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PART IV:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

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DESIGNATION OF MEDICALLY UNDERSERVED AREAS

**DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE**

Public Health Service

**MEDICALLY UNDERSERVED AREAS
AND POPULATION GROUPS**

Designation

The purpose of this notice is to publish the current list of medically underserved areas as designated by the Secretary of Health, Education, and Welfare. The notice describes how the index of medical underservice is used to produce the list of medically underserved areas, and sets forth the procedure for ongoing revision of the list.

The Secretary's first designation of medically underserved areas, under the provisions of the Health Maintenance Organization Act of 1973 (Pub. L. 93-222), appeared as a notice in the FEDERAL REGISTER on September 2, 1975 (40 FR 40315-451). The notice contained a full description of the methodology for determining medical underservice. Single copies can be obtained from the appropriate DHEW Regional Office.

Sections 1302(7) and 330(b)(3) of the Public Health Service Act state that the term "medically underserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.

Under the provisions of the Health Maintenance Organization Act, projects that will draw not less than 30 percent of their membership from medically underserved populations may receive priority funding.

Section 330 of the Public Health Service Act, established by Pub. L. 94-63, provides that grants may be made to public and nonprofit private entities for projects to plan, develop, or operate community health centers which serve medically underserved populations.

Section 1611(d)(2) under Title XVI of the PHS Act, established by Pub. L. 93-641, requires that in any fiscal year not less than 25 percent of the amount of a State's allotment under Part B of title XVI available for obligation in that fiscal year shall be obligated for projects for outpatient facilities which will serve medically underserved populations. The legislative history of title XVI makes clear that the Secretary is expected to utilize the same operational definition of a medically underserved population for title XVI purposes as is used elsewhere in the PHS Act. (See S. Rept. No. 93-1285 at 59.)

Health maintenance organization, community health center, and health facility applicants who wish to apply for funding under the above sections should consult this list to determine which areas in their localities are medically underserved. To learn if there have been changes subsequent to the publication of this list, applicants should contact their local planning agencies.

**APPLICATION OF THE INDEX OF MEDICAL
UNDERSERVICE**

The basis for identifying medically underserved areas and populations is the index of medical underservice (IMU). The IMU is obtained by applying weights to data on the following indicators:

- (1) Ratio of primary care physicians to population;
- (2) Infant mortality rate;
- (3) Percentage of the population which is age 65 or over; and
- (4) Percentage of the population with family income below the poverty level.

County-level data are used for two of the indicators: the physician-to-population ratio and the infant mortality rate. For the two census indicators (percentage of the population below the poverty level and percentage of the population age 65 or over), county, minor civil division (MCD), or census county division (CCD) data are used in non-metropolitan areas, and census tract data are used in metropolitan areas. A weighted value is determined for each indicator and the sum of these values forms the IMU score.

In the development of the current MUA list, the 1975 median IMU score of all U.S. counties, 62.0, was used as the cut-off point between underserved and adequately served areas. Index values were computed for each non-metropolitan county, and those counties with scores of 62.0 or below are listed as medically underserved. Index values were then computed for all MCD/CCDs in non-metropolitan counties with scores greater than 62.0, and those MCD/CCDs with scores of 62.0 or below are on the list. In metropolitan areas, defined here as census tracts which lie within standard metropolitan statistical areas (SMSA), the IMU was computed for each census tract and all census tracts with scores of 62.0 or below are on the list. Areas with a population of fewer than 500 (whether counties, MCD/CCDs, or census tracts) were excluded from consideration as underserved to eliminate listing such places as parks and airports.

The list of areas resulting from application of the IMU was then revised based on approved deletions and additions recommended by the comprehensive health planning (CHP)¹ agencies.

