

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: Maternity Care Health Professional Target 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 Maternity Care Health Professional Target Area (MCTA) criteria.

Introduction:

Access to a maternity care is an issue with particular importance to American Indian and Alaska Native (AI/AN) people. According to data from the Centers for Disease Control and Prevention (CDC), AI/AN women are 2-3 times more likely to die from a pregnancy-related cause than their non-Hispanic white counterparts.² Additional research reveals that access to health insurance coverage and access to affordable, high-quality health care is a contributing factor to the maternal mortality burden.³ Approximately 41% of AI/AN women do not receive the recommended number of prenatal visits⁴ and, compared to the non-Hispanic white population and AI/AN populations are more than twice as likely to lack medical insurance, meaning they may struggle to pay for—or

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.

² “Infographic: Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016,” Centers for Disease Control and Prevention, February 4, 2020 <https://www.cdc.gov/reproductivehealth/maternal-mortality/disparities-pregnancy-related-deaths/infographic.html>

³ Lucy Truschel and Cristina Novoa, “American Indian and Alaska Native Maternal and Infant Mortality: Challenges and Opportunities,” Center for American Progress, July 9, 2018 <https://www.americanprogress.org/issues/early-childhood/news/2018/07/09/451344/american-indian-alaska-native-maternal-infant-mortality-challenges-opportunities/>

⁴ “Healthy People 2010 Final Review,” National Center for Health Statistics, 2012 https://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review.pdf

even access—necessary services.⁵ It is essential that HRSA creates a formula that addresses these disparities and ensures that AI/AN women have access to safe and affordable pre-natal health care.

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 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. Congress has passed numerous Indian-specific laws to provide for Indian health care, including establishing the Indian health care system and permanently enacting the Indian Health Care Improvement Act (IHCA).⁶ In the IHCA, for instance, Congress found 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.”⁷ Title V of the IHCA authorized federal funding for urban Indian organizations to provide health services to American Indian/Alaska Natives (AI/ANs), many of whom had been relocated to urban areas by federal relocation programs. Congress also enacted the Indian Self-Determination and Education Assistance Act of 1975 to enable Tribes and Tribal Organizations to directly operate health programs that would otherwise be operated by the IHS, thereby empowering Tribes to design and operate health programs that are responsive to community needs. Together, this complex health care system makes up the “I/T/U” or Indian health system (hereinafter referred to as “Indian health care providers”).

Providers and Populations

First of all, we recommend that the agency uses a population-to-provider ratio in order to accurately represent the shortage of providers in Tribal communities. Population numbers are often small on reservations, and without a ratio, AI/AN communities might be excluded as a possible target area. We also noted that the RFI mentioned the possibility of using population subsets in the new formula and we believe that this could be a way for the agency to recognize the disproportionate burden that AI/ANs face when accessing maternal care. We recommend that the agency consider measuring the number of providers available per AI/AN woman in a given geographic area. We believe that this is necessary because AI/AN populations face a significant maternal mortality burden. As mentioned earlier, AI/AN women have a pregnancy-related mortality rate two times that of non-Hispanic white women (30.4 deaths per 100,000 live births compared to 13.0).⁸ AI/AN women are represented at a rate far above their percentage of the general population. CDC has also reported that in a 5 year period (2011-2015), out of the 700

⁵ Samantha Artiga and Kendal Orgera, “Key Facts on Health and Health Care by Race and Ethnicity,” Kaiser Family Foundation, November 12, 2019 <https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-4-health-coverage/>

⁶ 25 U. S. C. § 1601 et seq.

⁷ Id. § 1601(1)

⁸ Emily Petersen, Nicole Davis, David Goodman...et al., “Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016,” *Morbidity and Mortality Weekly Report*, September 6, 2019, 68(35), 762-765 <https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm>

women that died from pregnancy-related complications 10 to 13 of those deaths each year were AI/AN women, which averages to about 9% of maternal deaths in those years were attributed to AI/AN women, who make up less than 2% the overall population.

However, we recognize that merely counting AI/ANs as a population subset does not fully capture the extent of the issue. Given that racial misclassification contributes to undercounting AI/ANs, we also recommended that the agency include other subsets to cast a broader net to capture this at risk population. First of all, we recommend that the agency include, as a population subset, first pregnancies by age. In 2014, the average age of a mother's first birth for AI/AN women was 23.1 years, the youngest of all other race categories.⁹ Gestational diabetes as a population subset is also a vital inclusion because of its disproportionate impact on AI/AN women. In 2016, out of 31,375 pregnant AI/AN women, 9.2% had gestational diabetes¹⁰. Another important subset is substance use and pregnancy. In 2019, 7% of pregnant women reported to the CDC using prescription opioids, and 1 in 5 of those women reported misuse of prescription opioids¹¹. From 1999 to 2014, maternal opioid use more than quadrupled, indicating this as a growing and pertinent issue.¹²

