

February 16, 2011

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Office of Shortage Designation
Bureau of Health Professions
Health Resources and Services Administration
Parklawn Building, Room 9A-18
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RE: Comments on Criteria for Designation of Medically Underserved Populations for the Negotiated Rulemaking Committee on Designation of Medically Underserved Populations and Health Professional Shortage Areas

To the Negotiated Rulemaking Committee:

The national, regional, and state organizations who have signed on below promote and help advance the rights of low-income immigrant communities and their ability to secure quality affordable health care coverage and services. We are submitting these comments for your consideration during the committee's February 16-18, 2011 meeting to incorporate in your recommendations for designation of Medically Underserved Populations.

Population's Need for Access to FQHC

Immigrants of all statuses rely on Federally Qualified Health Centers (FQHCs) for their family's primary and acute care.¹ While the majority of the uninsured in the United States are citizens, immigrants, who represent 12% of the total U.S. population, are disproportionately represented among the uninsured due to a number of factors.² Although a majority of immigrants are employed, they often work in industries such as retail, construction, agriculture or in small, family-owned businesses or have employee statuses (contract or seasonal worker) where employer sponsored health insurance is unavailable.³ Federal eligibility restrictions imposed by the 1996 welfare law contribute to this lack of insurance by denying Medicaid, Medicare, and CHIP to most low-income immigrants for five years or longer.⁴ Immigrant eligibility restrictions, application and enrollment barriers also prevent eligible children in immigrant families from enrolling in Medicaid, CHIP or other insurance programs.⁵ Yet regardless of their

¹ Statistical Profiles of the Hispanic and Foreign-Born Populations in the U.S., Pew Hispanic Research Center March 30, 2010, available at: <http://pewhispanic.org/reports/report.php?ReportID=120>. See *Table 38: Persons Without Health Insurance, by Age, Race and Ethnicity: 2008*, Statistical Portrait of Hispanics in the United States, 2008, available at: <http://pewhispanic.org/files/factsheets/hispanics2008/Table%2038.pdf>

² *Five Basic Facts on Immigrants and Their Health Care*, Kaiser Commission on Medicaid and the Uninsured, March 2008, available at: <http://www.kff.org/medicaid/7761.cfm>; *Statistical Portrait of the Foreign-Born Population in the United States*, 2008, Pew Hispanic Center, January 21, 2010, available at <http://pewhispanic.org/files/factsheets/foreignborn2008/Table%201.pdf>

³ *The Role of Employer-Sponsored Health Coverage for Immigrants: A Primer*, Kaiser Commission on Medicaid and the Uninsured, July 2006, available at: <http://www.kff.org/uninsured/7524.cfm>

⁴ *Overview of Immigrant Eligibility for Federal Programs*, National Immigration Law Center, April 2010, available at: <http://www.nilc.org/immisps/special/overview-immeligfedprograms-2010-07.pdf>

⁵ *Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?*, Genevieve M. Kenney, Victoria Lynch, Allison Cook, and Samantha Phong, Health Affairs, October 2010, available at: http://images.gmimage3.com/members/18967/ftp/Newsletter/Kenney_final.pdf; see also, federal guidance issued on September 21, 2000 by the U.S. Department of Agriculture, Administration for Children and Families and Health Care Financing Administration, and the Department of Health and Human Services' Office for Civil Rights: *Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children's*

insurance status, immigrants often find the most affordable, culturally and linguistically appropriate, quality care at their local FQHC. They often are able to build trusted relationships with doctors and nurses at these health centers and consider the FQHC their medical home. For these reasons, many low-income immigrants' first and only experience with the U.S. health care system often occurs at a FQHC.

Under the Patient Protection and Affordable Care Act of 2010 (Public Law No. 111-148)(ACA), "lawfully present" immigrants will be eligible for affordable coverage through the new insurance exchange(s). Many of these newly eligible individuals will need access to culturally and linguistically competent health care and will continue to rely on their local FQHC as their medical home. Yet millions of immigrants and their family members will remain excluded from affordable health coverage under the ACA and will need access to a robust and strong safety-net for health care services.

FQHCs will play a critical role in providing immigrants of all statuses access to essential medical services. Additional federal investments are necessary to boost the quality and number of FQHCs and to ensure that their growth is targeted in the communities with the greatest need. Although a broad range of factors may be considered in defining a Medically Underserved Populations (MUP), which helps determine where a FQHC is needed, the current criteria for designating a MUP omit several key data indicators that would ensure those with the greatest need for a FQHC, including immigrants, are included within a medically underserved area or medically underserved population.⁶

Recommendations on MUP criteria and designation

We recommend that this committee incorporate the following changes to the MUP criteria to help ensure that FQHCs continue to provide health care to the most vulnerable and medically underserved areas

Currently, MUP criteria include:⁷

- The ratio of primary medical care physicians per 1,000 population;
- Infant mortality rate;
- The percent of population with incomes below the federal poverty level guideline (50% or less of FPL); and
- The percent of population who are 65 years or older.

