National Indian Health Board

Delivered by email to shirsch@hrsa.gov

January 4, 2013

Steven Hirsch
Office of Rural Health Policy
Health Resources and Services Administration
5600 Fishers Lane
Parklawn Building, 5A-05
Rockville, MD 20857

Dear Mr. Hirsch:

I write on behalf of the National Indian Health Board (NIHB) to submit comments on the proposed methodology for designation of frontier and remote ("FAR") areas.[1]

Established 40 years ago, the 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/AN). 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 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 rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate.

We appreciate the opportunity to comment on this proposed methodology. Although we have significant procedural and substantive concerns, we agree that there is a need to define "frontier and remote," that methodologies that rely principally on population density are insufficient, and with the explanation about why it is important to delineate frontier areas.

> Perhaps the fundamental and defining challenges facing frontier communities are the increased per capita costs of providing services. Access to health care is a primary concern motivating this research, but distance and low population densities increase costs of providing all types of social and public services, including schools, police and fire protection, public utilities, and transportation.[2]

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[1] 77 Fed. Reg. 66471 *et seq.*
[2] Id. At 66472.

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The Red Feather of Hope and Healing

A very significant percentage of Tribes face these challenges every day. It is perhaps because of the familiarity with the challenges that we are so deeply concerned about the failure of the Health Resources Services Administration ("HRSA") to involve Tribes meaningfully in this project and about the weaknesses in the product that we believe would have been remedied by such participation.

Health Care Delivery in Indian Country

Basic health services available to meet the needs of AI/ANs vary from geographic Area to Area. Some Tribes rely on IHS to operate their facilities, some Tribes operate their IHS health facilities on their own, some Tribes rely entirely on Contract Health Services (CHS) to secure purchased care from the private sector, and some Tribes undertake a strategic blend of some or all of these approaches. Reliance on referrals and care purchased through the contract health services program are essential even for minimum care since vast regions of the Indian health system have no hospitals at all and in other regions, the hospitals must serve communities not even connected to them by a road system through clinics that in some cases lack even running water.

Tribal Consultation

As a preliminary matter, we are concerned because, as far as we know, there has been no Tribal consultation regarding this project or the proposed methodology. The importance of such consultation cannot be stated more clearly than it is stated in your Consultation Policy.

> HRSA's policy promotes consultation with Tribes wherein elected officials and other authorized representatives of the Tribal Governments have an opportunity to provide meaningful and timely input prior to development of a legislative proposal, new/changed rule adoption, or other policy change that HRSA determines may significantly affect Indian Tribes, or where one or more Tribes has communicated that such action will significantly affect one or more Indian Tribes. An action is considered to significantly affect Tribes if it has substantial direct effects on one or more Indian Tribes, the relationship between the Federal Government and Indian Tribes, or the distribution of authority and responsibilities between the Federal Government and Indian Tribes.

While it may be true that "this is only a proposed methodology, and it is not current tied to any current federal program or allocation of resources,"[3] the project is clearly moving toward completion and will eventually be used for exactly those purposes.

Given the trust obligations owed to American Indian and Alaska Natives ("AI/ANs") and to Tribes and the likelihood that there is no group of people in this country who will be more highly represented in FAR designated areas, the failure to consult with Tribes is extremely

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[3] 77 Fed. Reg. 66475.

serious. Even if we had no reservations about the methodology, we would object to the project moving forward until there has been effective tribal consultation, but in fact, we do have concerns that make the importance of such consultation even more glaring.

SUBSTANTIVE CONCERNS

Uniformity of Application.

We are very concerned about the apparent lack of uniformity of application. We understood from the description on page 66474 that frontier status of all grid cells would be calculated, then aggregated to ZIP code areas. That would certainly be a change on aggregating to the county level for the reasons discussed in the Notice, but the Bethel, Alaska example makes clear that it is not zip codes being used. Moreover, even when ZIP codes are used, it is insufficiently precise to be reliably useful. In the lower 48 states, the use of zip codes creates an extremely inaccurate analysis because of application only to geography, not roads, populations, or mode of transportation. The result is an invalid portrayal of circumstances that are critical to frontier and remote residents. It is impossible to have confidence in, or even comment meaningfully on the proposed methodology, when it is unclear how it may actually be applied.

Population Threshold and the Central Place.

Comment is requested about using a population of 50,000 as the central place from which to measure, but the examples use not only 50,000 as a metric, but also add metrics for distance from other locations with the smallest being 15 minutes from an urban area of 2,500-9,999. Our concern is that population size as an indicator is not necessarily a reliable measure of the goods and services that will be available within the community. This has been shown in the literature repeatedly by researchers investigating 'food deserts' within cities and urban communities. One reviewer with whom we communicated suggested, not entirely tongue in cheek, that perhaps a measure should be distance from a "Walmart." While we do not go that far, it is absolutely true that a community that has to fly in all its commodities, including fuel oil, is not similarly situated to one of the same size that can rely on the road system. Similarly, access to a hospital with anesthesiology and the ability to perform a caesarian section or to respond to a cardiac event, might be a better metric for a "central place" than merely population size.

It seems to us the discussion of the variations among communities in this country is richer than the actual methodology. We appreciate the challenges faced in this project and the importance of not making the methodology too complicated to be meaningful, but we fear that the new methodology will not be sufficiently nuanced.

Use of 60 Minutes Travel Time from the Central Place.

