

National Indian Health Board



October 23, 2020

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

Re: Revised Geographic Eligibility for Federal Office of Rural Health Policy Grants

Dear Administrator Engels:

Please accept this letter as a response on behalf of the National Indian Health Board (NIHB),¹ to the agency's notice regarding the agency's definition of rural. NIHB has concerns about the extension of this definition to include outlying counties in metropolitan areas that have no urbanized population. We recognize that the spatial challenges faced by those communities are often similar to counties that are currently classified as "rural." However, we are concerned that the inclusion of a broader rural population may result in more restricted access to funding for our most rural Tribes, who face difficulties related to spatial isolation that are much greater than metropolitan outlying counties. If the agency decides to expand the definition of rural, we ask that funding be made exclusively available to Tribal communities so we do not experience any negative impacts from this change.

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 (AI/AN). 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 (IHCA).² In the IHCA, Congress reiterated that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal

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 25 U. S. C. § 1601 et seq.

Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.”³ We believe that ensuring that Tribes have access to resources is essential to fulfillment of this responsibility.

The Rurality of Indian Country

Much of Indian Country is rural. In fact, 46.1% of AI/ANs live in rural communities, a rate which is over twice the percentage of the rest of the population.⁴ Furthermore, AI/ANs are the only group who make up a larger share of the rural population than the urban population.⁵ Perhaps more than any population, AI/ANs are directly impacted by policies that are targeted to rural populations. It is extremely important that the agency consider the impact on Indian Country before moving forward with making this change.

Based on our analysis of the affected counties, we note that this will not result in much of Indian Country being newly classified as rural. While the change would provide little benefit to Indian Country, we fear that the inclusion of more counties under this definition will result in the diversion of funds from the most isolated rural counties, which is where AI/AN populations are most heavily concentrated. Any potential diversion of resources away from Tribal communities is troubling for us. In 2018, the United States Department of Agriculture estimated that rural AI/ANs had a poverty rate of 31%, compared to just 13.5% for white Americans.⁶ Rural Tribal communities regularly struggle with access to resources and we are deeply concerned about the prospect of one avenue to receive resources being further restricted.

We also believe that, consistent with the designation of Indian Health Service (IHS) and Tribal facilities as auto-Health Provider Shortage Areas (HPSAs), Tribal lands and those IHS and Tribal health facilities that serve this population should automatically be designed as rural. The agency has previously recognized that Tribal providers, regardless of geography, struggle with access to resources and personnel and we feel that it would be consistent for the agency to extend this recognition by considering all of Indian Country “rural” for the purposes of receiving grant funding.

We acknowledge the agency's argument that the geographic growth of metropolitan areas into outlying communities is more likely to reflect workers commuting longer distances to a center city, instead of any kind of urbanization at the end of the metropolitan core. We note that many of these communities are not experiencing widespread urbanization and remain rural in character and we certainly sympathize with the difficulty that these communities face when it comes to accessing amenities. However, we also acknowledge the reality of limited resources and believe that funding should be reserved for the health programs and communities that have the greatest need for it. We also kindly remind the agency that 201 of the 287 proposed counties already have Census tracts that qualify as rural under the agency's definition. We worry about the ramifications of broadening

³ Id. § 1601(1)

⁴ Janice C. Probst, Fozia Ajmal, “Social Determinants of Health among Rural American Indian and Alaska Native Populations,” Univ. of S.C. Rural and Minority Health Research Center, July 2019 https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/socialdeterminantsofhealthamongruralamericanindianandalaskanativepopulations.pdf

⁵ <https://www.ers.usda.gov/webdocs/publications/90556/eib-200.pdf>

⁶ <https://www.ers.usda.gov/webdocs/publications/90556/eib-200.pdf>

the definition to include the entire county and then adding additional counties that currently have no rural Census tracts.

Set Aside Funding

If the agency decides to expand the definition of rural, we believe that they should also expand their offering of set aside funding for rural Tribes and programs that serve this community. This action would not be without precedent. Earlier this year, HRSA set aside funding for rural Tribes to respond to COVID-19. As mentioned earlier, the federal government has a unique responsibility to Tribes and their citizens. Honoring that responsibility would mean ensuring that funding to help Tribes is there and available to them. In a situation where this definition is expanded without an expansion of set aside funding, it is possible that Tribes will have fewer funds and resources available to them, which is deeply concerning to us.

We also generally believe that competitive grant making, especially grant making that pits Tribes against cities and counties, places Tribes at a disadvantage. In an expansion of the definition of rural, Tribes would be forced to compete with a greater number of metropolitan counties, who likely have access to more resources such as professional grant writers, which in turn would give them a great advantage in the competition for grants. We believe that HRSA should set aside funding for rural Tribes and Tribal entities in order to ensure that they retain access to funding and are not harmed by the expansion of the definition of rural and the addition of well-resourced competitors.

Conclusion

While we acknowledge the difficulties faced by outlying metropolitan counties, we have concerns about expanding the definition of rural to include them in their entirety. We fear that the expansion of the definition will result in fewer resources being available to some of the most vulnerable and isolated rural communities. AI/ANs are a very rural population and reside in some of the most impoverished and isolated communities in the country. Given the general difficulty that Tribes face in accessing resources, we are skeptical of any change that may place them at a further disadvantage. If the agency moves forward with this change, they must increase their set aside funding for Tribes in order to ensure that they continue to have access to rural health funding. 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, written over a white background.

Stacy A. Bohlen
CEO
National Indian Health Board