Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and Health Professional Shortage Areas

(10/31/11)

Appendices and Addenda

Attachments

Attachment A: Statutory Language for MUPs

Sec. 330(b)(3) Medically underserved populations

(3) **Medically underserved populations**

(A) **In general**

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.

(B) **Criteria**

In carrying out subparagraph (A), the Secretary shall prescribe criteria for determining the specific shortages of personal health services of an area or population group. Such criteria shall—

(i) take into account comments received by the Secretary from the chief executive officer of a State and local officials in a State; and

(ii) include factors indicative of the health status of a population group or residents of an area, the ability of the residents of an area or of a population group to pay for health services and their accessibility to them, and the availability of health professionals to residents of an area or to a population group.

(C) **Limitation**

The Secretary may not designate a medically underserved population in a State or terminate the designation of such a population unless, prior to such designation or termination, the Secretary provides reasonable notice and opportunity for comment and consults with—

(i) the chief executive officer of such State;

(ii) local officials in such State; and

(iii) the organization, if any, which represents a majority of health centers in such State.

(D) **Permissible designation**

The Secretary may designate a medically underserved population that does not meet the criteria established under subparagraph (B) if the chief executive officer of the State in which such population is located and local officials of such State recommend the designation of such population based on unusual local conditions which are a barrier to access to or the availability of personal health services.

Attachment B: Statutory Language for HPSAs

42 U.S.C.A. §254e
Section 332 of the PHS Act [42 U.S.C. 254e]

§254e – Health professional shortage areas

(a) **Designation by Secretary; removal from areas designated; "medical facility" defined**

(1) For purposes of this subpart the term "health professional shortage area" means

(A) an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a health manpower shortage and which is not reasonably accessible to an adequately served area,

(B) (B) a population group which the Secretary determines has such a shortage, or

(C) (C) a public or nonprofit private medical facility or other public facility which the Secretary determines has such a shortage. All Federally qualified health centers and rural health clinics, as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x (aa)), that meet the requirements of section 254g of this title shall be automatically designated as having such a shortage. The Secretary shall not remove an area from the areas determined to be health professional shortage areas under subparagraph (A) of the preceding sentence until the Secretary has afforded interested persons and groups in such area an opportunity to provide data and information in support of the designation as a health professional shortage area or a population group described in subparagraph (B) of such sentence or a facility described in subparagraph (C) of such sentence, and has made a determination on the basis of the data and information submitted by such persons and groups and other data and information available to the Secretary.

(2) For purposes of this subsection, the term "medical facility" means a facility for the delivery of health services and includes—

(A) a hospital, State mental hospital, public health center, outpatient medical facility, rehabilitation facility, facility for long-term care, community mental health center, migrant health center, facility operated by a city or county health department, and community health center;

(B) such a facility of a State correctional institution or of the Indian Health Service, and a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act [25 U.S.C. 450f et seq.];

(C) such a facility used in connection with the delivery of health services under section 248 of this title (relating to hospitals), 249 of this title (relating to care and treatment of persons under quarantine and others), 250 of this title (relating to care and treatment of Federal prisoners), 251 of this title (relating to examination and treatment of certain Federal employees), 252 of this title (relating to examination of aliens), 253 of this title (relating to services to certain Federal employees), 247e of this title (relating to services for persons with Hansen's disease), or 254b(h) of this title (relating to the provision of health services to homeless individuals); and

(D) a Federal medical facility.

(3) Homeless individuals (as defined in section 254b (h)(5) of this title), seasonal agricultural workers (as defined in section 254b (g)(3) of this title) and migratory agricultural workers (as so defined)), and residents of public housing (as defined in section 1437a (b)(1) of this title) may be population groups under paragraph (1).

(b) **Criteria for designation of health professional shortage areas; promulgation of regulations**

Section 332 of the PHS Act [42 U.S.C. 254e]

The Secretary shall establish by regulation criteria for the designation of areas, population groups, medical facilities, and other public facilities, in the States, as health professional shortage areas. In establishing such criteria, the Secretary shall take into consideration the following:

(1) The ratio of available health manpower to the number of individuals in an area or population group, or served by a medical facility or other public facility under consideration for designation.

(2) Indicators of a need, notwithstanding the supply of health manpower, for health services for the individuals in an area or population group or served by a medical facility or other public facility under consideration for designation.

(3) The percentage of physicians serving an area, population group, medical facility, or other public facility under consideration for designation who are employed by hospitals and who are graduates of foreign medical schools.

(c) **Considerations in determination of designation**

In determining whether to make a designation, the Secretary shall take into consideration the following:

(1) The recommendations of the Governor of each State in which the area, population group, medical facility, or other public facility under consideration for designation is in whole or part located.

(2) The extent to which individuals who are

(A) residents of the area, members of the population group, or patients in the medical facility or other public facility under consideration for designation, and

(B) entitled to have payment made for medical services under title XVIII, XIX, or XXI of the Social Security Act [42 U.S.C. 1395 et seq., 1396 et seq., 1397aa et seq.], cannot obtain such services because of suspension of physicians from the programs under such titles.

(d) **Designation; publication of descriptive lists**

(1) In accordance with the criteria established under subsection (b) of this section and the considerations listed in subsection (c) of this section the Secretary shall designate health professional shortage areas in the States, publish a descriptive list of the areas, population groups, medical facilities, and other public facilities so designated, and at least annually review and, as necessary, revise such designations.

(2) For purposes of paragraph (1), a complete descriptive list shall be published in the Federal Register not later than July 1 of 1991 and each subsequent year.

(e) **Notice of proposed designation of areas and facilities; time for comment**

(1) Prior to the designation of a public facility, including a Federal medical facility, as a health professional shortage area, the Secretary shall give written notice of such proposed designation to the chief administrative officer of such facility and request comments within 30 days with respect to such designation.

(2) Prior to the designation of a health professional shortage area under this section, the Secretary shall, to the extent practicable, give written notice of the proposed designation of such area to appropriate public or private nonprofit entities which are located or have a demonstrated interest in such area and request comments from such entities with respect to the proposed designation of such area.

(f) **Notice of designation**

The Secretary shall give written notice of the designation of a health professional shortage area, not later than 60 days from the date of such designation, to—

(1) the Governor of each State in which the area, population group, medical facility, or other public facility so designated is in whole or part located; and

(2) appropriate public or nonprofit private entities which are located or which have a demonstrated interest in the area so designated.

(g) **Recommendations to Secretary**

Any person may recommend to the Secretary the designation of an area, population group, medical facility, or other public facility as a health professional shortage area.

(h) **Public information programs in designated areas**

The Secretary may conduct such information programs in areas, among population groups, and in medical facilities and other public facilities designated under this section as health professional shortage areas as may be necessary to inform public and nonprofit private entities which are located or have a demonstrated interest in such areas of the assistance available under this subchapter by virtue of the designation of such areas.

(i) **Dissemination**

The Administrator of the Health Resources and Services Administration shall disseminate information concerning the designation criteria described in subsection (b) of this section to—

(1) the Governor of each State;

(2) the representative of any area, population group, or facility selected by any such Governor to receive such information;

(3) the representative of any area, population group, or facility that requests such information; and

(4) the representative of any area, population group, or facility determined by the Administrator to be likely to meet the criteria described in subsection (b) of this section.

(j) **Regulations and report**

(1) The Secretary shall submit the report described in paragraph (2) if the Secretary, acting through the Administrator of the Health Resources and Services Administration, issues—

(A) a regulation that revises the definition of a health professional shortage area for purposes of this section; or

(B) a regulation that revises the standards concerning priority of such an area under section 254f–1 of this title.

(2) On issuing a regulation described in paragraph (1), the Secretary shall prepare and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report that describes the regulation.

(3) Each regulation described in paragraph (1) shall take effect 180 days after the committees described in paragraph (2) receive a report referred to in such paragraph describing the regulation.

Attachment C: Designation of MUAs

42 CFR Part 51c.102(e)
MUA designations

federal register

FRIDAY, OCTOBER 15, 1976

PART IV:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

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DESIGNATION OF MEDICALLY UNDERSERVED AREAS

42 CFR Part 51c.102(e)
MUA designations

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 under served 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 1811(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.

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)[1] 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, 5600 Fishers Lane, Rockville, Maryland 20852

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

[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 1512 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) began 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 metropolitan 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 V_1.

TABLE V_1

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

(2) 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 V_2.

TABLE V_2

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 V_3 using Table V_3.

TABLE V_3

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

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_4 using Table V_4.

TABLE V_4

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	18.1
.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 additiodn 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 a major portion of the year, distance to or time spent in 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 COOPER, M.D.,
Assistant Secretary for Health.

Attachment D: Designation of HPSAs

ignation (or withdrawal of designation), to:

(1) The Governor of each State in which the area, population group, medical facility, or other public facility so designated is in whole or in part located;

(2) Each HSA for a health service area which includes all or any part of the area, population group, medical facility, or other public facility so designated;

(3) The SHPDA for each State in which the area, population group, medical facility, or other public facility so designated is in whole or in part located; and

(4) Appropriate public or nonprofit private entities which are located in or which have a demonstrated interest in the area so designated.

(b) The Secretary will periodically publish updated lists of designated health professional(s) shortage areas in the FEDERAL REGISTER, by type of professional(s) shortage. An updated list of areas for each type of professional(s) shortage will be published at least once annually.

(c) The effective date of the designation of an area shall be the date of the notification letter to the individual or agency which requested the designation, or the date of publication in the FEDERAL REGISTER, whichever comes first.

(d) Once an area is listed in the FEDERAL REGISTER as a designated health professional(s) shortage area, the effective date of any later withdrawal of the area's designation shall be the date when notification of the withdrawal, or an updated list of designated areas which does not include it, is published in the FEDERAL REGISTER.

APPENDIX A TO PART 5—CRITERIA FOR DESIGNATION OF AREAS HAVING SHORTAGES OF PRIMARY MEDICAL CARE PROFESSIONAL(S)

Part I—Geographic Areas

A. Criteria.

A geographic area will be designated as having a shortage of primary medical care professionals if the following three criteria are met:

1. The area is a rational area for the delivery of primary medical care services.

2. One of the following conditions prevails within the area:

(a) The area has a population to full-time-equivalent primary care physician ratio of at least 3,500:1.

(b) The area has a population to full-time-equivalent primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has unusually high needs for primary care services or insufficient capacity of existing primary care providers.