¹ Prior to the implementation of Pub. L. 93-641, recommendations were made by the areawide CHP agencies under the authority of Section 314(b) of the PHS Act, and by State CHP agencies under Section 314(a) of the Act (Pub. L. 89-749). In April 1976, with the designation of the first health systems agencies under Section 1515 of the PHS Act (Pub. L. 93-641), phase-out of the 314(b) CHP agencies began. The CHP phase-out process is expected to be completed by early 1977 when all of the over-200 health systems are operational and the transfer of areawide health planning functions has been realized. For the 314(a) CHP agencies, a corresponding substitution of State health planning and development agencies (under the authority of Section 1521 of the PHS Act) be-

ONGOING REVISION OF THE MUA LIST

The MUA list will be revised and published periodically, based on the most recent data available nationally. The updates will be based on changes in the actual values of the indicators or adjustments in the cut-off level. Health systems agencies (HSA)² or CHP agencies may at any time recommend changes in the list to reflect local knowledge of medical underservice. As current local data are not available nationally and some areas may be included or excluded inappropriately, HSAs are urged to review the list and to recommend deletions and additions.

All health systems agency recommendations will be reviewed to determine acceptability. If the recommended deletion of an area is accepted, that deletion will be considered permanent until the HSA requests reinstatement of the area. If the recommended addition of an area is accepted, the addition will be subject to periodic review to determine the validity of its retention based on the latest available data, i.e., data for years more recent than those urged to support the recommendation for addition.

**PROCEDURE FOR SUBMISSION OF
RECOMMENDATIONS**

A recommendation for deletion or addition of an area must be accompanied by the agency's reason for the recommendation. All computations, as well as data sources and dates, must be submitted with a recommendation for addition of an area except when the area has a population of fewer than 500 and an IMU of 62.0 or less. If there has been public involvement in the recommendations, the material submitted should include a description of such involvement, e.g., documentation of relevant public meetings, copies of the agency's published notice of intent to review its area to identify pockets of medical underservice, or satisfactory demonstration that the agency governing or advisory board as representative of the community has had adequate review opportunity and has approved the recommendations of the HSA.

Health systems agencies and official CHP agencies are to send their recommendations to:

Division of Monitoring and Analysis, Bureau of Community Health Services, DHEW, 5800 Fishers Lane, Rockville, Maryland 20852.

Also, a copy of the recommendations is to be sent to the appropriate DHEW

gan on July 1, 1976. Until the phase-out is completed, federally funded CHP agencies will continue to make recommendations for the MUA list.

In Hawaii, Rhode Island, the District of Columbia, the Virgin Islands, Guam, the Trust Territories in the Pacific Islands, and American Samoa, the State health planning and development agencies (SHPDA) carry out the functions of health systems agencies (see Section 1536 of the PHS Act).

Regional Office (for address, see 45 CFR 5.31(b)).

Deletions. Recommendation for deletion of an area must be accompanied by identification of the area as it appears on the MUA list and the reasons for the recommendation.

Additions. Recommendation for addition of an area to the MUA list must be based on computation of an IMU score of 62.0 or less, using locally available data or data more recent than that used for this list. (See data sources under the heading, "The List of Medically Underserved Areas.") Before computing an IMU for an area with fewer than 500 population, the HSA should check with the Bureau of Community Health Services (address above) to determine whether or not the IMU for that area is 62.0 or less.

The following information must accompany a recommendation for addition of an area:

(a) Geographic identification of the area (names, census codes, or a map outlining the area proposed).

An area proposed for designation as medically underserved must be or approximate either:

(1) A county (in non-metropolitan areas),

(2) A minor civil division (MCD) or census county division (CCD) (in non-metropolitan areas),

(3) A census tract (in metropolitan areas), or

(4) A group of census tracts, MCDs, or CCDs which constitute a "natural neighborhood" for MUA designation. These groups can be listed as underserved if the IMU for the combined area is 62.0 or below. Because of the homogeneity of a neighborhood, such groupings may constitute more natural areas for designation as medically underserved than units such as individual census tracts, MCDs, and CCDs.

