

Designation of Medically Underserved Populations (MUP) and Health Professional Shortage Areas (HPSA); Michigan Department of Community Health (MDCH) Summary of the Proposed Rule:

Note: This document attempts to summarize the notice of proposed rule making on the designation of MUPs and HPSAs published in the *Federal Register* on February 29, 2008. Any omissions or inaccuracies are unintentional. Complete information is available in: Department of Health and Human Services. "42 CFR Parts 5 and 51 c Designation of Medically Underserved Populations and Health Professional Shortage Areas; Proposed Rule" *Federal Register* / Vol. 73, No. 41 / Friday, February 29, 2008 / Proposed Rules/ pg. 11232 – 11281.

The New Method:

Under the proposed rule, there would be a single process for designating Medically Underserved Populations and Health Professional Shortage Areas. What follows is a summary of the new criteria for MUP and HPSA designation with emphasis on those aspects of the new criteria that differ from current criteria.

Designation Populations:

For geographic designations, the base population is the resident civilian population of the RSA. Prior to use in the population-to-provider ratio calculation however, the base population is adjusted to reflect differential requirements by age and sex for primary care service using utilization rates for populations who are effectively "barrier free" in terms of accessing primary care. The adjusted population is called the "effective barrier free population".

Population group designations are allowed under the proposed rule for the low-income population, Medicaid-eligible population, linguistically isolated population, migrant and seasonal farmworkers and their families, homeless population, residents of public housing, and Native Americans.

There is a "simplified" designation procedure for migrant, homeless, and Native American populations in cases where the area in which the requested population group is located has been defined, data on the number of individuals in the population group is provided and the total is found to exceed 1000, but specific information on the number of FTE clinicians accessible to the population group is not available. In these cases, a population-to-clinician ratio of 3,000:1 may be assumed.

Requirements for the statutory "permissible" designation of "other population groups recommended by state and local officials" are included under the proposed rule (i.e. State Governor's requested Medically Underserved Population and Governor's Certified Shortage Area for Rural Health Clinics purposes).

Provider FTE Counts:

Each active physician in the primary care specialties is included as 1.0 FTE unless there is evidence of less than full-time practice. Physicians in residency training in primary care are counted as 0.1 FTE. Nurse Practitioners (NP), Physician Assistants (PA), and Certified Nurse Midwives (CNM) are included and counted as either 0.5 FTE, or 0.8 times a state-specific practice scope factor running from 0.5 to 1.0 FTE (at the applicants option).

For a Tier 1, geographic designation, all area providers are included in the designation. For a

Tier 2 designation, federally-sponsored clinicians including NHSC affiliated clinicians, clinicians obligated under the State Loan Repayment Program, physicians with J-1 visa return-home waivers, and other clinicians providing services at health centers funded under Section 330 are excluded from the FTE count. A description of the Tier 1 and Tier 2 designation differences is provided in the “Benefits of Designation” section below.

For population group designations, provider FTE should be calculated based on data relevant to the population group for which designation is sought, as nearly as possible, rather than on the population of the area as a whole.

The Adjusted Population-to-Provider Ratio:

Under the proposed rule, a score (the adjusted population-to-provider ratio) is calculated totaling the population-to-provider ratio and a series of adjustment factors intended to account for increases in need for primary care services based on community characteristics.

The population-to-provider ratio is calculated by dividing the effective barrier free population figure described above by the provider FTE figure also described above.

The adjustment factor scores are calculated for each of eight high need indicators: Percent Below 200% FPL, Unemployment Rate, Percent over Age 65, Population Density, Percent Hispanic, Percent Non-White, Death Rate, and Low Birth Weight Rate or Infant Mortality Rate. The actual value of each high need indicator is converted to a percentile relative to national county distribution, and that percentile is converted to a score based on the results of a regression analysis weighting the high need indicators in a statistically meaningful way (as opposed to the current MUA/P criteria methodology which apply equal weighting to 4 need indicators). Also of note is that the relative percentile ranks and the regression analysis scores can (and according to the proposed rule will) be recalculated periodically to adapt to changing national trends. This type of adjustment is not possible under current designation criteria.

For population group designations, each variable is to be calculated based on data for the population group for which designation is sought, as nearly as possible, rather than the population of the area as a whole. For low-income population group designations, this means that the Percent Below 200% FPL adjustment factor is calculated based on 100% of the population at 200% FPL.

The Threshold of Underservice

A county or other RSA will be designated as underserved if its final adjusted population-to-provider ratio equals or exceeds the proposed threshold level of 3,000 persons for every FTE primary care clinician.

Under the proposed rule, this is the only threshold for underservice. There are no adjustments to the threshold for “high need” populations or for population groups because these indicators are part of the adjustment factors added into the adjusted population-to-provider ratio.

Rational Service Areas (RSAs):

Criteria for RSAs under the new method can be consistent with existing criteria. However,

under the proposed rule, States are encouraged to develop a state-wide system of RSAs which divides the territory of the State into rational service areas (RSAs) for the delivery of primary care services. An approved state-wide system of RSAs eliminates the requirement for contiguous area analysis during submission of individual designation requests.

As currently written, there is no requirement under the proposed rule that at least 30% of the area's population be at or below 2 times the Poverty line for designation as a low-income or Medicaid Eligible population group. Similarly, there is no specific maximum population size for an RSA written in the proposed rule.