3. Primary medical care professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration.

B. Methodology.

In determining whether an area meets the criteria established by paragraph A of this part, the following methodology will be used:

1. *Rational Areas for the Delivery of Primary Medical Care Services.*

(a) The following areas will be considered rational areas for the delivery of primary medical care services:

(i) A county, or a group of contiguous counties whose population centers are within 30 minutes travel time of each other.

(ii) A portion of a county, or an area made up of portions of more than one county, whose population, because of topography, market or transportation patterns, distinctive population characteristics or other factors, has limited access to contiguous area resources, as measured generally by a travel time greater than 30 minutes to such resources.

(iii) Established neighborhoods and communities within metropolitan areas which display a strong self-identity (as indicated by a homogeneous socioeconomic or demographic structure and/or a tradition of interaction or interdependency), have limited interaction with contiguous areas, and which, in general, have a minimum population of 20,000.

(b) The following distances will be used as guidelines in determining distances corresponding to 30 minutes travel time:

(i) Under normal conditions with primary roads available: 30 miles.

(ii) In mountainous terrain or in areas with only secondary roads available: 15 miles.

(iii) In flat terrain or in areas connected by interstate highways: 25 miles.

Within inner portions of metropolitan areas, information on the public transportation system will be used to determine the distance corresponding to 30 minutes travel time.

2. *Population Count.*

The population count used will be the total permanent resident civilian population of the area, excluding inmates of institutions, with the following adjustments, where appropriate:

(a) Adjustments to the population for the differing health service requirements of various age-sex population groups will be computed using the table below of visit rates for 12 age-sex population cohorts. The total expected visit rate will first be obtained by multiplying each of the 12 visit rates in the table by the size of the area population within that particular age-sex cohort and adding the resultant 12 visit figures together. This total expected visit rate will then be divided by the U.S. average per capita visit rate of 5.1, to obtain the adjusted population for the area.

Sex	Age group					
	Under 5	5–14	15–24	25–44	45–64	65 and over
Male	7.3	3.6	3.3	3.8	4.7	6.4
Female	6.4	3.2	6.5	5.4	5.5	6.8

(b) The effect of transient populations on the need of an area for primary care professionals will be taken into account as follows:

(i) Seasonal residents, i.e., those who maintain a residence in the area but inhabit it for only 2 to 9 months per year, may be included but must be weighted in proportion to the fraction of the year they are present in the area.

(ii) Other tourists (non-resident) may be included in an area's population but only with a weight of 0.25, using the following formula: Effective tourist contribution to population = 0.25 × (fraction of year tourists are present in area) × (average daily number of tourists during portion of year that tourists are present).

(iii) Migratory workers and their families may be included in an area's population, using the following formula: Effective migrant contribution to population = (fraction of year migrants are present in area) × (average daily number of migrants during portion of year that migrants are present).

3. *Counting of Primary Care Practitioners.*

(a) All non-Federal doctors of medicine (M.D.) and doctors of osteopathy (D.O.) providing direct patient care who practice principally in one of the four primary care specialties—general or family practice, general internal medicine, pediatrics, and obstetrics and gynecology—will be counted. Those physicians engaged solely in administration, research, and teaching will be excluded. Adjustments for the following factors will be made in computing the number of full-time-equivalent (FTE) primary care physicians:

(i) Interns and residents will be counted as 0.1 full-time equivalent (FTE) physicians.

(ii) Graduates of foreign medical schools who are not citizens or lawful permanent residents of the United States will be excluded from physician counts.

(iii) Those graduates of foreign medical schools who are citizens or lawful permanent residents of the United States, but do not have unrestricted licenses to practice medicine, will be counted as 0.5 FTE physicians.

(b) Practitioners who are semi-retired, who operate a reduced practice due to infirmity or other limiting conditions, or who provide patient care services to the residents of the area only on a part time basis will be discounted through the use of full-time equivalency figures. A 40-hour work week will be used as the standard for determining full-time equivalents in these cases. For practitioners working less than a 40-hour week, every four (4) hours (or ½ day) spent providing patient care, in either ambulatory or inpatient settings, will be counted as 0.1

FTE (with numbers obtained for FTE's rounded to the nearest 0.1 FTE), and each physician providing patient care 40 or more hours a week will be counted as 1.0 FTE physician. (For cases where data are available only for the number of hours providing patient care in office settings, equivalencies will be provided in guidelines.)

(c) In some cases, physicians located within an area may not be accessible to the population of the area under consideration. Allowances for physicians with restricted practices can be made, on a case-by-case basis. However, where only a portion of the population of the area cannot access existing primary care resources in the area, a population group designation may be more appropriate (see part II of this appendix).

(d) Hospital staff physicians involved exclusively in inpatient care will be excluded. The number of full-time equivalent physicians practicing in organized outpatient departments and primary care clinics will be included, but those in emergency rooms will be excluded.

(e) Physicians who are suspended under provisions of the Medicare-Medicaid Anti-Fraud and Abuse Act for a period of eighteen months or more will be excluded.

4. *Determination of Unusually High Needs for Primary Medical Care Services.*

An area will be considered as having unusually high needs for primary health care services if at least one of the following criteria is met:

(a) The area has more than 100 births per year per 1,000 women aged 15–44.

(b) The area has more than 20 infant deaths per 1,000 live births.

(c) More than 20% of the population (or of all households) have incomes below the poverty level.

5. *Determination of Insufficient Capacity of Existing Primary Care Providers.*

An area's existing primary care providers will be considered to have insufficient capacity if at least two of the following criteria are met:

(a) More than 8,000 office or outpatient visits per year per FTE primary care physician serving the area.

(b) Unusually long waits for appointments for routine medical services (i.e., more than 7 days for established patients and 14 days for new patients).

(c) Excessive average waiting time at primary care providers (longer than one hour where patients have appointments or two hours where patients are treated on a first-come, first-served basis).

(d) Evidence of excessive use of emergency room facilities for routine primary care.

(e) A substantial proportion (2/3 or more) of the area's physicians do not accept new patients.

(f) Abnormally low utilization of health services, as indicated by an average of 2.0 or less office visits per year on the part of the area's population.

6. *Contiguous Area Considerations.*

Primary care professional(s) in areas contiguous to an area being considered for designation will be considered excessively distant, overutilized or inaccessible to the population of the area under consideration if one of the following conditions prevails in each contiguous area:

(a) Primary care professional(s) in the contiguous area are more than 30 minutes travel time from the population center(s) of the area being considered for designation (measured in accordance with paragraph B.1(b) of this part).

(b) The contiguous area population-to-full-time-equivalent primary care physician ratio is in excess of 2000:1, indicating that practitioners in the contiguous area cannot be expected to help alleviate the shortage situation in the area being considered for designation.

(c) Primary care professional(s) in the contiguous area are inaccessible to the population of the area under consideration because of specified access barriers, such as:

(i) Significant differences between the demographic (or socio-economic) characteristics of the area under consideration and those of the contiguous area, indicating that the population of the area under consideration may be effectively isolated from nearby resources. This isolation could be indicated, for example, by an unusually high proportion of non-English-speaking persons.

(ii) A lack of economic access to contiguous area resources, as indicated particularly where a very high proportion of the population of the area under consideration is poor (i.e., where more than 20 percent of the population, or the households have incomes below the poverty level), and Medicaid-covered or public primary care services are not available in the contiguous area.

C. *Determination of Degree of Shortage.*

Designated areas will be assigned to degree-of-shortage groups, based on the ratio (R) of population to number of full-time equivalent primary care physicians and the presence or absence of unusually high needs for primary health care services, according to the following table:

	High needs not indicated	High needs indicated
Group 1	No physicians	No physicians or $R \geq 5,000$
Group 2	$R \geq 5,000$	$5,000 > R \geq 4,000$
Group 3	$5,000 > R \geq 4,000$	$4,000 > R \geq 3,500$
Group 4	$4,000 > R > 3,500$	$3,500 > R \geq 3,000$

D. *Determination of size of primary care physician shortage.* Size of Shortage (in number of FTE primary care physicians needed) will be computed using the following formulas:

(1) For areas without unusually high need or insufficient capacity:

Primary care physician shortage = area population/3,500 − number of FTE primary care physicians

(2) For areas with unusually high need or insufficient capacity:

Primary care physician shortage = area population/2,000 − number of FTE primary care physicians

Part II—Population Groups

A. *Criteria.*

1. In general, specific population groups within particular geographic areas will be designated as having a shortage of primary medical care professional(s) if the following three criteria are met:

(a) The area in which they reside is rational for the delivery of primary medical care services, as defined in paragraph B.1 of part I of this appendix.

(b) Access barriers prevent the population group from use of the area's primary medical care providers. Such barriers may be economic, linguistic, cultural, or architectural, or could involve refusal of some providers to accept certain types of patients or to accept Medicaid reimbursement.

(c) The ratio of the number of persons in the population group to the number of primary care physicians practicing in the area and serving the population group is at least 3,000:1.

2. Indians and Alaska Natives will be considered for designation as having shortages of primary care professional(s) as follows:

(a) Groups of members of Indian tribes (as defined in section 4(d) of Pub. L. 94-437, the Indian Health Care Improvement Act of 1976) are automatically designated.

(b) Other groups of Indians or Alaska Natives (as defined in section 4(c) of Pub. L. 94-437) will be designated if the general criteria in paragraph A are met.

B. *Determination of Degree of Shortage.*

Each designated population group will be assigned to a degree-of-shortage group, based on the ratio (R) of the group's population to the number of primary care physicians serving it, as follows:

Group 1—No physicians or $R > 5,000$.
Group 2—$5,000 > R \geq 4,000$.
Group 3—$4,000 > R \geq 3,500$.
Group 4—$3,500 > R \geq 3,000$.

Population groups which have received "automatic" designation will be assigned to degree-of-shortage group 4 if no information on the ratio of the number of persons in the group to the number of FTE primary care physicians serving them is provided.

C. *Determination of size of primary care physician shortage.* Size of shortage (in number of primary care physicians needed) will be computed as follows:

Primary care physician shortage = number of persons in population group/3,000 − number of FTE primary care physicians

Part III—Facilities

A. *Federal and State Correctional Institutions.*

1. *Criteria.*

Medium to maximum security Federal and State correctional institutions and youth detention facilities will be designated as having a shortage of primary medical care professional(s) if both the following criteria are met:

(a) The institution has at least 250 inmates.