According to the notice, travel time will be measured by calculating a one-way trip by the fastest paved road route with one-hour travel time added for locations that are only accessible by air. While travel time clearly should be used in addition to population density, this methodology

fails in a number of ways. Even in locations in which there are paved roads, it does not take into account the quality of the paved road, if there is more than one choice of a road (often there may be only one road for access by emergency/disaster life saving measures), whether the road is maintained year round (for instance there are roads that are not even kept open during the winter), or weather conditions (road closures due to avalanches, heavy snow, wash-outs, floods are commonplace in many parts of the country. Some factor based on delays due to weather or road conditions must be added to fairly represent the degree of isolation that some communities experience and a location in which a road is not maintained year round should not be considered to have road access at all. Nor is there any reference to how unpaved roads will be treated, although in many rural areas, not least in Alaska, paved roads are the exception.

For locations accessible only by plane or some other alternative to a paved road, like a ferry or boat, consideration should be given to the frequency of the scheduled availability as well as the frequency with which the schedule is disrupted.

For communities reliant exclusively on planes for transportation, actual travel time from home to airport, waiting time at the airport, and transportation at the other end, all need to be considered, plus a factor for weather and airport conditions. A community that is dependent on airplane travel only, is considerably more isolated if it does not have runway lights than a community in which scheduled and emergency flights can occur after dark.

In all situations in which transportation by some means other than a personal vehicle is required, a metric based on added cost should be developed and used in the taxonomy. When ones only access to higher-level medical care is by airplane, the cost of those flights must be weighed when determining the real accessibility to care and the alternatives that should be considered for those communities.

Four Standard Levels.

The question posed to the commenter is "[w]hether the 50 percent population threshold for assigning frontier status to a ZIP code/census tract is the appropriate level for the four standard provided levels." The mere fact that ZIP code is used interchangeably with census tract in this question makes it impossible to answer, but the Bethel example, above, makes it clear that neither one is sufficient for designating the most remote communities in the United States. In reservations in the lower 48, similar scenarios exist. Often there may just be a "reservation store" that has minimal supplies and requires a reliable vehicle to access, often more than 30 miles away. The use of ZIP code/census tract methodology would produce an invalid analysis/profile. Aggregating population to that level will fail to adequately represent the most remote and isolated populations in our country, most of which are populated by American Indians or Alaska Natives. Therefore, we find the fifty percent population threshold per area is questionable.

In addition, it seems certain to us that limiting the number of standard levels to four will wash out the differences among the locations that are admittedly not urban, but are a world away from those villages in Alaska that have no running water, no road access, no runway lights, and

frequent bad weather, and even from remote locations on the Navajo Reservation to give just two examples.

Applicability of FAR to Island Populations.

The FAR methodology should accurately represent the degree of isolation of all communities. As our discussion of travel time reveals the factors that need to be considered are more complex than merely adding a benchmark number of minutes, but that does not mean some measures should not be identified.

Need for Census Tract and County Version of the FAR.

If the methodology is going to begin at the 1x1 kilometer grid level and is intended to be used flexibly by policymakers, then, of course, it should be organized so that aggregation at a variety of geographic and political levels should be possible. We suggest that the grid data should be organized in a data base in which it can be aggregated at a variety of levels, including, each town, county, Indian reservation (or other land designation), school district, county, census block, census tract, etc. But, most importantly, each aggregation should be accompanied by clear definition of how it was developed.

Recommendations.

The Notice points out that these methodologies have been used most with regard to health care, but that they have importance for many other matters of importance, such as economic development, job growth potential, cost of doing business, etc. We agree. At least, absent meaningful tribal consultation and a robust discussion including a far broader group of people than have had the opportunity to participate so far, we believe that the project should shift toward more developing more refined metrics and methods for applying them uniformly to all parts of the United State. The agencies and policy makers who need to be able to distinguish among communities in order to ensure that their resources are focused in the right locations could then select the metrics most appropriate to their program pulling down data from an interactive database in order to propose to the public, and to tribes in tribal consultation, what the factors should be.

In our comments above, we have mentioned some possibilities for such metrics using the ones identified in the Notice as a starting place. Consider:

- Population density using the 1x1 grids with ability to roll up to various political and geographic units;
- Distance by paved road to locations of a certain population with adjustment factors for other forms of required transportation, interference with the means of transportation due to weather and other conditions, using standardized measurements generally available, including cost;
- Distance from certain goods and services, including a hospital that can perform certain procedures (which ones will need consideration, but certainly should

factor in the level of trauma center that is available, as well as the ability to provide other health services), a broad array of grocery items (including fresh vegetables and fruit), police and other emergency services, the nearest elementary and secondary school, the nearest public swimming pool;

- Availability of public safe water and sanitation; and
- Cost of fuel measured against the cost in the largest community in the State.

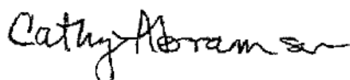
Each of these has its own limitations and the list is far from complete of items that should be considered. Some will require, and there should be included, new definitions. For instance, the Notice comments on the difference between high-order goods (advanced medical procedures, major appliances, regional airport hubs, professional sports teams) and low-order goods (grocery stores, gas stations, and basic health needs). It notes that closing stores, car dealerships, and movie theaters fall in between. The notice fails to address locations with "very low-order goods and services, which certainly should include communities with *no consistent access* to fresh foods (vegetables, fruit, dairy products), running water and sewer, police protections, and so on.

The point is that the designation of FAR needs to truly be able to be applied flexibly based on factors relevant to the funding being provided or program or policy being implemented. To do this a multi-variant database needs to be developed with agreed upon metrics for each item in the taxonomy. This is the task that we believe should be being pursued.

In addition, at every stage, in the development of the multi-variant database and in its utilization there should be robust tribal participation and formal consultation.

Thank you for the opportunity to comment. We believe this is important work, and we look forward to more meaningful opportunities to participate.

Sincerely Yours,



Cathy Abramson
Chairman, National Indian Health Board

cc: Yvette Roubideaux,IHS, Director
Stacy A. Bohlen, NIHB, Exeuctive Director
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