

<p>I. Overview</p> <p>This proposal addresses two issues regarding the designation process for Medically Underserved Populations:</p> <ul style="list-style-type: none"> 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) <p>The process employs the current MUA/P criteria:</p> <ol style="list-style-type: none"> Factors indicative of the health status of a population group Ability of the residents of a population group to pay for health services Accessibility to these health services Availability of health professionals to residents of a population group 	
<p>II. Streamlined MUPs Overview</p> <ul style="list-style-type: none"> Certain population groups are already recognized by HRSA or HHS 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. As new legislation recognizes other special population groups, these groups can be added to the streamlined group. Streamlined groups are assumed to meet criteria #1-3 already (health status, ability to pay, accessibility). For criteria #4, section 330 groups only have to prove that the population exists in that area. All other groups will need to demonstrate provider availability (p2p still to be defined). DO WE NEED TO ADD AMERICAN INDIANS TO 330 GROUPS AND CREATE A THIRD GROUP Mechanism for adding to list of legislation – now and in future? 	<p>Streamlined Groups</p> <ul style="list-style-type: none"> Medicaid, low income, linguistically isolated (taken out) Groups identified in HPSA statute: homeless individuals (as defined in section 330(h)(5)), seasonal agricultural workers (as defined in section 330(g)(3)) and migratory agricultural workers (as so defined), and residents of public housing (as defined in section 3(b)(1) of the United States Housing Act of 1937 (42 U.S.C. 1437a(b)(1)). Groups named as underserved in health care legislation that specifically identifies populations in need of health care access, coverage or service delivery) administered by HHS (<i>broadened from HRSA legislation</i>) – examples: <ul style="list-style-type: none"> Indian Health Care Improvement Act (IHCIA), Public Law 94-437 Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, PL 101-381 Native Hawaiian Health Care Improvement Act, Title 42, CHAPTER 122, 11701, 1988 Combating Autism Act of 2006 Developmental Disabilities Act The Traumatic Brain Injury Act of 2008 (P.L. 110-206) Disadvantaged Minority Health Improvement Act (NEW) <p><i>JSI TO LOOK AT POVERTY LEVELS OF THESE GROUPS (100% & 200%) – to determine threshold (>50% need to meet poverty level), expect that some groups may fall out. Concern about political clout over-riding actual need.</i></p>
<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 	<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 State data OR

<p>necessary to document that the group meets all 4 criteria.</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> ○ Local and proxy data –<i>Alice’s revised language accepted as criteria (see below, need to clarify proxy and local?)</i>. ○ Details need to be worked out when MUA approach finalized. May be able to apply (or revise) indicators, thresholds, etc to population-specific approach. <ul style="list-style-type: none"> • 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
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IV. MUA, HPSA and Facility Designations – Still Under Discussion

- 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 (these pops will travel far and wide to find culturally/linguistically competent providers who provide needed services). Endorse magnet facility designations that serve special populations or an alternative approach for clinics serving special populations that may not be defined geographically.
- Concern by some groups that may not be named; need to ensure inclusion through regulation language.

Healthy People 2020 defines a *health disparity* 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.”

SPECIAL POPULATION DESIGNATIONS (NON-STREAMLINED) USE OF PROXY DATA, DRAFT WORDING FOR THE REGULATIONS

For instances where the regulations call for specific data related to the population for which the designation is sought (e.g., poverty) and where no such local RSA data are available, the applicant shall be allowed to submit proxy information if a strong relationship between the proxy population and the application population can be proven. Data used to justify such a relationship must show a strong correlation between the proxy population and the applicant population (i.e., a significant proportion of the applicant population also have the characteristics of the proxy population) and must meet the guidelines for local data including specification of: source, coverage year/s, geographic area, population group and methodology.

Example: The applicant population are immigrants. No RSA local level poverty data exist for this population. There is sufficient data to show that 70% of immigrants in the local RSA are Hispanic. The argument is made to use Hispanic local RSA poverty rate as proxy data for the applicant population of immigrants

[NOTE TO POPULATION SUBCOMMITTEE MEMBERS: I have used “immigrants” as the applicant population in the above example but am not sure if that is appropriate.]