(b) The ratio of the number of internees per year to the number of FTE primary care physicians serving the institution is at least 1,500:1.

Here the number of internees is defined as follows:

(i) If the number of new inmates per year and the average length-of-stay are not specified, or if the information provided does not indicate that intake medical examinations are routinely performed upon entry, then—Number of internees = average number of inmates × (0.3) = number of new inmates per year.

(ii) If the average length-of-stay is specified as one year or more, and intake medical examinations are routinely performed upon entry, then—Number of internees = average number of inmates × (0.3) × (1 + ALOS/2) < number of new inmates per year where ALOS = average length-of-stay (in fraction of year). (The number of FTE primary care physicians is computed as in part I, section B, paragraph 3 above.)

2. Determination of Degree of Shortage.

Designated correctional institutions will be assigned to degree-of-shortage groups based on the number of inmates and/or the ratio (R) of internees to primary care physicians, as follows:

Group 1—Institutions with 500 or more inmates and no physicians.

Group 2—Other institutions with no physicians and institutions with R greater than (or equal to) 2,000:1.

Group 3—Institutions with R greater than (or equal to) 1,000:1 but less than 2,000:1.

B. *Public or Non-Profit Medical Facilities.*

1. *Criteria.*

Public or non-profit private medical facilities will be designated as having a shortage of primary medical care professional(s) if:

(a) the facility is providing primary medical care services to an area or population group designated as having a primary care professional(s) shortage; and

(b) the facility has insufficient capacity to meet the primary care needs of that area or population group.

2. *Methodology.*

In determining whether public or non-profit private medical facilities meet the criteria established by paragraph B.1 of this Part, the following methodology will be used:

(a) *Provision of Services to a Designated Area or Population Group.*

A facility will be considered to be providing services to a designated area or population group if either:

(i) A majority of the facility's primary care services are being provided to residents of designated primary care professional(s) shortage areas or to population groups designated as having a shortage of primary care professional(s); or

(ii) The population within a designated primary care shortage area or population group has reasonable access to primary care services provided at the facility. Reasonable access will be assumed if the area within which the population resides lies within 30 minutes travel time of the facility and non-physical barriers (relating to demographic and socioeconomic characteristics of the population) do not prevent the population from receiving care at the facility.

Migrant health centers (as defined in section 329(a)(1) of the Act) which are located in areas with designated migrant population groups and Indian Health Service facilities are assumed to be meeting this requirement.

(b) *Insufficient capacity to meet primary care needs.*

A facility will be considered to have insufficient capacity to meet the primary care needs of the area or population it serves if at least two of the following conditions exist at the facility:

(i) There are more than 8,000 outpatient visits per year per FTE primary care physician on the staff of the facility. (Here the number of FTE primary care physicians is computed as in Part I, Section B, paragraph 2 above.)

(ii) There is excessive usage of emergency room facilities for routine primary care.

(iii) Waiting time for appointments is more than 1 days for established patients or more than 14 days for new patients, for routine health services.

(iv) Waiting time at the facility is longer than 1 hour where patients have appointments or 2 hours where patients are treated on a first-come, first-served basis.

3. *Determination of Degree of Shortage.*

Each designated medical facility will be assigned to the same degree-of-shortage group as the designated area or population group which it serves.

[45 FR 76000, Nov. 17, 1980, as amended at 54 FR 8737, Mar. 3, 1989; 57 FR 2480, Jan. 22, 1992]

APPENDIX B TO PART 5—CRITERIA FOR DESIGNATION OF AREAS HAVING SHORTAGES OF DENTAL PROFESSIONAL(S)

Part I—Geographic Areas

A. *Criteria.*

A geographic area will be designated as having a dental professional shortage if the following three criteria are met:

1. The area is a rational area for the delivery of dental services.

2. One of the following conditions prevails in the area:

(a) The area has a population to full-time-equivalent dentist ratio of at least 5,000:1, or

(b) The area has a population to full-time-equivalent dentist ratio of less than 5,000:1 but greater than 4,000:1 and has unusually high needs for dental services or insufficient capacity of existing dental providers.

3. Dental professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration.

B. *Methodology.*

In determining whether an area meets the criteria established by paragraph A of this part, the following methodology will be used:

1. *Rational Area for the Delivery of Dental Services.*

(a) The following areas will be considered rational areas for the delivery of dental health services:

(i) A county, or a group of several contiguous counties whose population centers are within 40 minutes travel time of each other.

(ii) A portion of a county (or an area made up of portions of more than one county) whose population, because of topography, market or transportation patterns, distinctive population characteristics, or other factors, has limited access to contiguous area resources, as measured generally by a travel time of greater than 40 minutes to such resources.

(iii) Established neighborhoods and communities within metropolitan areas which display a strong self-identity (as indicated by a homogeneous socioeconomic or demographic structure and/or a traditional of interaction or interdependency), have limited interaction with contiguous areas, and which, in general, have a minimum population of 20,000.

(b) The following distances will be used as guidelines in determining distances corresponding to 40 minutes travel time:

(i) Under normal conditions with primary roads available; 25 miles.

(ii) In mountainous terrain or in areas with only secondary roads available; 20 miles.

(iii) In flat terrain or in areas connected by interstate highways; 30 miles.

Within inner portions of metropolitan areas, information on the public transportation system will be used to determine the distance corresponding to 40 minutes travel time.

2. *Population Count.*

The population count use will be the total permanent resident civilian population of the area, excluding inmates of institutions, with the following adjustments:

(a) Seasonal residents, i.e., those who maintain a residence in the area but inhabit it for only 3 to 6 months per year, may be included but must be weighted in proportion to the fraction of the year they are present in the area.

(b) Migratory workers and their families may be included in an area's population using the following formula: Effective migrant contribution to population=(fraction of year migrants are present in area)×(average daily number of migrants during portion of year that migrants are present).

3. *Counting of Dental Practitioners.*

(a) All non-Federal dentists providing patient care will be counted, except in those areas where it is shown that specialists (those dentists not in general practice or pedodontics) are serving a larger area and are not addressing the general dental care needs of the area under consideration.

(b) Full-time equivalent (FTE) figures will be used to reflect productivity differences among dental practices based on the age of the dentists, the number of auxiliaries employed, and the number of hours worked per week. In general, the number of FTE dentists will be computed using weights obtained from the matrix in Table 1, which is based on the productivity of dentists at various ages, with different numbers of auxiliaries, as compared with the average productivity of all dentists. For the purposes of these determinations, an auxiliary is defined as any non-dentist staff employed by the dentist to assist in operation of the practice.

TABLE 1—EQUIVALENCY WEIGHTS, BY AGE AND NUMBER OF AUXILIARIES

	<35	35-49	50-64	65+
No auxiliaries	0.8	0.7	0.6	0.5
One auxiliary	1.0	0.8	0.6	0.7
Two auxiliaries	1.2	1.0	1.0	0.8
Three auxiliaries	1.4	1.2	1.0	1.0
Four or more auxiliaries	1.5	1.5	1.3	1.2

If information on the number of auxiliaries employed by the dentist is not available, Table 2 will be used to compute the number of full-time equivalent dentists.

TABLE 2—EQUIVALENCY WEIGHTS, BY AGE

	<35	35-49	50-64	65+
Equivalency weights	1.2	0.9	0.8	0.6

The number of FTE dentists within a particular age group (or age/auxiliary group) will be obtained by multiplying the number of dentists within that group by its corresponding equivalency weight. The total supply of FTE dentists within an area is then computed as the sum of those dentists within each age (or age/auxiliary) group.

(c) The equivalency weights specified in tables 1 and 2 assume that dentists within a particular group are working full-time (40 hours per week). Where appropriate data are available, adjusted equivalency figures for dentists who are semi-retired, who operate a reduced practice due to infirmity or other limiting conditions, or who are available to the population of an area only on a part-time basis will be used to reflect the reduced availability of these dentists. In computing these equivalency figures, every 4 hours (or ½ day) spent in the dental practice will be counted as 0.1 FTE except that each dentist working more than 40 hours a week will be counted as 1.0. The count obtained for a particular age group of dentists will then be multiplied by the appropriate equivalency weight from table 1 or 2 to obtain a full-time equivalent figure for dentists within that particular age or age/auxiliary category.

4. *Determination of Unusually High Needs for Dental Services.*

An area will be considered as having unusually high needs for dental services if at least one of the following criteria is met:

Attachment E: Draft Negotiated Rulemaking Committee Ground Rules

DRAFT NEGOTIATED RULEMAKING COMMITTEE GROUND RULES

This Negotiated Rulemaking is intended to facilitate discussion and agreement on a proposed rule.

Participants should enter these negotiations with an open mind hopeful of reaching a speedy and amicable resolution of the negotiations. All members agree to make a good faith effort to reach agreement in all aspects of these negotiations.

PARTICIPATION

A. The Negotiating Committee: The Committee shall be comprised of one representative from each organization that is a party to the negotiation. Each organization may designate a Committee Member and an alternate.
B. Attendance at Meetings: Each Committee Member agrees to make a good faith effort to attend every meeting. Only the Committee Member shall have the privilege of sitting at the table and participating in the consensus process. Comments by non committee members may be arranged through the Facilitator/Mediator at the request of the Committee Member.
C. Constituents Interests: Committee Members are expected to represent the concerns and interests of their constituents.

DECISION MAKING

A. Decision by Consensus: The Negotiating Committee (hereafter the "Committee") will make decisions by consensus. Consensus is defined as a decision which all Committee Members or designated alternates present at the meeting can agree upon. The decision may not be everyone's first choice, but they have heard it and everyone can live with it.
B. Subgroups may be formed to address specific issues, and to make recommendations to the Committee.
C. Schedule of Meetings: Meetings will be scheduled by consensus or by direction of the Facilitator/Mediators.

AGREEMENT

A. The goal of the Committee is to prepare a draft Notice of Proposed Rule Making (NPRM). If consensus is not reached on some of the issues presented in the negotiated rulemaking, the Committee shall identify the areas of agreement and disagreement and explanations for any disagreement. Upon conclusion of the negotiated rule process, the members reserve the right to comment adversely on those areas of disagreement in which no consensus has been reached.
B. The Department will issue the consensus of the Committee as a Notice of Proposed Rule Making unless it is inconsistent with statutory authority of the agency or for other legal reasons.
C. If consensus is reached, the members of the Committee will support the consensus when published in a Notice of Proposed Rulemaking.