(b) Data on the four indicators and computations of the index of medical underservice.

(1) Percentage of population with incomes below the poverty level. (The definition of poverty used is the 1964 Social Security Administration version adopted by the Federal Interagency Committee in 1969.)

This percentage must be computed from 1970 Census of Population data or more recent update thereof, if any, as follows: The number of persons in families with incomes below the poverty level in the identified area is added to the number of unrelated individuals with incomes below the poverty level; this total is divided by the resident population minus members of the Armed Forces living in barracks, students in dormitories, and inmates of institutions; and the result multiplied by 100.

The figures used to compute this percentage (the resident population, inmates of institutions, Armed Forces living in barracks, students in dormitories, and the number of persons with incomes below the poverty level) must be stated. The data can be obtained from the 1970 U.S. Census Bureau publications or tapes. If the data are obtained from

more recent sources, both data and sources must be identified.

Compute the percentage of population with incomes below the poverty level for the appropriate area: census tracts or combinations of census tracts in metro-

politan counties; MCD/CCD or combinations of MCD/CCDs in non-metropolitan counties; or the whole non-metropolitan county. Convert the computed percentage to the weighted value V_1 using Table V₁.

TABLE V₁

PERCENTAGE OF POPULATION BELOW POVERTY LEVEL

In the left column find the range which includes the percentage of population below poverty level for the area being examined. The corresponding weighted value, found opposite in the right column, should be used in the formula for determining the IMU.

Percent Below Poverty	Weighted Value V_1
0	25.1
.1- 2.0	24.6
2.1- 4.0	23.7
4.1- 6.0	22.8
6.1- 8.0	21.9
8.1-10.0	21.0
10.1-12.0	20.0
12.1-14.0	18.7
14.1-16.0	17.4
16.1-18.0	16.2
18.1-20.0	14.9
20.1-22.0	13.6
22.1-24.0	12.2
24.1-26.0	10.9
26.1-28.0	9.3
28.1-30.0	7.8
30.1-32.0	6.6
32.1-34.0	5.6
34.1-36.0	4.7
36.1-38.0	3.4
38.1-40.0	2.1
40.1-42.0	1.3
42.1-44.0	1.0
44.1-46.0	.7
46.1-48.0	.4
48.1-50.0	.1
50+	0

(3) Percentage of population age 65 or over.

This percentage must be computed from 1970 U.S. Census of Population data or more recent update thereof, if any, as follows: the number of persons age 65 or over in the identified area is divided by the resident population of that area, and the result multiplied by 100.

The figures used to compute this percentage (number of persons age 65 or over, and the resident population) must be stated. These data can be obtained

from U.S. Census Bureau publications or tapes. If data are obtained from other more recent sources, data and sources must be identified.

Compute the percentage of population age 65 or over for the appropriate area: census tract or combination of census tracts in metropolitan counties; MCD/CCD or combination of MCD/CCDs in nonmetropolitan counties; or the whole non-metropolitan county. Convert the computed percentage to the weighted value, V_2 , using Table V₂.

NOTICES

TABLE V₂
 PERCENTAGE OF POPULATION
 AGE 65 AND OVER

In the left column find the range which includes the percentage of population age 65 and over for the area being examined. The corresponding weighted value, found opposite in the right column, should be used in the formula for determining the IMU.

Percent Age 65 and Over	Weighted Value V ₂
0- 7.0	20.2
7.1- 8.0	20.1
8.1- 9.0	19.9
9.1-10.0	19.8
10.1-11.0	19.6
11.1-12.0	19.4
12.1-13.0	19.1
13.1-14.0	18.9
14.1-15.0	18.7
15.1-16.0	17.8
16.1-17.0	16.1
17.1-18.0	14.4
18.1-19.0	12.8
19.1-20.0	11.1
20.1-21.0	9.8
21.1-22.0	8.9
22.1-23.0	8.0
23.1-24.0	7.0
24.1-25.0	6.1
25.1-26.0	5.1
26.1-27.0	4.0
27.1-28.0	2.8
28.1-29.0	1.7
29.1-30.0	.6
30+	0

(3) Infant mortality rate.