Facility Designations:

The current criteria for designation of public and non-profit private, primary medical care facilities as HPSAs are eliminated under the proposed rule. Instead, designation of "safety-net facility" primary care HPSAs is allowed. Eligibility for this type of designation is limited to FQHCs, RHCs, or other public or non-profit private clinical sites providing primary medical care services on an ambulatory or outpatient basis. Eligible facilities must provide services regardless of an individual's ability to pay for such services, have a posted, discounted sliding-fee-scale which is available to all uninsured patients with incomes below 200% of the poverty line, and these facilities must provide a minimum level of service to the indigent uninsured and/or Medicaid-eligible population as described in the table below:

Minimum Levels of Service to Indigent Uninsured and/or Medicaid-Eligibles

Metropolitan Areas	Non-Metropolitan areas (except frontier areas)	Frontier Areas
At least 10% of all patients are served under a posted, sliding fee schedule, or for no charge	At least 10% of all patients are served under a posted, sliding fee schedule, or for no charge	At least 10% of all patients are served under a posted, sliding fee schedule, or for no charge
At least 40% of all patients are served either under Medicaid, under a posted sliding fee schedule, or for no charge.	At least 30% of all patients are served either under Medicaid, under a posted sliding fee schedule, or for no charge.	At least 20% of all patients are served either under Medicaid, under a posted sliding fee schedule, or for no charge.

The criteria for designating federal and state correctional institutions and youth detention facilities as primary care HPSAs is essentially unchanged under the new criteria.

Benefits of Designation:

Designation of an area under the proposed rule carries with it comparable benefits to simultaneous designation as both a HPSA and an MUP. Programs requiring HPSA and MUA/P designation do not require changes to this requirement.

Under the proposed rule, there is a 2 tier system of designations intended to alleviate what has been described as the "yo-yo effect" seen under the current system of designation (i.e. a designated area is provided with resources to alleviate the shortage of providers, the area loses the designation as a result of these new resources, this causes the area to also lose the availability of these resources, that eventually leads to a shortage of providers again, and ultimately the area is re-designated in a cyclical pattern).

Both types of designations (Tier 1 and Tier 2) would be eligible for federal programs authorized to place resources in MUPs and HPSAs. However, Tier 2 areas (those designated with federally sponsored providers excluded from provider counts) would typically be eligible only to maintain the approximate levels of federal resources already deployed, while Tier 1 areas (those designated even with federally sponsored providers included in provider counts) could apply for additional resources. Interpretation of the Tier system for designations in terms of available benefits to designated areas is largely left up to individual federal programs and agencies (NHSC, CMS, etc.).

Under the proposed rule, a new category of MUP is recognized, consisting of those uninsured and Medicaid-eligible patients who are served by safety net facilities designated as primary care HPSAs. This facility designation allows FQHC organizations located in an otherwise non-designated area to continue operating as caring for a medically underserved population.

Similar to current regulations, facility designations are likely not sufficient to meet the HPSA designation requirement for establishment of an RHC.

Procedural Notes:

The proposed approach to processing MUA, MUP, and HPSA designation requests closely follow the present HPSA designation procedures. Below is a discussion of some notable differences between the proposed rule and current practice.

Review Schedule:

Under the proposed rule, the Secretary of DHHS will annually review all designations with emphasis on those for which updated data have not been submitted during the previous three years; this extends to MUA/Ps the review process previously used only for HPSAs.

Review Process:

The latest relevant data from national sources (for those previously-designated areas which the Secretary of DHHS requires be updated) will be made available to the appropriate State entities and others for review and comment. If no corrections are provided, the national data will be used as the Secretary's basis for decisions. Use of State and local data regarding provider locations and FTEs (which is often more up-to-date and accurate than national data) will continue to be encouraged.

Under the new criteria, an expedited review process is also proposed for urgent cases allowing designations to be obtained within 30 days of the date of request when a practitioner dies, retires, or leaves an area, thereby causing a sudden and dramatic increase in the area's population-to-clinician ratio.

Transitioning to the New Criteria:

The new criteria for designation of MUA/Ps and/or HPSAs will be phased in over a period of three years from the date of publication of the final rule in the Federal Register, with state input on the review schedule but with the oldest MUA/P and primary care HPSA designations being reviewed first.

Upon publication of a final regulation, HRSA will first score all existing MUAs and HPSAs using the national databases. Areas that qualify using those calculations will be designated as underserved with no need for input from the State or local level. The submission of additional information will only be required for those areas that do not qualify based on national data.

All FQHCs and RHC delivery sites that are automatically designated will be listed separately as “automatic” HPSAs until the area or population group they serve or the facility achieves designation under the proposed criteria or until 6 years from the date of their automatic designation, whichever comes first. Any FQHC or RHC sites still being carried on the list of “automatically” designated sites six years from their date of automatic designation will then be required to demonstrate that they meet the new criteria for designation.

Impact Analysis:

A thorough analysis of the impact the new criteria would have on existing designations (with 1999 designations as a baseline) and potential new HPSA and MUA/P designations (determined using 1998 Claritas data and 1998 national primary care clinician data) at the national level is included in the Federal Register notice with the proposed rule. In general, this analysis demonstrates that the new criteria tend to allow re-designation of a higher percentage of existing designations than the current criteria and the criteria proposed in 1998 (NPRM1), and that with new designations included, the new criteria tend to designate (with 1998 national data) a higher total population and number of areas (the closest of the options to the baseline designation population and number of areas designated) than do the current criteria and NPRM1.

As stated in the proposal, the areas designated under the new criteria should differ from those designated under the current criteria (to some degree) as a result of the new criteria more effectively identifying areas with an unmet need than do the current criteria. However, the impact analysis performed suggests that the new criteria would be less “disruptive” to current designations and to the scope of population and areas identified for designation than NPRM1 would have been.