PROCEDURES

A. Minutes: Summary minutes will be prepared, certified and distributed under the supervision of the Facilitator/Mediators.
B. Meetings: All meetings shall be open to the public. Meetings shall be scheduled consistent with the schedules of the participants and allow appropriate time to study and confer on proposals. To expedite the process, the Facilitator/Mediators may meet with members separately or via telephone, mail, electronically or arrange subgroup meetings as may be appropriate.
C. Caucuses: Any member may request a caucus at any time. The Committee Members and the Facilitator/Mediators shall endeavor to keep the length of the caucus reasonable.

PUBLIC RECORD

Information and data provided to the Committee will be a matter of public record.

FACILITATOR/MEDIATORS

The Federal Mediation and Conciliation Service will serve as the neutral Facilitator/Mediator to assist the Committee in reaching agreement. (See Appendix A, Facilitator/Mediator and Recorder Ground Rules). The role of the Facilitator/Mediator may include developing draft agendas, chairing Committee and subgroup discussions as appropriate, and working to resolve any impasses that may arise. They will also supervise preparation of meeting summaries, assist in the location and circulation of either background or other materials the Committee develops. The Facilitator/Mediators will perform other functions as appropriate.

GROUND RULE AMENDMENTS

The members may amend these ground rules, by consensus, at any time.

We the undersigned agree to participate fully in the negotiation process, on behalf of ourselves and the organizations we represent, and to be bound by the terms of these Committee ground rules.

Date:

1. _____
Mark Babitz

2. _____
Andrea Brassard

3. _____
Roy C. Brooks

4. _____
Jose Camacho

5. _____
Kathleen A. Clanon

6. _____
Beth Giesting

7. _____
David Goodman

8. _____
Daniel Hawkins

9. _____
Sherry Hirota

10. _____
Steve Holloway

11. _____
Barbara Kornblau

12. _____
Tess Kuenning

13. _____
Nicole Lamoureux

14. _____
Alice Larson

15. _____
Tim McBride

16. _____
Lolita McDavid

17. _____
Alan Morgan

18. _____
Ronald Nelson

19. _____
Charles Owens

20. _____
Robert Phillips

21. _____
Alice Rarig

22. _____
Patrick Rock

23. _____
Edward Salsberg

24. _____
William J. Scanlon

25. _____
Sally H. Smith

26. _____
John Supplitt

27. _____
Donald Taylor

28. _____
Elizabeth Wilson

Attachment F: Negotiated Rulemaking Committee Membership

Negotiated Rulemaking Committee on Designation of Medically Underserved Populations and Health Professionals Shortage Areas: Membership

The members, all of whom were appointed for the duration of the Committee, were:

Marc Babitz, M.D.
Director, Division of Family and Health Preparedness
Utah Department of Health
Salt Lake City, Utah

Andrea Brassard, R.N., D.N.Sc., M.P.H., F.N.P.
Strategic Policy Advisor
Center to Champion Nursing in America
AARP
Washington, DC

Roy C. Brooks
County Commissioner, Tarrant County, Texas
National Association of Counties
Forest Hill, Texas

Jose Camacho, J.D.
Executive Director/General Counsel
Texas Association of Community Health Centers
Austin, Texas

Kathleen A. Clanon, M.D., F.A.C.P.
Chief of the Division of HIV Services
Alameda County Medical Center
Oakland, California

Beth Giesting
Chief Executive Officer
Hawaii Primary Care Association
Kailua, Hawaii

David Goodman, M.D., M.S.
Director
Center for Health Policy Research, Dartmouth Institute for Health Policy and Clinical Practice
Etna, New Hampshire

Daniel Hawkins
Senior Vice President
Policy and Research Division
National Association of Community Health Centers
Washington, D.C.

Sherry Hirota
Chief Executive Officer and Director
Asian Health Services
Oakland, California

Stephen Holloway
Director
Colorado Primary Care Office
Denver, Colorado

Barbara L. Kornblau, J.D., O.T.R./L., FAOTA, DAAPM, CCM, CPE
School of Allied Health Sciences
Division of Occupational Therapy
Florida A&M University
Tallahassee, Florida

Tess Kuenning, R.N.
Director
BiState Primary Care Association
Bow, New Hampshire

Nicole Lamoureux
Executive Director
National Association of Free Clinics
Alexandria, Virginia

Alice Larson, Ph.D.
Research Analyst
Larson Assistance Services
Vashon Island, Washington

Negotiated Rulemaking Committee on Designation of Medically Underserved Populations and Health Professionals Shortage Areas: Membership

Timothy McBride, Ph.D., M.S.
Professor, Associate Dean for Public Health
Washington University
St. Louis, Missouri

Alan Morgan
Chief Executive Officer
National Rural Health Association
Washington, D.C.

Gail Nickerson
Director of Clinical Services
Adventist Health
Roseville, CA

Robert Phillips, M.D., M.S.P.H.
Director
American Academy of Family Practice
Robert Graham Center
Washington, D.C.

Patrick Rock, M.D.
Chief Executive Director
Milwaukee Indian Health Board
National Council on Urban Indian Health
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[1] Ronald Nelson passed away on June 11, 2011. Gail Nickerson served on the Committee as Mr. Nelson's alternate until his passing and served in his place after he passed.

Attachment G: Proposed Revisions to Designation Methodology and Criteria (1998, 2008)

There have been two recent attempts to revise the MUA/P and HPSA designation methodology. A Notice of Proposed Rule Making (NPRM) was released in 1998 and again in 2008, but in each case the proposed rule was not finalized. Both proposed rules would have combined the application processes for HPSA and MUA/P designation, in an attempt to make the designation methodology both more accurate and less burdensome for states and communities applying for designation.

1998 NPRM

On September 1, 1998, HRSA released a NPRM [63 FR 46538-55] outlining a consolidated, revised methodology and implementation process for MUA/Ps and HPSAs. The proposed Index of Primary Care Services (IPCS) score would have been based on a weighted combination of seven variables: population-to-primary care clinician ratio, infant mortality or low birthweight rate, low population density, and the percent of the population that is below 200 percent of the Federal Poverty Level, racial minorities, Hispanic, and linguistically isolated. HPSAs were defined as a subset of the MUPs, consisting of those MUPs with a population-to-practitioner ratio exceeding a certain level. Nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM) would have been included in provider counts within Rational Service Areas, with a weight of 0.5 full time equivalents (FTE) relative to primary care physicians.

Two tiers of designations were proposed; first tier designations would be available to areas that meet the criteria when all primary care clinicians practicing in the area are counted. The second tier would consist of those additional areas that meet the criteria, but only when certain categories of federally-supported practitioners are excluded from clinician counts, such as NHSC clinicians and those practicing in FQHCs.

The public submitted over 800 comments on topics such as the deleterious impact that the proposed rules would have on safety net programs that lose their designation, burdensome data collection requirements, and a possible bias towards urban areas due to the inclusion of factors such as race, linguistic isolation, and low birthweight.

A June 3, 1999 *Federal Register Notice* outlined HRSA's plan to conduct further analysis, including a thorough, updated analysis of the impact of the approach that was proposed, including testing alternatives based on analysis of the comments received, using the most current national data. Upon verification of the impact testing a new NPRM would then be published for public comment.

2008 NPRM

On February 29, 2008 the Secretary of Health and Human Services released a NPRM [73 FR 11232-81] for the designation of Medically Underserved Populations (MUPs) pursuant to section 330(b)(3) of the Public Health Service Act (as amended by the Health Centers Consolidation Act of 1996, Pub. L. 104-299), 42 U.S.C. 254b, and for the designation of Health Professional Shortage Areas (HPSAs) pursuant to section 332 of the Act (as amended by the Health Care Safety Net Amendments of 2002, P.L.107-251), 42 U.S.C. 254e.

HRSA formulated the 2008 proposed rule in collaboration with the Cecil G. Sheps Center of the University of North Carolina and a group of sixteen State Primary Care Office representatives. The NPRM states that guiding principles were to create a system that was simple, intuitive and valid, based on improved measures or correlates of health status and access, replicable and scientifically sound, and able to more fairly and consistently identify areas and populations experiencing primary care underservice with a minimum of disruption to currently designated entities.

The proposed revision creates a system that would be better able to identify new areas of underservice while also detecting when a currently designated area or population is no longer experiencing underservice. The application process would be improved by automating the scoring method and reducing the need for burdensome population group designations. Though the state role in defining RSAs would be expanded, the overall burden on states and communities would be reduced.

The revised methodology would create a single IPCU to determine the level of underservice experienced by both HPSAs and MUA/Ps. Three types of designation would be considered in order: geographic HPSA, population MUP, and safety-net HPSA. The first two designations would be based on a population-to-provider ratio modified by nine factors that affect the demand for primary care: percent of the population below 200 percent FPL, unemployment rate, death rate, low birth weight rate, infant mortality rate, percent nonwhite, percent Hispanic, percent elderly, and population density. The population-to-provider ratio is calculated and the area is designated if it is above 3000:1. Safety net facility HPSAs would be designated if it was demonstrated that the population served faced barriers to access.

The geographic designations would have two tiers: Tier 1 used the adjusted population-to provider ratio, counting all primary care physicians, and Tier 2 excluded federally supported providers. Counting federally-supported providers such as NHSC clinicians and J-1 visa waiver physicians, who might not remain in the area beyond their service requirements, would create a "yo-yo effect" where entities churn in and out of designation as these clinicians enter and leave service.

It was estimated that the proposed methodology would retain 90 percent of the current HPSA and MUA designations, while adding a number of newly designated areas. There would also be an update process for MUA/Ps similar to the current update requirements for HPSAs, prioritizing designations that are based on data over three years old.

HRSA received over 700 public comments in response to the proposed methodology; in response to the initial comments two 30-day extensions of the comment period were granted. Comments included the complexity of the proposed rule, the unclear the policy implications of the safety net designation which did not have a scoring method, the negative impact on certain populations and communities, and a perceived bias in the process against urban areas.

A July 23, 2010 *Federal Register Notice* [73 FR 42743] stated that HRSA had received many substantive comments, and concluded that the proposed rule would require changes prior to becoming final.