This rate must be computed as an aggregate rate for the 5-year period 1969 through 1973, or more recent period of 5 consecutive years, as follows: the total number of deaths of infant residents (deaths between birth and age 1 year) during the 5-year period in the county containing the identified area is divided by the total number of live births to residents of the county during the same period and the result multiplied by 1,000. For counties with fewer than 100 live births over the 5-year period, the IMU may be computed using the State infant mortality rate instead of the county rate. The infant mortality rate for a subcounty

area which includes the identified area and has had at least 4,000 births over the 5-year period will be accepted in lieu of the county rate. The number of infant deaths and live births for the subcounty area and the sources of data used must be stated, together with the infant mortality rate computed from them. Data on infant deaths and live births may be obtained from official State agencies or the annual editions of the U.S. Public Health Service publication entitled "Vital Statistics of the United States."

Compute the infant mortality rate for the county and convert it to the weighted value V₂ using Table V₂.

TABLE V₃
 INFANT MORTALITY RATE

In the left column find the range which includes the infant mortality rate for the area being examined or the area in which it lies. The corresponding weighted value, found opposite in the right column, should be used in the formula for determining the IMU.

Infant Mortality Rate	Weighted Value V ₃
0-10.0	26.0
10.1-11.0	25.6
11.1-12.0	24.8
12.1-13.0	24.0
13.1-14.0	23.2
14.1-15.0	22.4
15.1-16.0	21.5
16.1-17.0	20.5
17.1-18.0	19.5
18.1-19.0	18.5
19.1-20.0	17.5
20.1-21.0	16.4
21.1-22.0	15.3
22.1-23.0	14.2
23.1-24.0	13.1
24.1-25.0	11.9
25.1-26.0	10.8
26.1-27.0	9.6
27.1-28.0	8.5
28.1-29.0	7.3
29.1-30.0	6.1
30.1-31.0	5.4
31.1-32.0	5.0
32.1-33.0	4.7
33.1-34.0	4.3

NOTICES

Infant Mortality Rate	Weighted Value V_3
34.1-35.0	4.0
35.1-36.0	3.6
36.1-37.0	3.3
37.1-38.0	3.0
38.1-39.0	2.6
39.1-40.0	2.3
40.1-41.0	2.0
41.1-42.0	1.8
42.1-43.0	1.6
43.1-44.0	1.4
44.1-45.0	1.2
45.1-46.0	1.0
46.1-47.0	.8
47.1-48.0	.6
48.1-49.0	.3
49.1-50.0	.1
50+	0

(4) Ratio of primary care physicians to population.

This ratio should be computed by dividing the number of primary care physicians in the county which contains the identified area by the civilian non-institutional population, and multiplying the result by 1,000. Figures used for the number of primary care physicians and the civilian non-institutional population (resident population minus the resident members of the Armed Forces and inmates of institutions) and their sources must be stated. For the purpose of these

computations, primary care physicians are defined to include the total number of active doctors of medicine (M.D.) and doctors of osteopathy (D.O.) who spend at least 50 percent of their time engaged in direct patient care in the fields of general or family practice, internal medicine, pediatrics, or obstetrics and gynecology. The computations must include all non-Federal physicians meeting the above definition.

Compute the physician ratio for the county and convert to weighted value V_3 using Table V.

TABLE V₄
PRIMARY CARE PHYSICIANS
PER 1,000 POPULATION

In the left column find the range which includes the ratio of primary care physicians per 1,000 population for the county being examined, or the county in which the area being examined lies. The corresponding weighted value, found opposite in the right column, should be used in the formula for determining the IMU.

