the Indian Health Care Improvement Act.

[2]Tulsa and Oklahoma City are under a demonstration project as I.H.S. service units although originally funded under Title V. They are still considered urban programs under the I.H.S. structure.

Urban Indian programs receiving Title V funds vary in size and types of services offered. Major differences in size and services result from the availability of non-Indian funding in the region to supplement the Title V appropriation, or to finance new services for the local community. Of the 20 cities with the largest populations of American Indians and Alaska Natives in the 2000 Census, ten—Albuquerque, Chicago, Denver, Oklahoma City, Minneapolis, Portland, San Diego, San Jose, Seattle, and Tulsa,—have an urban Indian health care program that provides medical services. Six of these cities—Dallas, Fresno, Los Angeles, New York, Phoenix, and Tucson—have programs that mainly offer referral services rather than comprehensive primary care. Four of the 20 cities with the largest urban Indian populations—Anchorage, Houston, Mesa, and San Antonio—have no urban Indian health program or other I.H.S.—funded facility that serves all urban Indians.

Unlike I.H.S. and tribal clinics where services are free to the eligible Indian client, medical and dental services at urban Indian programs are provided on a sliding fee basis. The scope of services at urban Indian programs is restricted to primary care. Referrals for inpatient hospital care, specialty services, diagnostics, etc., are at the client's expense. Efforts are made to mitigate these expenses through negotiations and other arrangements. Of the urban Indian programs that provide medical care, several function as "safety net" clinics for the uninsured, not unlike the federally-funded community health centers with which they have much in common (Rosenbaum, 2000).

## Federal Coverage Options for Urban Indians

Urban Indians, like other American citizens, are eligible for health coverage under Medicaid, Medicare, or the State Children's Health Insurance Program (S-CHIP) if they otherwise meet the eligibility requirements for these programs. This is true whether or not the urban Indian is a member of a federally-recognized tribe or is receiving I.H.S.-funded services from an urban Indian program, an I.H.S. facility, or a tribal provider. Low-income urban Indians who meet the financial and non-financial eligibility criteria for the Medicaid program in the state in which they reside are entitled to Medicaid benefits (Schneider and Martinez,1997). Similarly, urban Indians are eligible to enroll in Medicare if they are age 65 and over and have paid the Medicare payroll tax during their working years, have received Social Security disability payments for 24 months, or need a kidney transplant or renal dialysis because of end stage renal disease (The Henry J. Kaiser Family Foundation, 2001).[20] Finally, urban Indian children who are uninsured and meet the family income requirements in their state are eligible for coverage under their state's S-CHIP program (Cohen-Ross and Cox, 2000).

For different reasons, many eligible Indians do not enroll in public programs such as Medicaid or Medicare. Many Indians, both urban Indians and those living on or near reservations, believe that the Federal government is obligated by treaty and law to pay for their health care and that

[20] People age 65 and older qualify for Medicare if they (or their spouse) worked for 40 quarters or more. For an overview of basic issues about Medicare coverage, see The Henry J. Kaiser Family Foundation, *Talking With Your Parents About Medicare and Health Coverage* (2001).

they should not have to enroll in health care programs for the general population. In addition, many Indians refuse to subject themselves to the intrusive Medicaid application process. Others may not qualify for Medicare because they were not in jobs that were subject to the Social Security payroll tax. Self-imposed barriers are reinforced when Indian people apply for coverage through Medicare or Medicaid and they are told that they are supposed to apply to the I.H.S. (Burhansstipanov, 2000), or they feel mistreated by social workers or health care staff.

Despite the reluctance of many urban Indians to enroll in public programs, Medicaid has become an increasingly important financial resource for urban Indian health providers of direct clinical services. The grant or contract dollars flowing to Title V providers from the I.H.S. often do not cover all the costs incurred for outpatient health services. The providers are expected to make up the shortfall from other sources of payment that their patients may have, as well as from local or charitable contributions. Because a large number of the urban Indian and other patients served by Title V providers have low-incomes, and because many are eligible for Medicaid benefits, enrollment of a patient in Medicaid gives the Title V provider the opportunity to bill Medicaid for the cost of the services rendered to that beneficiary.[21]