Other Considerations

In addition to the factors mentioned above, we also recommend a careful consideration of certain data points HRSA should consider incorporating into the MCTA criteria. As previously described, pregnancy-related deaths attributable to AI/ANs, gestational diabetes and substance use during pregnancy are data points that should be considered. Additionally, the historical and contemporary experience of native patients being treated by white providers is rife with examples of unethical treatment and discrimination. These instances have caused many AI/AN patients, and specifically AI/AN mothers, to feel distrustful of white providers. This underscores the need more Native providers¹³ to be treating native people. We believe that HRSA should work to eliminate all barriers to access, including cultural barriers. We urge HRSA to consider prioritizing assigning AI/AN providers to work in Tribal communities, and explore other ways to bring more native people into the medical profession.

We also recommend considering economic data for incorporation into MCTA criteria. AI/AN peoples experience higher rates of poverty than other populations. In 2017, 26.8% of AI/AN peoples were living in poverty, compared to the average of 4.6% for the entire US population⁶. However, current poverty rates are only a snapshot in time. We believe that a formula that

⁹ TJ Mathews and Brady Hamilton, "Mean Age of Mothers is on the Rise: United States, 2000–2014," NCHS Data Brief, No. 232, January 2016 <https://www.cdc.gov/nchs/data/databriefs/db232.pdf>

¹⁰ Nicholas Deputy, Shin Kim, Elizabeth Conrey...et al. "Prevalence and Changes in Preexisting Diabetes and Gestational Diabetes Among Women Who Had a Live Birth — United States, 2012–2016." *Morbidity and Mortality Weekly Report*, November 2, 2018, 67(43);1201–1207, https://www.cdc.gov/mmwr/volumes/67/wr/mm6743a2.htm#T1_down

¹¹ "Data and Statistics About Opioid Use During Pregnancy," Centers for Disease Control and Prevention, August 13, 2020 <https://www.cdc.gov/pregnancy/opioids/data.html>

¹² Sarah Haight, Jean Ko, Van Tong...et al. "Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014," August 10, 2018, 67(31);845–849 <https://www.cdc.gov/mmwr/volumes/67/wr/mm6731a1.htm>

¹³ JD Hanson. Understanding prenatal health care for American Indian women in a Northern Plains tribe. *J Transcult Nurs.* 2012;23(1):29-37.

incorporates poverty rates should also take into account persistence of that poverty. The failure to do so results in a formula that 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.”¹⁴ 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”.¹⁵ 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.¹⁶ 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 Mississippi and many points in between, Tribal nations exist in some of the most entrenched poverty in this country.¹⁷ Because poverty rates are so high and the majority of AI/AN communities live on reservations in rural areas, pregnant women are not able to access and/or pay for the appropriate care they require.

Telehealth services have been suggested in the past for increased health service access to rural populations. While we appreciate the opportunities that telehealth can bring to rural communities, we note that Tribal populations are disproportionately underserved in broadband connectivity. According to the 2019 Federal Communications Commission (FCC) Report, only 46.6% of homes on Tribal lands had access to a fixed terrestrial broadband at standard speeds. Based on these presented data points, it is clear that providers are physically needed in Tribal communities.¹⁸ Relying on telehealth alone will not be sufficient for serving the needs of AI/AN people. We urge HRSA to consider broadband connectivity and access in their formula.

Conclusion

We thank HRSA for considering revisions to this formula and for some of the suggestions that they set forth in the RFI. AI/AN women face unique and often daunting hurdles when attempting to access even basic maternity care. The results of these struggles are horrific, AI/AN women are more likely to experience fatal complications during their pregnancy than other groups and do so at a rate that exceeds their share of the population. It is important that HRSA consider this and the other factors outlined above in their new formula. We believe that the dire maternal health

¹⁴ P.L. 111-5, Section 105

¹⁵ Kathleen Miller and Bruce Weber, “Persistent Poverty Dynamics: Understanding Poverty Trends over 50 years”, Rural Policy Research Institute, July 2014.

¹⁶ *Id.*

¹⁷ For a thorough listing of Persistent Poverty Counties, see: <https://fas.org/sgp/crs/misc/R45100.pdf>

¹⁸ “Report on Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018,” Federal Communications Commission, May 2019 <https://docs.fcc.gov/public/attachments/DOC-357269A1.pdf>

outcomes for AI/AN women deserves special attention in this new formula. Thank you 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 stroke at the end.

Stacy A. Bohlen

CEO

National Indian Health Board

CC:

Stacey Ecoffey

Principal Advisor for Tribal Affairs

HHS Office of Intergovernmental and External Affairs

Devin Delrow

Associate Director for Tribal Affairs

HHS Office of Intergovernmental and External Affairs

Dr. Elijah K. Martin, Jr.

CAPT, USPHS

Tribal Health Affairs

HRSA Office of Health Equity