

# Health Professional Shortage and Medically Underserved Designations

Current Approach, Legislation, and  
Rulemaking History



John Snow, Inc.



## DESIGNATION HISTORY

- **Designations established in the 1970's to support 2 programs:**
  - HPSAs for the National Health Service Corps
    - Section 332(a)(1)(A,B) of the Public Health Service Act (42 USC 254e)
  - MUA/P for the Community and Migrant Health Center program
    - Section 330(b)(3) of the Public Health Service Act (42 USC 254b)
- **Now:**
  - Dozens of Federal Programs use these designations as a requirement or preference
  - State and other non-federal programs reference them as well



# Designation Requirements for Selected Federal Programs

Shortage Designation Type	National Health Service Corps (NHSC)	Federally Qualified Health Ctr Program (FQHC)	Rural Health Clinic (RHC) Program	Medicare Incentive Payment (MIP) Program (CMS)	J-1 Visa Waiver Programs (HHS, ARC, States)	Preferences for BHP Title 7 Awards if Graduates Serve Underserved Communities
Geographic PC HPSA	X		X	X	X	X
Population PC HPSA	X		X		X	X
Facility PC HPSA	X				X	X
Dental Care HPSA	X					X
Mental Health HPSA	X				X	X
Medically Underserved Area (MUA)		X	X		X	X
Medically Underserved Population (MUP)		X			X	X
“Governor’s” Exceptional MUP (Unique Local Conditions)		X			X	X
Governor’s Certified Shortage Area (State Criteria)			X			

# Current Designation Summary

Primary Care HPSAs				
Type	Designations		Population	
	Count	%	Count	%
Geographic Area	1,690	27%	37,118,604	56%
Population Group*	1,506	24%	25,508,474	39%
Facility**	3,063	49%	3,152,927	5%
<b>Total</b>	<b>6,259</b>		<b>65,780,005</b>	

Medically Underserved Areas/Populations				
Type	Designations		Population	
	Count	%	Count	%
Medically Underserved Area	3,447	86%	75,092,844	79%
Medically Underserved Population*	389	10%	7,509,561	8%
Governor	188	5%	12,453,309	13%
<b>TOTAL</b>	<b>4,024</b>		<b>95,055,714</b>	

\* Population reflects designated sub-population group only – MUP is estimated using Low Income pop.

\*\* Population for Facility HPSAs does not include patients served at facilities covered by automatic designation status. Facility designation count includes the FQHC grantees but not their individual sites.

# CURRENT METHODOLOGIES <sup>(1)</sup>

- Rational Service Area criteria defined for both HPSA and MUA/P designations
- HPSAs – Geographic Areas, Population Groups, or Facilities
  - Population-to-Provider (FTE) ratio must exceed 3500:1
    - 3000:1 for population groups or areas with high need or insufficient capacity
      - Excessive productivity, long waits, closed practices, use of ED for primary care, low overall utilization
  - Contiguous Area Analysis required
  - Renewal required
    - Each area reviewed every 3-4 years
  - Basic Criteria finalized 1980



## **CURRENT METHODOLOGIES** (2)

- **MUA/Ps - Geographic Areas or Population Groups**
  - **Index of Medical Underservice**
    - **Component indicators:**
      - Percent of Population at or below 100% Poverty
      - Percent Population  $\geq 65$
      - Infant Mortality Rate
      - Primary care physicians per 1,000 Population
    - **Weighted values for each component**
    - **Sum of values must be  $\leq 62.0$**  (median score for all counties in 1975)
  - **No renewals required**
  - **Last update of component indicator scales done in 1980-1981**
    - **Existing designations tested for renewal using new parameters**
  - **No Contiguous Area Analysis requirement**

## *Legislative Requirements*

### **Health Professional Shortage Areas**

- Rational service area, population group, or public/nonprofit private facility meeting HPSA criteria
- Secretary shall consider:
  - The ratio of available health manpower to population
  - Other indicators of a need for health services
  - The percentage of physicians who are employed by hospitals and who are graduates of foreign medical schools
  - Extent to which those eligible for services under Medicare, Medicaid, or SCHIP cannot obtain such services because of physician suspensions
- All FQHCs, and those RHCs accepting patients without regard to ability-to-pay, are automatically designated
  - Federally recognized tribes are automatically designated by regulation