Attachment H: Productivity Studies of Providers

Based on 2009 data	UDS			MGMA			MGMA / UDS Prod. Ratio
	(n)	Mean Productivity	Ratio to UDS MD Avg.	*(n)*	Mean Productivity	Ratio to UDS MD Avg.	
Family Physicians *	*4,260*	3,768	100%	*540*	3,853	102%	102%
General Practitioners	*381*	3,915	104%	*Not Reported*		0%	N/A
Internists	*1,545*	3,670	98%	*2,103*	3,533	93%	96%
Obstetrician/Gynecologists	*864*	3,535	94%	*957*	2,917	77%	83%
Pediatricians	*1,764*	3,952	105%	*1,596*	4,633	122%	117%
Other Specialty Physicians	*310*	3,191	85%	*N/A*		N/A	N/A
Total Physicians	***9,125***	**3,752**	**100%**	***5,196***	**3,791**	**100%**	101%
Nurse Practitioners**	*3,389*	2,865	76%	*487*	2,546	67%	89%
Physician Assistants**	*1,881*	3,162	84%	*482*	2,932	77%	93%
Certified Nurse Midwives	*489*	2,496	67%	*75*	1,401	37%	56%
Total Non-Physician Providers	***5,758***	**2,931**	**78%**	***1,044***	**2,642**	**N/A**	N/A

** with OB in MGMA*

*** also available by specialty in MGMA*

Note that UDS MD Avg. Productivity is based on the provider mix found at CHC's.

Note that MGMA MD Avg. Productivity is based on the mix of providers represented in the sample

Both data sets describe results for CY 2009 data, reported in 2010 - data updated annually

Attachment I: Sample Survey of Primary Care Providers

1.	Form completed by, if different than provider (NAME, PHONE): _____	__ __ / __ __ / __ __ DATE COMPLETED
PROVIDER'S INFORMATION		
2.	Provider's name (LAST, FIRST, MIDDLE, SUFFIX): _____	__ __ __ __ YEAR OF BIRTH
3.	Professional degree:	MD ☐ DO ☐ PA ☐ NP ☐ CNM ☐
4.	***Primary*** specialty, mark ***all*** that apply (if none of these, answer question 5, then stop, and return the survey):	FAMILY MEDICINE ☐ GENERAL MEDICINE ☐ GENERAL INTERNAL MEDICINE ☐ GENERAL PEDIATRICS ☐ ADOLECENT PEDIATRICS ☐ GERONTOLOGY ☐ GENERAL OB/GYN ☐ NONE OF THESE ☐
5.	List any ***other specialty or subspecialty*** that is not listed in question 4, which is part of the provider's routine practice (leave blank if none):	OTHER: _____ OTHER: _____
6.	Is the provider a full time hospitalist ? (if yes, stop here and return survey)	YES ☐ NO ☐
7.	Is the provider currently in an internship or residency program?	YES ☐ NO ☐
8.	Is the provider and employee of a federally qualified health center or certified rural health clinic?	YES ☐ NO ☐
9.	Is the provider on a J-1 Visa waiver obligation?	YES ☐ NO ☐
10.	Is the provider currently an obligated provider on a National Health Service Corps scholarship or loan commitment?	YES ☐ NO ☐
11.	Is the provider currently an obligated provider on a State Loan Repayment Program commitment?	YES ☐ NO ☐
12.	Is the provider currently a Federal Provider (e.g. IHS, PHS)?	YES ☐ NO ☐
13.	Is the provider currently practicing on a restricted license?	YES ☐ NO ☐

PROVIDER'S OUTPATIENT PRACTICE		MAIN PRACTICE	ADDITIONAL PRACTICE, IF ANY
14. List the name and location of each ***outpatient practice*** then respond to the following questions for ***each practice location***.	NAME:	_____	_____
	ADDRESS:	_____	_____
	CITY, ZIP:	_____	_____
15. How many hours per week does the provider typically provide outpatient ***primary care*** to patients at this location (defined by the specialties listed in question 4)? Do not include practice administrative or hospital hours.		_____ HOURS/WEEK AT THIS SITE	_____ HOURS/WEEK AT THIS SITE
16. In a typical week, what is the total ***number*** of patients seen by the provider for primary care?		_____ PATIENTS/WEEK AT THIS SITE	_____ PATIENTS/WEEK AT THIS SITE
17. a. Does the provider accept ***Medicaid***?		YES ☐ NO ☐	YES ☐ NO ☐
b. If yes, what ***percent*** of patients in the practice are on Medicaid? Include duel eligible patients in this total. (enter 0 if none)		_____ MEDICAID PERCENT	_____ MEDICAID PERCENT
c. If yes, is the provider accepting ***new*** patients on Medicaid?		YES ☐ NO ☐	YES ☐ NO ☐
18. a. Does the provider accept Medicare?		YES ☐ NO ☐	YES ☐ NO ☐
b. If yes, what percent of patients in the practice are on Medicare? Include those on Medicare only (not duel eligible) in this total.		_____ MEDICARE PERCENT	_____ MEDICARE PERCENT
c. If yes, is the provider accepting new patients on Medicare?		YES ☐ NO ☐	YES ☐ NO ☐

19.	a. Does the provider accept SCHIP?	YES ☐ NO ☐	YES ☐ NO ☐
	b. If yes, what percent of patients in the practice are on SCHIP?	SCHIP PERCENT	SCHIP PERCENT
	c. If yes, is the provider accepting new patients on SCHIP?	YES ☐ NO ☐	YES ☐ NO ☐
20.	a. Does the provider offer a sliding fee schedule (a sliding fee schedule is a formal, posted, discount policy based on income or ability to pay. Bad debt write-off policies are excluded)?	YES ☐ NO ☐	YES ☐ NO ☐
	b. If yes, what is the percent of patients in the practice where a sliding fee scale is used to assess payment due? (enter 0 if none)	SLIDING FEE SCALE PERCENT	SLIDING FEE SCALE PERCENT
21.	a. Is the provider accepting new patients?	YES ☐ NO ☐	YES ☐ NO ☐
	b. If yes, what is the typical number of days a new patient waits for a routine appointment? (enter 0 if none)	DAYS FOR AN APPOINTMENT	DAYS FOR AN APPOINTMENT
22.	What is the typical number of days an established patient waits for a routine appointment? (enter 0 if none)	DAYS FOR AN APPOINTMENT	DAYS FOR AN APPOINTMENT
23.	a. Can the provider provide care in a language other than English? (may include spoken, through a qualified staff person or interpretation service, or American Sign Language)	YES ☐ NO ☐	YES ☐ NO ☐
	b. If yes, what languages are available?		
24.	a. Does the provider see migrant farm workers?	YES ☐ NO ☐	YES ☐ NO ☐
	b. If yes, what is the number of migrant farm workers seen in a typical week? (you may also report number per month or year, if notated as such)	per PATIENTS PER WEEK/MONTH/YEAR	per PATIENTS PER WEEK/MONTH/YEAR
25.	a. Does the provider see the homeless?	YES ☐ NO ☐	YES ☐ NO ☐
	b. If yes, what is the number of homeless seen in a typical week? (you may also report number per month or year, if notated as such)	per PATIENTS PER WEEK/MONTH/YEAR	per PATIENTS PER WEEK/MONTH/YEAR

Attachment J: Multiplier for Calculating Age/Gender Adjustment

Calculating Age/Gender Adjustment Multiplier:

Steps:

1. Obtain local (Service Area) population by age and gender groupings.

2. Multiply the population in each age/gender group by the National Age/Gender Specific Primary Care Visit rate per person (per table in regulation) to obtain standardized visits needed.

3. Divide sum of standardized visits needed locally by the total local population to obtain Visits per Person for the service area.

4. Divide the local Visits per Person by 2.44 *(visits per person nationally based on same calculations for the 2010 U.S. population)* to obtain the Age/Gender Adjustment Multiplier. This is then multiplied by the 'raw' Population:Provider ratio to get the adjusted ratio.

Calculating Age/Gender Adjustment Multiplier

Example:

Anytown, US Population	**0-<5 yrs**	**5-<15 yrs**	**15-<30 yrs**	**30-<40 yrs**	**40-<50 yrs**	**50-<65 yrs**	**65-<75 yrs**	**75+ yrs**	**Total Local Population**
Females	120	256	325	163	355	401	136	310	
Males	126	262	427	183	362	419	131	129	**4,105**

National Age/Gender Specific Primary Care Visits/Person *(Per MEPS analysis for those with unimpeded access, health status standardized)*									
P.C. Visits / Year	**0-<5 yrs**	**5-<15 yrs**	**15-<30 yrs**	**30-<40 yrs**	**40-<50 yrs**	**50-<65 yrs**	**65-<75 yrs**	**75+ yrs**	**Visits/Person US 2010 Pop.**
Female	3.55	1.70	2.52	3.66	2.54	3.12	3.61	4.16	
Male	3.93	1.74	1.08	1.44	1.34	2.32	3.24	3.55	**2.44**

Anytown, US P.C. Visits Needed	**0-<5 yrs**	**5-<15 yrs**	**15-<30 yrs**	**30-<40 yrs**	**40-<50 yrs**	**50-<65 yrs**	**65-<75 yrs**	**75+ yrs**	**Total Local Visits Needed**
Female	426	435	819	597	902	1251	491	1290	
Male	495	456	461	264	485	972	424	458	
Total	921	891	1280	860	1387	2223	915	1748	**10,225**

Numerator:	**Visits/Person Anytown, US**	**2.49**
Denominator:	**Visits/Person US 2010 Pop.**	**2.44**
Result:	**Age/Gender Adj. Multiplier**	**1.02**

Note: This example shows a +2% adjustment in the local need for primary care providers based on age and gender differences in the local population compared to the national population.

Addenda to the Report

Additional Views of NRM Committee Members

submitted by:

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Additional Views of NRM Committee Members

This addendum, which represents the views of certain members of the Negotiated Rulemaking (NRM) Committee, presents important information in support of several key Committee decisions related to the designation process presented in the full Committee report.

Purpose of the Committee

Before presenting this information, however, it is important to keep in mind the original purpose of the NRM Committee, as established by Congress. In enacting the Patient Protection and Affordable Care Act (PPACA), Congress directed HHS to establish a comprehensive methodology and criteria for designation of Medically Underserved Populations (MUPs) and Health Professional Shortage Areas (HPSAs) utilizing a Negotiated Rulemaking (NRM) process. In doing so, Congress directed that the methodology and criteria should take into account the following factors:

- The timely availability and appropriateness of data used to determine a designation to potential applicants for such designations;
- The impact of the methodology and criteria on communities of various types and on health centers and other safety net providers;
- The degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data; and
- The extent to which the methodology accurately measures various barriers that confront individuals and population groups in seeking health care services.

