

The Children's Health Fund
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BY ELECTRONIC TRANSMISSION

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**Re: Designation of Medically Underserved Populations and Health Professional Shortage Areas 42 CFR Part 5
75 Fed. Reg. 26167 (May 11, 2010)**

The Children's Health Fund (CHF) is submitting the following comments in regards to the Notice of Intent to Form Negotiated Rulemaking Committee issued on May 11, 2010 in regards to the revision of Medically Underserved Population and Health Professional Shortage Area designations.

CHF is a non-profit organization and designated as a 501(c)3 by the Internal Revenue Service. Since its inception in 1987, CHF has supported direct patient care to medically underserved children and families in both rural and urban areas. CHF's national network of child health programs has grown to include through 24 programs in 14 states and the District of Columbia. The most recent addition to our national network includes a program in rural southern Arizona in partnership with Chiricahua Community Health Center. Our programs operate in Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA) and serve Medically Underserved Populations (MUP), therefore we hope our comments are taken into consideration as HRSA, HHS and the committee moves forward during negotiated rulemaking.

2008 Proposed Rule

In 2008, when HRSA and HHS released a Notice of Proposed Rule Making (NPRM) changing the methodology of designation for HPSAs and MUAs, CHF had several concerns. As the Rulemaking Committee is sure to revisit the proposed rules from 1998 and 2008, we feel it is imperative to re-state our concerns about the 2008 proposed rule as a way to answer the questions posed by HRSA in the most recent notice.

Tiered System

CHF was concerned over the creation of a tiered system, due to the fact that it was not clear how this would affect health center funding and further guidance was required to clarify what it would mean for a health center with Tier 2 as opposed

to Tier 1 or Safety Net Facility designation. If the committee considers such a system, examples must be given as to a health centers operating in all tiers.

Definition of "Medical Facility"

In the 2008 NPRM, the definition for "Medical Facility" was an outdated federally qualified health center (FQHC) definition that could have potentially disenfranchised certain populations, specifically homeless persons who depend on Health Care for the Homeless (HCH) programs. We ask that as the committee moves forward, that HRSA use the current FQHC definition of a "medical facility." Using the old definition would deny "medical facility" designation to HCH programs.

Data Used

In 2008, HRSA used data that were ten years old, e.g., 1998 Claritas estimates, 1998 Bureau of Labor Statistics, and 1998 National Center for Health Statistics. This was deeply concerning. When estimating the far ranging impact the change in HPSA/MUP designation will have on primary care throughout the country, we feel strongly that more recent data must be used as a basis for revision. More current data are available from The Dartmouth Institute for Health Policy and Clinical Practice, Rural Health Research and Policy Centers, Kaiser Family Foundation State Health Facts and federal household surveys including National Comorbidity Survey Replication and Medical Panel Expenditure Survey. Data for pediatric populations should be specifically included including the Annie E. Casey Foundation Kids Count data set.

Population Density

In 2008, a population density variable was introduced in the equation to determine HPSA/MUP designation to adjust for the needs of rural populations. The negative impact on urban areas was made clear by analysis conducted by the George Washington University School of Public Health, 29 million people living in urban areas would no longer be considered medically underserved.¹ If the rulemaking committee considers including population density as a factor for determination, it must be in conjunction with serious consideration the barriers urban populations face. While different than rural counterparts, barriers exist in urban areas that may be overlooked in the population density factor, such as the limited number of providers that take publicly insured patients, transportation and affordability of care.

Provider Ratio

CHF disagrees with the continued use of the 3000:1 ratio of population to provider as the threshold of underservice. Previously, HRSA had stated that

¹ Shin, Peter, et al, *Analysis of the Proposed Rule on Designation of Medically Underserved Populations and Health Professional Shortage Areas*, George Washington University School of Public Health and Health Services, Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Issued April 14, 2008, Revised May 1, 2008.

3000:1 represents “twice the normal load for a busy primary care physician”^{2, 3}, and that such a ratio represents a deficit that would be addressed adequately by the addition of another primary care provider.

CHF wishes to point out that although “it was in agreement with prior policies that used similar ratios in federal designation systems” this does not justify the continued use of a ratio or trigger point that undermines the ability of a provider to adequately treat and provide a medical home to 1500 individuals. These concerns were raised by the planning committee nine years ago, by current reviewers and acknowledged in the 2008 proposed rule.⁴

CHF believes this threshold should be revisited for these reasons. In addition, revising the threshold would acknowledge the reality that underserved populations usually present with more complicated health needs, requiring a more intensive primary care visit. When patients require more time per visit, fewer patients can be seen per day or per week. Increasing the ratio by just one additional provider per 1500 would not be enough to adequately treat the health care needs of underserved populations. CHF recommends a threshold closer to the reasonable level of 1500:1 as the underservice threshold score.