## *Legislative Requirements (2)*

### **Medically Underserved Populations**

- Area or Population-group level designations
- Include factors indicative of
  - health status
  - ability to pay for health services
  - availability/accessibility of health professionals & services
- Permissible for Secretary to designate areas that do not meet established criteria if Governor and local officials recommend it based on ‘unusual local conditions’

## *Legislative Requirements (3)*

- Health Professional Shortage Areas and Medically Underserved Areas/Population are separately authorized in the legislation
  - Technically will remain two separate designations regardless of any degree of alignment in methods
- Programmatic references to the designations in legislation vary
  - Designation generally dictates eligibility to apply or grants preference in scoring/placement
  - Program references do not directly constrain or define rules for designation
    - Can/should be considered in defining rules and determining factors for MUA/P vs HPSA

# STIMULI FOR UPDATING METHODOLOGY

- *Outdated MUA/P designations no longer reflect areas of need accurately*
- *Critical 1995 GAO REPORT : “Major Changes Needed in Approach to Identifying Medical Underservice”; Follow up report in 2006*
  - *IMU no longer felt to be useful in identifying need and targeting/ allocating resources*
  - *Midlevel providers not included for HPSAs and MUAs*
  - *No or poor accounting for federally linked resources*
  - *Outdated parameters for IMR; other available access and health status measures should be added*
- *Desire for Simplification*
  - *Perception that methods overlap and differences cause confusion*
  - *Desire to move towards common definitions*
  - *Goal to reduce local burden in obtaining/maintaining designations*

# Revising the Rules – “NPRM-1”

1994 – Work begins on NPRM-1

NPRM-1 Rule published in 1998

- Combined HPSA and MUA
- Index of Primary Care Shortage (IPCS) based on a weighted sum of access-related variables for the area/population group
- OVER 800 COMMENTS RECEIVED
  - *NEGATIVE REACTION TO PERCIEVED IMPACT*
    - *ESPECIALLY FROM RURAL AREAS, SAFETY NET PROGRAMS*
  - *Estimates indicated 25-40% of designations would be lost; many existing safety net programs would lose eligibility*
  - *A number of other issues raised about the proposed criteria*
- Rulemaking was suspended for revisions; a revised method was to be developed, with a more thorough impact analysis, and published for further comment



## Revising the Rules – “NPRM-2”

### 1999 -Work Begins on New “NPRM-2” Method

- Focus on better data, science-based approaches, more testing
- Academic and stakeholder involvement
- Goal of minimal disruption of existing safety net
- Acceptable performance
- *Contract with UNC-SHEPS center*
- *Involvement of other Rural Health Research Centers, Health Workforce Centers, and ‘Group of 16’ PCO/PCA advisors*
- *Development work on revised methodology and impact analysis were completed by 2003, but review stalled at various levels*

## **NPRM-2** (cont.)

- *NPRM-2 was published for comment February 28, 2008*
  - *the comment period was extended twice*
- *Impact Analysis published with NPRM was outdated - used 2002 data*
  - *Efforts made to address this concern during the comment period*
  - *A "calculator" was provided to help States and others retesting impact with more current data*
- *700+ Comments*
  - *Range of methodological concerns*
  - *Strong concern expressed over potential impact on safety net providers*
- *Rulemaking suspended in July 2008 for further review – intent to develop another revised NPRM was stated in FRN*

# Revising the Rules – “NPRM-3”

## Efforts to Date

- *Competitive contract awarded in 2008 to John Snow Inc.*
- *A provision in the Affordable Care Act (ACA) required that this effort be done through a Negotiated Rulemaking process*
  - *Separate outside facilitator contracted (Federal Mediation and Conciliation Service)*
  - *JSI Logistics role expanded to accommodate additional external meetings*
  - *Federal Register Notice of Intent published, and Committee member nomination/selection process carried out*
- *Preparatory work to date*
  - *Initial meetings with OSD, prior contractor, and HRSA program staff*
  - *Review of methods for analyzing demand, capacity, and access*
  - *Procurement/analysis of most likely underlying datasets and integration into GIS framework*
  - *Examination of other potential data sets for relevance and possible inclusion*



# Purpose of Designation

- Identify areas/populations with health care access issues, needing federal assistance
- Describe and quantify the nature of need in the community
  - Provide information and framework to support the most effective targeting of resources by federal programs