

I. Overview

This proposal addresses two issues regarding the designation process for Medically Underserved Populations:

- Streamlined process for groups that are assumed to already meet most of the required designation criteria
- Non-streamlined process to be used by all other groups who want to apply for MUP status (including those listed in HP 2020)

There are additional issues still under discussion:

- Relationship between MUP and the special population HPSAs
- Facilities designation as it applies to special populations

The process employs the current MUA/P criteria:

- 1) Factors indicative of the health status of a population group
- 2) Ability of the residents of a population group to pay for health services
- 3) Accessibility to these health services
- 4) Availability of health professionals to residents of a population group

NOTE – italics are used for clarification purposes and/or to identify areas still under discussion

II. Streamlined MUPs

(previously called pre-identified or automatic)

- Certain population groups are already recognized by HRSA and named in current designation and/or programmatic regulations because they have sufficient documentation to meet the top three criteria.
- There may be other population groups with sufficient recognized documentation to meet these same criteria, including those named in health care legislation.
- Streamlined groups assumed to meet criteria #1-3 already, and would only have to prove #4.
- *NPRM2 suggested streamlined process for criteria #4 as well - only need to prove number of people in that population, not availability of providers.*

Streamlined Groups

- Groups named in the current designation rules: Medicaid recipients, low income and linguistically isolated (*need exact language from rule*).
- Groups identified in Section 330 of the Public Health Service Act (42 USCS § 254b) and named in current designation: Migrant and seasonal farm workers, persons experiencing homelessness, public housing residents.
- Groups named as underserved in health care legislation that specifically identifies populations in need of health care access, coverage or service delivery (*administered by HRSA?*) – examples:
 - Indian Health Care Improvement Act (IHCIA), Public Law 94-437, enacted based upon findings that the health status of Indians ranked far below that of the general population
 - Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, PL 101-381, enacted in 1990 to provide emergency relief to cities, states and clinics so that they could meet the medical and treatment needs of people living with HIV due to the high rates of poverty, poor insurance coverage and barriers to accessing health care experienced by people disproportionately affected by HIV disease
 - Native Hawaiian Health Care Improvement Act, Title 42 > CHAPTER 122 > § 11701, enacted in 1988 to raise the health status of Native Hawaiians to the highest possible health level; and to provide existing Native Hawaiian health care programs with all resources necessary to effectuate this policy.
 - *Others?*

<p>III. Populations that do not meet streamlined MUP process can still apply for MUP status</p> <ul style="list-style-type: none"> • For any other group not pre-identified, it would be necessary to document that the group meets all 4 criteria. • Communities would make case for specific populations in their service area. • HP 2020 would help to identify groups for consideration and may provide sufficient documentation to meet one or more of the criteria (e.g. disparities in health status). <ol style="list-style-type: none"> 1. Health status factors – review MUA health status factors; apply or revise as needed. 2. Ability to pay – review MUA criteria; apply or revise as needed. 3. Accessibility – include menu of barriers (<i>under development</i>); apply or revise as needed. 4. Availability - review MUA criteria and thresholds; consider adjustments as needed for MUP. 	<p>For each criteria (health status, ability to pay, accessibility and availability), must prove with:</p> <ul style="list-style-type: none"> ○ National data OR ○ Nationally accepted documentation (HP 2020) OR ○ State/local data • Details need to be worked out when MUA approach finalized. May be able to apply (or revise) indicators to population-specific approach. • Advantages of this approach: <ul style="list-style-type: none"> ○ Builds on existing criteria but with population-specific perspective ○ Includes more underserved population groups ○ Addresses new and emerging groups – would be includes as data and documentation recognize groups and enable them to meet criteria ○ Allows for local communities to make their case ○ Uses HP 2020 - widely accepted and backed by scholarship and community input; updated every 10 years. • Challenges: <ul style="list-style-type: none"> ○ Impact testing ○ Standards for/validity of locally collected data ○ In the event that HP 2020 is not updated or accepted in the future, may need to consider alternative sources
<p>IV. MUA, HPSA and Facility Designations – Still Under Discussion</p> <ul style="list-style-type: none"> • MUA and HPSAs must consider special populations • HPSA Special Populations – how will this be the same and how will it be different? • Governor’s exception for both HPSAs and MUA/Ps • Facility designations important for many special populations • Concern by some groups that may not be named; need to ensure inclusion through regulation language. 	
<p>Healthy People 2020 defines a <i>health disparity</i> as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”</p>	