Dependent Programs

CHF respectfully asks that HRSA, and the as yet to be formed rulemaking committee, take into account how the HPSA/MUP designation affects state and federal funding and eligibility for specific programs and benefits, such as the National Health Service Corps, Community Health Center 330 federal grants, Federal Tort Claims Act, and Federally Qualified Health Center Medicaid rates.

In light of previous efforts to create tiers, HRSA and the Rulemaking Committee must consider how any new designation or tier will affect these programs.

Beyond these concerns with the 2008 NPRM, CHF believes the issues raised by the current notice are all relevant concerns and has the following responses to questions posed by the notice.

1. Are the objectives of the MUP and HPSA designations clearly different, therefore justifying two separate processes?

While the objectives of the MUP and HPSA designations are similar, unifying the designations poses potential disruption in funding streams for MUP and HPSA depended programs. MUPs are useful in designating special populations within non-HPSA areas. If the Committee decides to unify these designations, they must

² 73 Fed. Reg. 11246

³ Ricketts, Thomas, et al. *Designating Places and Populations as Medically Underserved: A Proposal for a New Approach*, *Journal of Health care for the Poor and Underserved* 18 (2007): 567-589.

⁴ 73 Fed. Reg. 11246

examine the affect on MUP dependent programs, including health care for the homeless grantees.

We believe that a designation should be available based on geographic areas that takes into account health providers, population, population density and distribution, and proximity of population centers to health facilities. In addition, a designation should continue to be available for special populations. Urban homeless families, for example, may be sheltered in an area with an adequate supply of health professionals but nonetheless be an underserved population. The population-based designation for the homeless should apply regardless of geographic/regional considerations.

2. What specific underservice indictors should be included? To what extent should state and local data be used? What provider availability measures, economic factors, health status indicators, measures of utilization and/or demographic indicators should be included?

In regards to demographic indicators, the Committee should consider taking into account the number of children in a service area, and the percent of minority population in the area. The Committee should also take into account emergency department use for ambulatory sensitive conditions, using hospital discharge data, as a measure of utilization that would be prevented by an increase in primary care providers. The Committee should also continue to use poverty as an underservice indicator and revisit the 2008 NPRM proposal of raising the bar of poverty consideration to 200% of the federal poverty level as a way to more accurately reflect the number of persons living in poverty.

Another determinant of health care utilization among vulnerable populations is the degree to which transportation may be available. In communities with health professional shortages, often the distance to travel to get health care is ten or more miles. This is prohibitive if there are no public transportation resources or privately owned vehicles available. The availability of transportation resources in a community or county is difficult to quantify from existing data sources. Children's Health Fund is currently engaged in the development of a "Transportation Disadvantage Index" which will become available to identify areas that are deficient in both health professional supply and availability of transportation resources.

4. Within provider availability measures, which clinicians/providers should be included?

In the 2008 NPRM, it was proposed that physicians placed in shortage areas be counted towards the ratio, therefore endangering the shortage designation. It is our opinion that physicians placed in shortage areas should not be counted in the designation; otherwise the shortage area may face losing the designation and therefore the funding to keep that clinician in the shortage area.

7. What types of population groups should be considered for designation?

CHF believes that homeless populations and children in seasonal farm worker families should continue to be considered as a vulnerable population group. Children in foster care should also be included.

8. What is the role of facility designations?

Facility designations are especially important to health care for the homeless providers who may operate within an area not designated as a shortage area, but who serve a population that faces a shortage of services. In addition, homelessness disrupts existing health care relationships and creates new access barriers which persist regardless of health professional supply in the surrounding area.

11. How should the Committee assess the potential impact of revised MUP/HPSA methodologies, versus continued use of the current methods?

CHF urges the Committee to consider which community health centers and providers will lose the shortage designation when assessing the potential impact of revised methodologies, and request such information from state primary care associations. CHF also urges the Committee to look at the budget impact of losing the shortage designation on community providers. A contingency plan must be put in place for those health centers and providers as several funding streams are affected by the designation.

Rulemaking Committee

CHF supports the formation of the Rulemaking Committee to address the long overdue revision of the HPSA/MUP designation. In terms of Primary Care Associations, CHF is supportive of the work of the Community Health Center Association of New York State in this arena and believe they would be a productive member of the committee.

However, there are certain groups not represented in the proposed representatives, specifically, consumers of health care, child health advocates and health care for the homeless representatives. We strongly urge that HHS and HRSA consider including representatives from these groups.

Conclusion

Thank you for the opportunity to comment. We trust that HHS and HRSA will take into consideration all of the comments from the health care community and continue to do so as the negotiated rulemaking committee moves forward.

Sincerely,

Children's Health Fund