Urban Indian programs that deliver primary health services and are receiving funding under Title V hold a favored place in the Medicaid program. They are recognized in statute as Federally-qualified health centers (FQHCs).[22] This legal status has two consequences: it requires state Medicaid programs to cover in their benefits' package the services provided by FQHCs, and it entitles FQHCs to payment for these services at a statutorily-specified rate.[23] Moreover, if an FQHC subcontracts with a Medicaid managed care organization (MCO), and if the FQHC serves a Medicaid beneficiary who is enrolled in the MCO, and if the MCO pays the FQHC less than the amount to which it is entitled under the prospective payment system, the State Medicaid program is required by law to make up the difference to the FQHC with a supplemental payment.[24]

Urban Indian health programs funded under Title V also have opportunities to enroll eligible urban Indians in Medicaid. States are required to outstation eligibility workers at FQHCs, including Title V providers, to receive and process applications for Medicaid from pregnant women and children.[25] In addition, Title V providers that participate in Medicaid and that deliver prenatal care to pregnant women or outpatient services to children may, with the approval of the

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[21] Medicare, in contrast, is only a small source of revenue for most urban Indian health programs. In addition to the general reluctance of eligible Indians to enroll in public programs like Medicare, some urban Indian elders are not eligible for Medicare benefits because they lived their entire lives on a reservation and they (or their spouse) never worked at a job subject to Social Security withholding that would enable them to qualify.

[22] Section 1905(n)(2)(B) of the Social Security Act, 42 U.S.C. 1396(d)(n)(2)(B).

[23] Effective January 1, 2001, states are required to pay FQHCs using rates that are determined under a prospective payment system. Prior to that time, FQHCs were entitled to reimbursement at no less than 95 percent of reasonable costs. See Health Care Financing Administration, Letter to State Medicaid Directors, January 19, 2001, www.hcfa.gov/medicaid/smd119a1.htm. As of August, 2001, implementation of the new prospective payment system had not been achieved in many communities.

[24] Section 1902(a)(13)(C)(ii) of the Social Security Act, 42 U.S.C. 1396a(a)(13)(C)(ii).

[25] Section 1902(a)(55) of the Social Security Act, 42 U.S.C. 1396(a)(55).

State Medicaid program, make determinations of "presumptive eligibility" for both pregnant women[26] and children.[27] Unfortunately, many urban Indian health programs are unable to implement outstationing due to administrative barriers (e.g., insufficient state eligibility workers to outstation at all eligible sites), and not all states have chosen to implement the presumptive eligibility options (Cohen-Ross and Cox, 2000).

Changes in Medicaid in the past decade have had profound effects on urban Indian health programs. In particular, the shift in many state Medicaid programs from fee-for-service payment to managed care has posed significant challenges for Title V providers. These providers lack the financial resources or the expertise to become Medicaid managed care organizations (MCOs) themselves, they are left with the choice of subcontracting with one or more Medicaid MCOs operating in their service areas or remaining unaffiliated with any MCO. Either option has significant implications in terms of patient volume and Medicaid revenues (Kaye and Rawlings-Sekunda, 1999).

## Policy Implications

The growing recognition of urban Indians and their health care needs raises important issues for both federal and state policymakers. Among these are: the collection and reporting of data on the health status of urban Indians and their access to health care services; the adequacy of the Title V program for serving the health needs of urban Indians; and the changes needed in the Medicaid program to improve access of eligible urban Indians to covered services.

*Need for Improved Data.* As this Issue Paper makes abundantly clear, there is very little national-level data on urban Indians, their health status, their health insurance coverage, their access to health services, or their expenditures for health services. Neither the I.H.S. nor any other agency of the Department of Health and Human Services currently collects and reports such data in a timely, reliable fashion. Therefore, it is extremely difficult for policymakers to be informed about health care issues confronting urban Indians, much less to frame a coherent policy response to those issues.

*Adequacy of Title V.* Most provisions of the Indian Health Care Improvement Act, including those in Title V, expired on September 30, 2000. The last major changes to the Act were made in 1992. This expiration presents an opportunity to make needed adjustments based on the experience of the past decade and the anticipated needs of the new decade. The urban Indian community supports the revision and extension of the Act as a whole and of Title V in particular (Hall, 2001). However, current federal policies regarding Indian health continue to be directed at Indians living on or near a reservation. These policies deserve to be revisited given the migration and relocation of Indians to large cities. Expiration of the underlying authorization does not bar

[26] Section 1920(b)(3)(A)(i)(I) of the Social Security Act, 42 U.S.C. 1396r-1(b)(3)(A)(i)(I).