We believe that the expectation of Congress, as evidenced by the language of the statute, was that the NRM Committee should define methodologies and criteria to identify all areas and populations experiencing either underservice or a shortage of primary care providers and services, and that the issue of resource allocation would be the responsibility of program managers at HRSA, consistent with the manner in which such decisions have been made for the past 35 years. Congress did not direct the Committee to consider the amount or level of available resources which could be allocated to the communities or populations designated in developing the new methodologies and criteria. In fact, the current methodologies do not include an analysis of existing resources. Rather, resource allocation is a separate process determined by the Health Resources and Services Administration (HRSA) in the context of federal resources provided by the Congress, based on various factors including, but not limited to, the extent of shortage and/or underservice in the respective community/population. In this respect, securing a shortage or underservice designation is merely the eligibility threshold which must be met for a community or population to be considered for the placement of federal resources – the designation itself neither directs such placement nor functions as the determinative factor in making resource allocations.

While we respect the few NRM Committee members who voiced a dissenting opinion to the Committee's recommendations, because they believed that the Committee should include a consideration of currently available resources in their decisions, we also believe that their position, while well-meaning, is not only at variance with both the language of the authorizing statute and with prior practice but also with the clear charge to the Committee to establish a methodology which when promulgated as regulation would transcend any particular point in time or level of available resources, and be in place for years to come. In other words, the rule

established by the NRM Committee should stand the test of time; basing it on present circumstances that more than likely will change before the rule is even published stagnates what should otherwise be a dynamic methodology, and makes for less than ideal policy.

Rationale for Specific Provisions

The Committee agreed to use four criteria to guide its development of MUA/P and HPSA designations: the criteria and methodologies should be evidence-based, easy to explain, reasonable, and not harmful to existing safety net providers. We feel the Committee's recommendations met these criteria.

Setting the MUA Designation Threshold at a Meaningful Level

Given the lack of a uniformly agreed-to national definition of "medical underservice," the Committee was tasked with determining a method to identify medically underserved communities. This necessitated recommending an upper limit or threshold by which communities can be designated as underserved, thus becoming eligible for, but not entitled to, federal resources. After much deliberation regarding the point at which the nation's neediest communities would be adequately captured by the designation process, the vast majority of Committee members agreed to a one-third cut off (that is, a threshold under which areas containing one-third of the US. civilian population would qualify). Those communities below the cut off would be deemed designated. It is noteworthy that this newly proposed threshold is more restrictive than the original, and still current, designation threshold (50%).

It is important to note that the awarding of federal resources to address the needs of people living in designated MUA/Ps is based on a *competitive* process that requires applicants to submit extensive documentation of need, as well as other information regarding the applicant's ability to properly utilize the resources in question and its compliance with numerous programmatic requirements. Thus, securing an MUA/P designation is merely the initial step necessary to apply for federal resources, but it does not, in itself, determine whether resources will be awarded nor the extent of such resources. HRSA has effectively managed dozens, if not hundreds, of such application solicitations, reviews, and award cycles over the past several decades, and has managed that process admirably. Most recently, it received more than 800 applications for health center New Access Points – almost 3 times the number of awards it expected to make; every one of the applications was reviewed and scored, and only the highest-scoring applications were funded. This process is clearly the most appropriate way of prioritizing and managing the distribution of resources which can vary significantly from year to year.

Recent studies and reports underscore the appropriateness of the Committee's recommended threshold. For example:

- The Medical Expenditure Panel Survey (MEPS) found that 35% of poor adults and 30% of near poor/low income adults did not have an ambulatory care visit in 2008. That same year, 44% of Hispanics, 35% of African Americans, and 36% of Asian Americans also went without an ambulatory care visit. More than half of the uninsured (57%) did not have a visit.[2]
- Latest Census figures document that more than a third of the US population is low income (below twice the federal poverty line), with racial/ethnic disparities widening. More than 1 in 5

[2] Soni A and Roemer M. Characteristics of Those Without Any Ambulatory Care Visits in 2008: Estimates for the U.S. civilian Noninstitutionalized Adult Population. MEPS Statistical Brief 334. July 29, 2011. http://www.meps.ahrq.gov/mepsweb/data_files/publications/st334/stat334.pdf .

children – and more than 1 in 3 minority children – lives in poverty (at or below the federal poverty line).[3]

- People without a usual source of health care are more likely to have unmet needs for care, more hospitalizations, and higher costs of care while receiving fewer preventive care services.[4] More than half of the uninsured have no usual source of care.[5] Nearly 30 percent of young adults (18-24 years) had no usual source of care as well as 33 percent of Hispanics. For individuals who were low-income 32 percent of those living in poverty and 31 percent between 100-199% FPL did not have a usual source of care.
- A Commonwealth Fund survey found that 28% of working age adults (52 million) were uninsured at some point during 2010, up from 26% (45 million) in 2003. At the same time, 16% (29 million) were underinsured – double the rate in 2003 (16 million). Together, these two groups make up 44% of working age adults.[6]
- A UCLA-RAND study revealed that high community-wide uninsurance rates have adverse "spillover" effects that may harm even insured individuals living there. Privately insured, working age adults residing in communities with high uninsurance are less likely to have a usual source of care in communities with lower uninsurance rates. They are also more likely to report difficulty getting needed care and less likely to report being satisfied with their care.[7]
- A recent study published in the *New England Journal of Medicine* found that community characteristics can have a detrimental effect on the health of individuals living there. Communities that have high poverty rates also show much greater prevalence of poor overall health than communities with more elevated income levels.[8]
- Using 2006 MEPS data, researchers found that the odds of African Americans having at least one office-based physician visit were almost 30 percent lower than Whites. However odds improved for African Americans in predominantly White neighborhoods. Therefore, efforts to improve access to health care services and to eliminate health care disparities for African Americans and Hispanics should not only focus on individual-level factors but also include community-level factors.[9]

Given the above information, it is clear that the one-third threshold for MUA designation, supported by an overwhelming majority of the Committee, is appropriate – it is evidence-based, easy to explain, and

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[3] DeNavas C, Proctor BD, Smith JC. Income, Poverty, and Health Insurance Coverage in the United States: 2010. US Census Bureau, September 2011. http://www.census.gov/prod/2011pubs/p60-239.pdf.

[4] Starfield, B., & Shi, L. (2004). The Medical Home, Access to Care, and Insurance: A Review of Evidence. *Pediatrics, 113*(5 Suppl), 1493-1498

[5] National Center for Health Statistics. Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD. 2011

[6] Collins SR, Doty MM, Robertson R, Garber T. Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010. The Commonwealth Fund. March 16, 2011. http://www.commonwealthfund.org/Publications/Fund-Reports/2011/Mar/Help-on-the-Horizon.aspx?page=all.

[7] Gresenz CR and Escarce JJ. Spillover Effects of Community Uninsurance on Working-age Adults and Seniors: An Instrumental Variables Analysis. 2011 *Medical Care* 49(9):e14-e21. http://www.rwjf.org/coverage/product.jsp?id=72828

[8] Ludwig J, et al. Neighborhoods, Obesity, and Diabetes – A Randomized Social Experiment. 2011 *NEJM* 365(16):1509-1519.

[9] Gaskin, D J et al. Residential Segregation and Disparities in Health Care Services Utilization *Med Care Res Rev* published online 4 October 2011

reasonable given the purpose of designation and the data available. Moreover, using a one-third cut off for designation of communities and areas does not mean that resources will be targeted to the entire population of such areas. Subsequent federal intervention resources will be targeted to those populations within the designated rational service area that clearly have unmet health care needs. As such, we urge the Secretary to adopt the threshold identified in the NRM Committee report and supported by a substantial majority of the Committee.

Provider "Back-Out": Avoiding a "Yo-Yo" Designation Cycle

The vast majority of Committee members also support a recommendation to exclude federally-supported MDs, NPs, and PAs from the provider to population (P2P) count. In particular, the P2P should exclude or "back out" those providers who are serving there as a direct result of a federal intervention in these underserved and under-resourced communities: National Health Service Corps Scholars and Loan Repayment recipients, State Loan Repayment Program (SLRP) recipients and providers who work at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that accept patients regardless of ability to pay. A substantial majority of the Committee was concerned that including these providers could trigger a "yo-yo" effect, under which a designated area is assigned resources to address the identified need, and those resources are then included in the subsequent provider count, which results in the area losing its designation and consequently losing the resources assigned there, once again making it eligible for designation. The Committee believed that by backing out these federally-supported providers, this "yo-yo" effect could be avoided.

National P2P estimates run by John Snow International (JSI) for HRSA and the Committee demonstrate that these clinicians, when counted, effectively increase provider-to-population ratios. In other words, as was noted by several Committee members, the community's capacity to provide adequate primary care to its residents is heavily dependent on these federally-supported clinicians, especially in rural and frontier areas. Including these individuals in the provider counts may result in areas losing their designations, thus creating real harm to underserved communities and the populations residing within such communities. This is particularly critical for those communities on the "margin" of designation, that are in danger of cycling on and off designation, placing communities already at risk for poor health and poor access at even greater risk.

In early MUA and HPSA model tests, JSI compared the impact of the full provider back out with a model that backs out only 50% of the same providers. These impact tests show notable impacts on the designation status of areas with FQHCs and RHCs, resulting in anywhere from 5 percent to 25 percent of FQHCs and RHCs losing their designations, compared with a full provider back-out. It follows, then, that a model run without any back outs would lead to even fewer designations.

It is important to bear in mind that the primary reason we have not seen a "natural experiment" exploring the consequences of the "yo-yo" effect is because such an experiment has been deemed harmful policy. To attempt to fully demonstrate the existence and extent of the "yo-yo" effect would necessitate creating the very situation that the placement of federally-supported providers hopes to avoid – real harm to underserved communities resulting in poorer health status and less access. Thus, not including a back out of federally-supported providers is contrary to one of the NRM Committee's guiding criteria: to cause minimal disruption to existing safety net providers.

Based on the above, we believe that excluding federally-supported providers in the provider count to determine P2P ratio is necessary to ensure appropriate placement of federal resources while not

creating any undue harm to underserved communities which could result from the "yo-yo" effect discussed above. As such, we urge the Secretary to adopt the full provider "back-out" included in the Committee's report and supported by a substantial majority of the Committee.

