

National Indian Health Board



Submitted via email to RFIComments@hrsa.gov

September 18, 2020

The Honorable Thomas Engels
Administrator
Health Resources and Services Administration (HRSA)
5600 Fishers Lane
Rockville, MD 20857

Re: Health Provider Shortage Area Scoring Request for Information

Dear Administrator Engels:

Please accept this letter as a response on behalf of the National Indian Health Board (NIHB),¹ to the HRSA Dear Tribal Leader Letter from June 18, 2020 which provided information on the Health Professional Shortage Area Scoring (HPSA) Criteria.

Discussion & Background

As you know, HRSA uses HPSA scores to designate priority for the assignment of practitioners from the National Health Service Corps (NSCP). Because we rely heavily on NHSC providers, this process impacts our system greatly. Scores that do not reflect the true needs in Indian Country virtually ensure that our system will continue to experience critical staffing shortages that undermine our ability to deliver required care.

The current process falls far short of the recommendations Tribal leaders have historically shared when HRSA instituted the changes to the HPSA scoring. We believe that in order to reflect the dire need of our providers, IHS and Tribal facilities should have the highest possible HPSA score in every category. We believe that this action would be in accordance with the trust responsibility and the federal government's relationship with Tribal nations.

Trust Responsibility

We kindly remind the agency that the United States has a unique legal and political relationship with Tribal governments established through and confirmed by the United States Constitution, treaties, federal statutes, executive orders, and judicial decisions. Central to this relationship is

¹ Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

the Federal Government's trust responsibility to protect the interests of Indian Tribes and communities, including the provision of health care to American Indians and Alaska Natives. In recognition of the trust responsibility, Congress has passed numerous Indian-specific laws to provide for Indian health care, including laws establishing the Indian health care system and those providing structure and detail to the delivery of care, such as the Indian Health Care Improvement Act (IHCIA).² In the IHCIA, Congress reiterated that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."³

Alternative Components of the Formula

If the above request cannot be accommodated and our providers cannot be given the highest possible score, we have recommendations that should help ensure that our need is better reflected in the HPSA scoring formula.

First of all, we generally support the idea that all three formulas, Primary Care, Mental Health, and Dental Health incorporate population to provider ratio, percentage of population below 100% of the federal poverty line, and travel time to the nearest source of care. We believe that these common factors help capture the rurality of many Tribal populations and amount of poverty that many of them face. It is a solid base from which to build.

However, we believe that the current formula does not accurately reflect the dire levels of poverty that are faced by many Tribal nations. Current poverty rates are only a snapshot in time. The current formula makes no distinction between a Tribal community that has suffered from deep and entrenched poverty for generations and another community that may have only begun to experience it in the last generation. There is a federal definition for counties that have experienced high rates of poverty over the course of decades. "Persistent Poverty" counties are defined as "any county that has had 20 percent or more of its population living in poverty over the past 30 years, as measured by the ... decennial censuses."⁴ Deeply entrenched poverty has a real and measurable impact on a community, it reflects low social mobility and feeds a seemingly perpetual cycle.

According to a 2014 study by the Rural Policy Research Institute, persistent poverty counties have a lower median income and higher unemployment rate than "new entrant" counties, defined as counties that have only been measured as high poverty since the last measurement year, 2009, and counties who have only intermittently been designated as "high poverty".⁵ Perhaps more striking however was the finding that persistent poverty counties are 44.6% people of color, compared to only 27.3% and 27.5% in intermittent and new entrant poverty counties respectively.⁶ Persistent poverty is an issue that predominantly affects communities of color. These counties are also found in every corner of Indian Country. From Arizona to Alaska to Oklahoma to South Dakota to

² 25 U. S. C. § 1601 et seq.

³ *Id.* § 1601(1)

⁴ P.L. 111-5, Section 105

⁵ Kathleen Miller and Bruce Weber, "Persistent Poverty Dynamics: Understanding Poverty Trends over 50 years", Rural Policy Research Institute, July 2014.

⁶ *Id.*

Mississippi and many points in between, Tribal nations exist in some of the most entrenched poverty in this country.⁷

We believe that any updates to the HPSA formula must take into account the entrenchment of poverty in Indian Country. Persistent poverty is a public health crisis and the health challenges of those who are experiencing entrenched, multi-generational poverty differ from those who are not. Many of these counties also struggle with high rates of obesity, diabetes, and substance use, the outgrowth of the struggles born of multiple generations of living in poverty. A 2020 study by the United States Department of Agriculture found that persistent poverty was even tied to poor health outcomes for children.⁸ In order to adequately address these issues, the HPSA formula must take into the account the persistent poverty status of a given locality. A mere snapshot in time does not adequately convey the depth of poverty faced by Indian Country.

We also think that rurality could be better captured in the formula. While distance to provider is a good proxy for this, we do not feel that it adequately captures the full picture. We support the idea of the agency incorporating the Federal Office of Rural Health Policy's definition of rurality, which accepts all non-Metro counties as rural and uses Rural-Urban Commuting Area (RUCA) codes for greater specificity.⁹ However, we also believe that this metric could be made more specific. We urge the agency to consider also using the Rural-Urban Continuum Codes (RUCC), as used by the United States Department of Agriculture (USDA).¹⁰ The Rural-Urban Continuum Codes operate on a 1-9 scale with 1-3 denoting metropolitan status and 6-9 denoting non-metropolitan status. Generally speaking, a county with a 1 designation is most urban and a county with 9 designation is most rural. RUCC measures rurality on the county level, which we believe complements the census tract level measurements of the RUCA. Having an additional measurement will allow for comparison of census tracts with similar RUCA codes that are in counties with different RUCC codes. Using these metrics in combination would allow for a nuanced view of rurality and the ability to compare rural places to each other to find areas of greater need.

Much of Indian Country is incredibly rural and we believe that a metric that allows for greater examinations of rurality would capture this more accurately and our need would be more generally reflected. We also believe that rurality needs to be more accurately captured because of the rise of telehealth. Incredibly rural areas often do not have access to broadband internet or cellular phone reception, making it more difficult for their residents to take advantage of telehealth options. Addressing provider shortages in the most rural areas will be essential because their residents do not have access to a tool that could otherwise be used to bridge that gap. The time has come to more accurately measure degree of rurality.

Conclusion

We believe that HRSA must make key improvements in the formula to accurately reflect the need in Indian Country. Our primary stance is that Indian health providers should be afforded the

⁷ For a thorough listing of Persistent Poverty Counties, see: <https://fas.org/sgp/crs/misc/R45100.pdf>

⁸ "Rural Poverty & Well-Being," United States Department of Agriculture, February 2020, <https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/>

⁹ See <https://www.hrsa.gov/rural-health/about-us/definition/index.html>

¹⁰ For more information: <https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/>

highest possible HPSA score. However, if this cannot be accommodated, we believe that the recommendations outlined above will result in scores that more accurately reflect the need of Indian Country.

Thank you in advance for your consideration of our comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Stacy A. Bohlen". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Stacy A. Bohlen

CEO

National Indian Health Board

CC:

Stacey Ecoffey

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