[27] Section 1920A(b)(3)(A)(i)(I) of the Social Security Act, 42 U.S.C. 1396r-1a(b)(3)(A)(i)(I).

Congress from appropriating funds for Title V providers for fiscal year 2001 or thereafter.[28] The reauthorization process, however, provides an opportunity to make changes that would improve the ability of the Act, generally, and Title V programs, specifically, to better serve the health needs of Indian people.

*Increasing the Federal Medicaid Matching Percentage.* Under current law, states receive federal Medicaid matching payments for the costs of covered services used by individuals enrolled in Medicaid. These matching payments are made at each state's regular federal Medicaid matching rate, which range from 50–77 percent, depending on the state's per capita income (The Kaiser Commission on Medicaid and the Uninsured, 2001).

In the case of a Native American Medicaid beneficiary who receives services directly from an I.H.S. hospital or clinic, the state's federal matching rate is 100 percent (i.e., the federal government pays the entire cost).[29] Under the terms of a Memorandum of Agreement (MOA) between the I.H.S. and CMS (Centers for Medicare and Medicaid Services, formerly HCFA) dated December 19, 1996, a state's federal matching rate is also 100 percent in the case of an Indian Medicaid beneficiary who receives covered services directly from a tribal provider contracting with the I.H.S. under the Indian Self-Determination Act (P.L. 93-638). The 100 percent matching rate does not, however, apply in the case of Native American Medicaid beneficiaries who receive services from an urban Indian health program funded under Title V; instead, a state must pay its share of the costs of these services. Extension of this 100 percent matching rate to services provided by Title V providers to Medicaid-eligible urban Indians may give state Medicaid programs an incentive to treat these "safety net" clinics more favorably in both a fee-for-service and managed care context.

## Conclusion

Dramatic changes have occurred in Indian Country in the past century. Among these has been the quiet migration of Indians from reservations to urban areas, so that today the majority of American Indians and Alaska Natives live in cities. Policymakers at both the federal and state levels must understand that Indian Country now extends beyond the reservation borders and into America's cities.

In leaving their reservations, urban Indians did not always escape the conditions that made life so difficult for many tribal communities, including poverty, racism, inadequate education, alcoholism, drug dependence, teen pregnancy, etc. These conditions are acutely felt in cities as the loss—of cultural identity, family support, and social contact, combined with the pressures of money, jobs, crowding, competition—place urban Indians at great physical and emotional risk for health problems.

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[28] The Congress has appropriated just over $112 billion for fiscal year 2001 for programs and activities with expired authorizations. Congressional Budget Office, *Unauthorized Appropriations and Expiring Authorizations* (January, 2001), www.cbo.gov/showdoc.cfm?index=2723&sequence=0&from=1.

[29] Section 1905(b) of the Social Security Act, 42 U.S.C. 1396d(b).

As this nation enters the 21st century, the struggles of Indian people, whether in urban or rural areas, for identity, respect, and fulfillment must increasingly be recognized as a vital part of the overall health status equation.  To achieve the goal of raising the health of urban Indian people to meet national standards, the U.S. must strengthen its resolve to find the resources, talent and money, to make this a reality.

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## Appendix 1
# Places of Residence of American Indians and Alaska Natives, 2000

| Places of Residence | American Indian and Alaska Native (alone)[1] Number | Percent | American Indian and Alaska Native (alone or in combination)[1] Number | Percent |
|---|---|---|---|---|
| **United States** | **2,475,954** | **100%** | **4,119,301** | **100%** |
| American Indian Reservation and Off-Reservation Trust Lands | 520,332 | — | 538,322 | — |
| American Indian and Alaska Native Statistical Areas[2] | 374,799 | — | 488,094 | — |
| *Subtotal for Reservations and Census Defined Tribal Areas* | 895,131 | 36.2% | 1,026,416 | 24.9% |
| *Other Urban and Rural Geographical Areas* | 1,580,825 | 63.8% | 3,092,885 | 75.1% |

[1] "Race alone" refers to individuals who reported only one racial category. "Race alone or in combination with one ore more other races" refers to persons who reported only one race together with those who reported that same race plus at least one other racial category. In this situation, it means a person indicating "American Indian and Alaska Native" and another Census race category, such as "White," "Black or African American," or "Asian." These two classifications are not mutually exclusive.

[2] Oklahoma Tribal Statistical Areas, Alaska Native Village Statistical Areas, Tribal Designated Statistical Areas, State Designated American Indian Statistical Areas.


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