Additionally, at least one Committee member believes that providers working at corrections facilities (federal, state, and local), should each be counted *for the population of the facility they work at ONLY,* for purposes of determining facility designations.

Addendum to the Report to the Secretary

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October 28, 2011

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5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Sitko:

As a member of the Negotiated Rulemaking Committee (the Committee) on the Designation of Medically Underserved Populations (MUPs) and Health Professional Shortage Areas (HPSAs) it was a privilege to serve as one of 28 members and as the representative of the American Hospital Association. While the Committee was unable to reach a consensus on its recommendations on a process for designation of MUPs, HPSAs, and Medically Underserved Areas (MUAs), the Committee did identify many thoughtful options for use in a designation process.

When the Committee last met it was primarily for the purpose of discussing recommendations to the designation process for MUPs and MUAs and come to some closure regarding the final recommendations for MUPs, MUAs, and HPSAs. Numerous votes were taken on approval or rejection of components that would contribute to the designation process for MUPs, MUAs, and HPSAs. Although represented by an alternate, I was not present at the final meeting and thus have several unanswered questions regarding the origins of some of the factors that form the infrastructure for designation that were justifiable anecdotally, but not adequately supported by scientific research at least to my satisfaction.

Furthermore, we did not review a final report at the last meeting and our review of that report was done through electronic communication on drafts circulated by staff from the Health Resources and Services Administration (HRSA). This final review process was necessary in order to meet the October 31, 2011 deadline established by HRSA. Consequently the review of the final report was hasty and cumbersome. As a result there have been issues that were confused in translation and merit clarification. For these reasons and again, given the lack of consensus, I am taking the opportunity as allowed by § 566(f) of the Negotiated Rulemaking Act (Pub. L. 101–648, 5 U.S.C. 561–570) to submit as an addendum to the report some additional comments.

Conceptual Framework
As stated in the final report, the Committee identified several key concepts to guide us during our analysis and evaluation of methodological alternatives. From this conceptual framework the Committee made dozens of decisions regarding rational service areas (RSAs), population-to-provider (P2P) ratios, medically underserved areas (MUAs), medically underserved populations (MUPs), and geographic health professional shortage areas (HPSAs). The decisions were made using a balance of scientific and expert knowledge that thoughtfully and judiciously weighed the impact of multiple variables.

The following concepts were selected to reflect the Committee's desire to have a relatively simple, data-driven designation process for increasing access and placing providers in areas of greatest need:

- The proposed new methodologies should be based on scientifically-recognized methods, and the contribution of each variable to the overall measure should be informed by evidence or some scientifically verifiable relationship.
- The proposed methodological approaches are intended to be understandable and usable by those seeking or affected by the designation.
- New criteria should be reasonable and have face validity.
- The development of new designation criteria and processes should involve a consideration of their potential impact on existing safety-net providers and the communities they serve.

This conceptual framework has served its purpose well in leading the Committee towards its recommendations and serves as the framework used by me in the comments which follow.

Rational Service Area
The Committee proposes to define a rational service area (RSA) as an area that meets four critieria:

1. Made up of discrete geographic basis areas,
2. Area is continuous,
3. Different parts of area are interrelated, and
4. Area is distinct from adjacent contiguous areas.

Regarding this fourth criterion, RSAs will be considered distinct if, among other criteria, clinician capacity of the adjacent service areas is unable to accommodate the primary care needs of the service area. The threshold of insufficient capacity should be defined as P2P of 2000:1.

The scientific basis for setting this P2P ratio as the threshold for insufficient capacity is not apparent. A reference to the evidence or scientifically verifiable relationship between P2P of 2000:1 and insufficient capacity is warranted as the conceptual framework requires if it is to be accepted.

The Committee provides States the option of petitioning HRSA to create a State-wide RSA that divides a State into RSAs that are each discrete, continuous, interrelated and distinct. I am supportive of this petitioning process and believe it permits a more reasoned and meaningful RSA particularly for States with large frontier areas.

Population-to Provider Ratio
The Committee recommends some significant revisions to the process of counting primary care clinical providers. First, members support broadening the definition to include not only primary care physicians but also midlevel primary care providers. Second, members support excluding or backing-out from the

count certain primary care providers who may be practicing in an area or site under a federal service obligation or as part of a federally-funded or supported health center or clinic.

Including midlevels such as nurse practitioners (NPs), physician assistants (PAs), and certified nurse midwives (CNMs) as primary care providers expands the number of providers significantly so it is essential that one has an understanding of their productivity. Presently the Committee proposes a 0.75 relative weighting to NPs, PAs, and CNMs as an estimate of contribution to primary care. However, scope of practice for midlevel clinical professionals varies considerably from State to State, and the Committee wants to avoid creating a scenario that makes it more difficult for RSAs within States with a narrower scope of practice to become eligible for designation as HPSAs, MUPs, or MUAs than is warranted given the limitations on productivity of these professional in their states. Furthermore we need to correct a maldistribution of primary care physicians by allocating available resources to those designated as HPSAs, MUPs, or MUAs.

The scientific basis for determining the relative weight for productivity of NPs, PAs, and CNMs is not apparent as the conceptual framework requires. A reference to the evidence or scientifically verifiable relationship on weighting of midlevels is warranted if it is to be accepted.
In addition, PAs or NPs specializing in obstetrics and gynecology would be included as .25 FTE, in a manner consistent with the weighting of OB/GYN physicians. I believe it would be more consistent if PAs or NPs specializing in obstetrics and gynecology are weighted as 75% of .25 (or .1875) of an FTE (consistent with the .75 weighting of midlevels) or whatever relative productivity weight is assigned to other midlevel providers.

The Committee recommends continuing to exclude certain foreign medical graduates from the primary care provider count. The Committee also recommends excluding National Health Service Corps scholars and loan-repayment recipients, State Loan Repayment Program recipients, and providers who work at HRSA grant-funded health centers, FQHC look-alikes, and hospital-based or independent RHCs that accept patients regardless of ability to pay. I agree these adjustments are necessary to avoid the “yo-yo” effect in which an area is designated as underserved; an intervention occurs as a result of the designation; the newly placed practitioners are counted and result in a loss of designation; the intervention is removed; and the area again becomes underserved.

Medically Underserved Areas
Medically Underserved Areas (MUAs) are determined based on four statutory components: health status, the availability of health professionals, accessibility of care and ability to pay. However, there is no statutory requirement to limit the U.S. population eligible for designation to a specific threshold under this revised methodology.

According to the final report, the Committee established a threshold on the resulting index for designating MUAs such that the impact testing models would designate the worst scoring 33% of the U.S. population.

For MUAs, the current index of medical underservice (IMU) is set at 62 which represented the score of the median of all U.S. counties at the time the Regulation was drafted. The level at which the IMU is set for designation of future MUAs is not the purview of the Committee, but rather it is contingent upon the

demand for and allocation of program resources being administered by an Agency within HHS such as CMS or HRSA.

Therefore, any reference to a threshold for designation should be clear that it serves only for modeling and comparative analysis and not as a benchmark for eligibility or designation of MUAs. In addition, it should be made clear that the Committee did not discuss scoring for MUAs, MUPs, or HPSAs, which, given its key role in determining designations is a deficiency in the overall Negotiated Rulemaking process.

Geographic Health Professional Shortage Areas
To qualify for a geographic primary care health professional shortage area (HPSA) designation, applicants need to demonstrate they are in a RSA for primary care and meet P2P thresholds adjusted as appropriate by health status and poverty. Additionally, the Committee recommends revising the geographic HPSA designation method to allow for a scoring adjustment that addresses the unique needs of frontier areas. By adjusting the requirement to measure standardized mortality rates and percent low income, all frontier areas with P2P ratios above 1500:1 will be designated as geographic HPSAs. Whatever the appropriate ratio may be, I enthusiastically support this adjustment so that the well known needs of frontier areas are adequately captured in a manner that is reasonable and offers face validity as implied by the conceptual framework.

Population Group HPSAs
Not all populations within geographic areas have equal access to primary care clinicians. Therefore the Committee recommends maintaining population group-specific HPSA designations. In fact the Committee recommends two distinct paths to population group HPSA designation. I support this recommendation.

Facility HPSA
The Committee recommends revising the criteria for facility HPSA designation. FQHCs and RHCs meeting the requirements of the NHSC statute for service without regard to ability to pay would remain automatically eligible for designation as facility HPSAs as statutorily required. The Committee recommends continuing the current process of allowing facilities not located in designated geographic HPSAs to apply for facility designations provided that they can demonstrate service to existing designated areas or population groups. I support continuing the current process.

In addition, the Committee revised the criteria for facility HPSA designation by creating new pathways to designation for magnet facilities, safety net providers, and essential primary care providers in a community. I am generally supportive of the new pathways for facility HPSAs. However, it is not apparent as to the scientific basis for determining that essential primary care providers in a community are facilities providing primary care services to at least 70% of the population in a RSA as required by the conceptual framework. A reference to the evidence or scientifically verifiable relationship between the primary care services provided by providers and the percent population in an RSA is warranted if it is to be accepted.

Furthermore, under the proposed revised facility designation process, a medical facility could demonstrate insufficient provider capacity by satisfying at least two of four additional criteria such as a P2P of 1500:1, counting all patients seen (by the provider) in a facility in the last year; the wait for appointments is more than 14 days for new and 7 days for established patients or the practice is closed to new patients; patient encounters per clinician exceed 4400 per year; or the average patient care hours per clinician exceed 40 hours per week.

It is not apparent that the criteria for insufficient provider capacity are scientifically verifiable, have face validity, or are reasonable for designation of a facility as a HPSA as required by the conceptual framework. Therefore, references supporting the criteria for insufficient provider capacity are warranted if they are to be accepted for this purpose.

Facility HPSA- Dependent Medically Underserved Population Designation
According to the report, the Committee recommends creating a facility HPSA-specific medically underserved population (MUP) designation to address concerns that some safety-net facilities, despite serving populations that are clearly underserved, might be located in areas that no longer meet geographic or population group criteria.

If a facility cannot meet the criteria for either a geographic HPSA, population HPSA, or MUP, that is if a facility or a provider otherwise cannot demonstrate that it addresses the components of health status, barriers to access, ability to pay, or P2P then it cannot be meeting a shortage or addressing underservice and without further evidence, it seems unlikely that such a facility serves an underserved population. This category of facility HPSA seems to fail the guidelines of the conceptual framework requiring understandable methodological approaches that are reasonable and have face validity.