Many uninsured immigrants are between 18 and 64 years old, are generally healthier than the broader population, and are among the millions of working poor in the U.S. The current MUP criteria therefore do not adequately account for these individuals who are primarily of working age, with incomes above 50% of the federal poverty level, and who remain uninsured and in need of basic health care.

The Secretary of Health and Human Services has the authority to determine the criteria used to define a Medically Underserved Population.⁸ The criteria should specifically include "factors indicative of the health status of a population group or residents of an area, the ability of the residents of an area or of a population group to pay for health services and their accessibility to them, and the availability of health professionals to residents of an area or to a population group." 42 C.F.R. § 254b(b)(3)(B)(ii).

health Insurance program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits ("Tri-Agency Guidance") available at: <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/tanf/triagencyletter.html>

⁶ For example, per HRSA, "[m]edically Underserved Populations (MUPs) may include groups of persons who face economic, cultural or linguistic barriers to health care." <http://bhpr.hrsa.gov/shortage/> (page last updated May 28, 2010; website last accessed February 14, 2011),

⁷ Index of Medical Underservice (IMU) variables. <http://bhpr.hrsa.gov/shortage/muaguide.htm>

⁸ 42 C.F.R §254b

Consistent with these principles, we recommend that the Negotiated Rulemaking Committee incorporate these factors explicitly in the MUP criteria:

- Rates of the uninsured and insured at all age levels;
- Percent of the population who are Limited English Proficient;
- Participation rates in the federal free or reduced school lunch program, SNAP, TANF, and Earned Income Tax Credits; and
- Census data on the citizen and non-citizen population, and state migration data.

Additional factors that may also be helpful to explicitly include as MUP criteria are:

- Health indicators such as: the portion of population who are smokers vs. non-smokers; rates of childhood immunizations or high-risk births; and rates of asthma, diabetes, hypertension, and obesity at all age levels;
- Evidenced based indicators of social health determinants such as alcoholism, domestic violence, hunger, and lack of affordable housing; and
- Percent of the population who are homeless, migrant/seasonal workers, or residents of public housing.⁹

We recommend that these new MUP criteria should be reviewed not only at the time of an initial application for FQHC designation but when renewing the designation of existing FQHCs.

Recommendations on Confidentiality and Non-Discrimination Protections

We strongly support HRSA's policy of not requiring individuals to provide information about their immigration status and the policy that any use of immigration status on an individual or aggregate basis be used only for the administration of federal health programs. We suggest that the agency rely on existing data or estimates of immigrant populations in a geographic area to help assess whether an area is a medically underserved population rather than introducing criteria or questions that would raise privacy concerns for immigrants and would deter families from seeking the care for which they are eligible. We recommend that the Negotiated Rule Making Committee recommend that HRSA reaffirm its existing privacy and confidentiality policies with regard to immigration status. Where appropriate, HRSA should enact new privacy policies that comply with the ACA's privacy, confidentiality, and non-discrimination provisions.¹⁰

Recommendation for Transparency and Consumer Input

Finally, we recommend that the Negotiated Rulemaking Committee recommend that HRSA establish a transparent and open process when considering proposed changes to the MUP criteria. This would help ensure fair notice to consumer stakeholders and would provide a feedback mechanism that incorporates the patient perspective.

We also recommend that the Negotiated Rulemaking Committee recommend that HRSA establish a stakeholder process that accounts for the patient perspective during the application and renewal of an FQHC designation. This will help ensure that the current population's needs in a specific MUP are reflected in the process.

⁹ HRSA allows specific award grants targeting these three populations – homeless, seasonal/migrant workers, and residents in public housing. 42 C.F.R. § 254b(g) - 254b(i). Because these groups are already recognized by HRSA as specific populations in higher need of medical care, the percent of the population that are in these particular categories should be among the explicit criteria used by HRSA in designating a MUP/MUA.

¹⁰ See e.g., Sections 1411(g) and 1557 of the ACA.

Thank you for allowing us the opportunity to provide these comments. If you have any questions or need additional information, please contact Sonal Ambegaokar, National Immigration Law Center, at ambegaokar@nilc.org.

Sincerely,

Alliance for a Just Society
Asian Pacific American Legal Center (California)
California Immigrant Policy Center (California)
California Pan Ethnic Health Network (California)
California Partnership (California)
California Primary Care Association (California)
Center for Immigrant Healthcare Justice
Community Catalyst
Faithful Reform in Health Care
Hands Across Cultures (New Mexico)
Having Our Say (California)
Illinois Coalition for Immigrant and Refugee Rights (Illinois)
La Clinica de La Raza (California)
La Clínica del Pueblo (District of Columbia)
La Fe Policy Research and Education Center (Texas)
Latino Coalition for a Healthy California (California)
National Council of La Raza (NCLR)
National Health Law Program (NHeLP)
National Immigration Law Center (NILC)
National Latina Institute for Reproductive Health
New York Immigration Coalition (New York)
Service Employees International Union (SEIU)
Southeast Asia Resource Action Center (SEARAC)
Valle del Sol (Arizona)
Washington Community Action Network (Washington)