Primary Care Physicians Per 1,000 Population	Weighted Value V ₄
0	0
.001-.050	.5
.051-.100	1.5
.101-.150	2.8
.151-.200	4.1
.201-.250	5.7
.251-.300	7.3
.301-.350	9.0
.351-.400	10.7
.401-.450	12.6
.451-.500	14.8
.501-.550	16.9
.551-.600	19.1
.601-.650	20.7
.651-.700	21.9
.701-.750	23.1
.751-.800	24.3
.801-.850	25.3
.851-.900	25.9
.901-.950	26.6
.951-1.000	27.2
1.001-1.050	27.7
1.051-1.100	28.0
1.101-1.150	28.3
1.151-1.200	28.6
Over 1.200	28.7

(5) Computation of the index of medical underservice. The IMU is computed by using the formula: $IMU = V_1 + V_2 + V_3 + V_4$.

If the IMU score for an area is 62.0 or below, the area may be recommended for addition to the MUA list. If the IMU score is greater than 62.0, the area may be recommended for deletion.

POSSIBLE EXCEPTIONS

The Secretary recognizes that there may be certain areas which do not qualify for the MUA list solely on the basis of the computed IMU. An area can have unusual conditions which reduce the availability or accessibility of primary medical care but which are not reflected in the area's overall IMU score. If there

are mitigating circumstances which would bear on the value of a particular indicator, there can be in-depth review of the additional information affecting the factors involved in computing the IMU.

Conditions that reduce the availability of medical services by increasing demand could be, for example, an area that has a large influx of migrant farmworkers which substantially alters the physician-to-population ratio during the growing season; or an area that has had a significant increase since the 1970 census in the number of persons age 65 or over, or in the number of persons living in poverty. Also, accessibility factors, such as physical barriers, lack of all-weather roads, severe weather and a major

portion of the year, distance to or time spent to reach sources of primary care, or relevant socio-economic factors may help to qualify an area for consideration. To the extent possible, the information describing unusual conditions should be quantified and verified by the recommending HSA. Areas designated as Critical Health Manpower Shortage Areas (as authorized by Section 329(b) of the PHS Act) are designatable as medically underserved.

Recommendations for designation as a medically underserved area based on unusual conditions should (a) be prepared by the health systems agency, (b) state the primary cause of the medical underservice, (c) describe all factors causing the underservice, (d) be supported by all relevant data, sources, and dates, and (e) be submitted through the Regional Office to:

Director, Bureau of Community Health Services, DHEW, 5600 Fishers Lane, Rockville, Maryland 20852.

Alternatively, the Regional Office, with the concurrence of the health systems agency, can directly supply such information to the Bureau of Community Health Services.

THE LIST OF MEDICALLY UNDERSERVED AREAS

The index of medical underservice on which the list is based was computed using data from the following sources:

Center for Health Services Research and Development, 1973 Physician County Summary File, Chicago. American Medical Association, 1974.

Master File of Osteopathic Physicians, December 31, 1974. Chicago. American Osteopathic Association, 1975.

U.S. Bureau of the Census, 1970 Census of Population, 2d and 4th Count Files.

Maternal and Child Health Studies Project, 1969-1973 Infant Mortality County Summary File, Washington. Information Sciences Research Institute, 1976.

The list is structured with the States in alphabetical order. There are four headings which identify total counties, minor civil divisions/census county divisions within counties, census tracts within counties, and groups of census tracts. The MCD/CCDs are identified by name; the census tracts are identified by number. Areas in each of the sections are listed alphabetically by county.

Groups of census tracts are listed only when the HSA or CHP agency has certified that particular groupings form natural areas for designation. Census tracts which individually qualify for designation but have been combined with other tracts in groups have been marked with double asterisks in the group listings.

The following areas are designated by the Secretary as medically underserved.

Dated: October 4, 1976.

THEODORE COPPER, M.D.,
Assistant Secretary for Health.