It seems a contradiction to allow facilities to qualify for designation under this process if they no longer qualify for HPSA, MUA, or MUP designation. For these reasons I oppose this specific designation category and hope it will be rescinded in the final rule.

Impact Analysis
JSI was diligent in modeling dozens of scenarios for consideration by the Committee, and we owe them a debt of gratitude for the time and expertise that was put into the effort. JSI delivered detailed models of the national impact of all the scenarios requested by the Committee in a very timely manner. However, as stated in the final report, some gaps in data exist. Furthermore, it was not possible to run full impact testing of the population designation methodologies or facility designation methodologies because the data requirements make testing difficult if not impossible at a national level. The Committee recommendations reflect the knowledge gleaned from the available data, which however, cannot be considered an absolute determinant of the overall impact of the models.

In addition, there was not sufficient time for JSI to model the final options on a State level for final consideration. State level modeling was requested so there would be a greater understanding of the advantages and disadvantages of the recommendations as proposed by the Committee at a State level. In addition, according to JSI the impact analysis was inaccurate for some areas such as frontier areas that should clearly have been identified, but were not. This information is necessary to make recommendations that consider the impact at a State level and not just the average impact across the nation. Voting on final recommendations with incomplete information compromised my confidence in some of the scenarios and further research is warranted.

Transition Plan
As the transition is made from the current designation process to the new designation process the Committee recommends re-evaluation of existing HPSA and MUA/P designations over a four year period which seems a reasonable period of time. In addition, for those who upon re-evaluation lose their designation, it is only reasonable to establish a grace period to phase out their participation in any agency program in which they are participating.

Frequency of Publication and Withdrawal

In the case of a proposed withdrawal of a designation and subsequent appeal, the Secretary may request, and the State primary care organization must submit within 30 days such data and information as necessary to evaluate particular proposals or request for designation or withdrawal of designation. Given the appeal process requires submission of data by a State agency or organization and the information they submit may come from and would otherwise affect a provider it seems reasonable that this timeline should be extended to 90 days.

Urgent Review and Automatic Designations
In the event a sudden and dramatic change in primary medical care services that leaves an area or population underserved or with a shortage, the Committee recommends the Secretary review urgent requests on behalf of the affected community within 30 days of receipt. I support this process and timeframe for urgent review and automatic designations.

I appreciate the opportunity and it was a privilege to serve on the Committee. I think our task was ambitious, but in the end, the negotiated rulemaking process was unsatisfactory and could not produce a consensus. There is clearly a need for more analysis on the part of HRSA before a final rule can be promulgated. I strongly urge you to keep in mind the dissenting opinions in the areas where consensus was not reached or even in the cases where there were abstentions as these have merit.

I would like to extend my thanks to the Committee's members, HRSA staff, and JSI who worked diligently and honorably and with the best interests of patients and providers in mind. In conclusion, the recommendations represent the best effort of the group and however imperfect the outcome may appear it is a step forward from where we were 14 months ago.

Sincerely,

/s/

John T. Supplitt
Senior Director
American Hospital Association
Constituency Sections for Metropolitan and Small or Rural Hospitals

Addendum Minority Report

submitted by:

Timothy McBride, PhD
William Scanlon, PhD

Introduction

This minority report is submitted to the Final Report of the **Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and Health Professional Shortage Areas, since the Committee did not reach** full consensus on the report to the Secretary. It is the understanding of the signatories to this Minority Report that the Secretary will now consider the work of the committee and make her determination as to the contents of a proposed rule.

The committee accomplished a great deal in the 14 months of its deliberations. But due to a number of factors, including a fixed deadline on the completion of the report, we feel that the Committee did not complete its work of drafting a proposed rule that has been fully vetted and tested. We further believe that much positive and useful analysis has been completed by the committee, the statistical consultants hired to support the committee, and the analysts staffing the committee from the Health Services Resources Administration (HRSA). This analysis provides the record of the committee's work, and was presented to the committee, most especially in the last few meetings the committee held. However, we believe it is important for the Secretary to conduct the additional analyses that can validate the final decisions made by a majority of the committee, or identify modifications to those decisions, to assure that the rule will be most effective in promoting the objectives of the affected programs. Our objective in writing this minority report is to achieve the best possible public policy in this area for the American people, and if we had felt that the final report had achieved this goal, we would in good conscience supported the final report.

In this Minority Report we describe our principal reasons for not supporting the Final Report. The two authors of this document, Timothy McBride and William Scanlon, support and endorse this document. In addition, the authors of this Minority Report have sought input on this Minority Report from members of the Committee to make sure we are presenting the best possible course for adjusting the final policy recommendations by the Secretary. However, the opinions expressed here are our own, and not those of any other members of the committee, who voted to support the final report.

Principles guiding Committee Decisions

As noted in the Final Report, the committee adopted a framework that specified its decisions should meet four criteria. The decisions were to be:

- Evidence-based;
- Simple enough to explain and implement;
- Reasonable, and
- Protective of the safety net.

In general, it is with regard to the first of these criteria that we believe the committee's decisions fall short. The committee assembled a large amount of data during its deliberations and had extensive discussions regarding analyses based on these data, largely produced by an external consultant. However, with a deadline to complete its work, the committee made numerous decisions based on its collective expert judgment and without direct support from any external data or published evidence that would justify a particular choice. In some instances, conflicting evidence had been presented over the course of the committee's deliberations without reconciliation as to which was valid. In addition, due to the variety of backgrounds and perspectives of persons on the committee, what constituted evidence was often unclear, or viewed differently by different members. The varieties in these perspectives were not reconciled adequately in the end.

In addition, we believe that in some cases the decisions made by the committee violated the criteria of being "simple enough to explain". Instances of this will be identified below, but an example is a formula used in the HPSA rule, which is quite complex, and based on a mathematical formula that was not revealed to the full committee until the final day of deliberations. Whether justifiable or not, policy in the U.S. needs to be simple enough so that its impacts can be transparent to the individuals affected by the policy, otherwise the constituents affected will not be likely to support the policy change.

Finally, a full understanding of the impacts of the decisions made by the committee was not possible due to the pressing deadline facing the committee. Selected impact analyses were provided, but these should be regarded more as starting points that suggest areas that need fuller attention, rather than a complete analysis that would validate the underlying decisions. In an important instance, the definition of medically underserved populations, a partial impact analysis was conducted between the penultimate and the last meeting which revealed a substantial problem with the decisions made at the penultimate meeting (93% of the nation could be designated underserved). While the designation decisions were adjusted at the last meeting, no impact analysis of the revised criteria was conducted. Further analyses can likely shed light on many important issues, both improving policy and increasing confidence in same.

Concerns about Designation of Too Many Areas and Persons

There is no precise demarcation between shortage or underservice and adequate supply. The shortage or underservice designation process can then be viewed as an instrument to direct the resources of programs like the National Health Service Corps or Section 330 funding to areas or persons most in need. Historically there have been concerns that the shortage and underservice designations have resulted in too many areas and persons designated and that program resources -- rather than going to the neediest areas -- are disproportionately received by less needy areas.[10] The result is not surprising as individual providers supported by these programs are more likely to choose better off communities with better amenities, fewer problems and challenges, and more professional colleagues. The disparity that exists among current HPSAs as shown in Table 1, which compares the HPSAs in the top quartile and the bottom quartile in terms of HPSA score.

Table 1. Descriptive information on shortage areas in the U.S.

	Top Quartile-Worst "Shortage"	Bottom Quartile-Lesser "Shortage"
Average HPSA Score	16.9	7.6
Percent with 0 FTEs	23.6 %	9.9%
Number of FTEs	2.42	7.26
Number of FTEs Short of Dedesignation	2.94	1.07
Percent in Poverty	22.38 %	13.58 %
Average Population	17,315	28,034
Source: Tabulation of HRSA Supplied Data.		

Even with the ARRA and ACA funds available in the last two years, the competition for the limited available resources remained high as shown by the number of vacancies in the National Health Service Corps (Table 2). In fact, with the additional funding, restrictions on the number of vacancies a site could post were relaxed—adding more competition for these finite resources. With the likelihood of more limited future funding in the future (which seems very likely in the current fiscal environment), this situation will undoubtedly be worse.

[10] US GAO, *Health Professional Shortage Areas: Problems Remain with Primary Care Shortage Area Designation System.* GAO-07-84. Washington, D.C.: October 24, 2006. _____, *Health Workforce: Ensuring Adequate Supply and Distribution Remains Challenging*. GAO-01-1042T. Washington, D.C.: August 1, 2001; _____, *Health Care Access: Programs for Underserved Populations Could Be Improved*. GAO/T-HEHS-00-81. Washington, D.C.: March 23, 2000.

Table 2. National Health Service Corps

Fiscal Year	Field Strength	New Vacancies	Total Vacancies
2007	3,820	2,774	5,022
2008	3,601	2,529	6,356
2009	4,760	2,772	7,697
2010	7,530	2,643	9,039
Source: HRSA			

The newly proposed HPSA criteria will not lessen the competition for resources, and in fact is likely to increase competition by expanding the areas that are designated. The thresholds defining HPSA disparities were selected so that the aggregate amount of Medicare bonus payments would remain roughly the same. However, the impact analysis indicates the committee's decisions would result in a 25 percent increase in the designated population and a similar increase in the number of elderly designated. It was acknowledged, however, that the impact analysis does not account for the number of RSAs that will be defined when local data are taken into account that are more accurate than the data available to the committee (such as hours worked, influencing FTE provider counts, the key variable defining HPSA). The committee did not seek to estimate the increase in Medicare bonus payments and HPSA designations that could result. There is only a 3 percent gap between the estimated Medicare spending under the new designation and current spending.

These considerations raise particularly important issues. An argument was made that designating a large segment of the population as underserved does no harm. The premise is that HRSA determines the allocation of program funds and that the agency can determine those most in need. This premise is problematic on two grounds. First, the designation of too many areas means that the volume of applications HRSA receives may strain its resources and preclude more comprehensive reviews. Second, areas that are better off will likely have more resources to assemble data and other materials to support their applications. This is particularly worrisome given the option for locally generated survey data to be used to define areas. One can imagine a larger higher income area with pockets of poverty having the resources to conduct an extensive survey to have some of those pockets designated. In contrast, areas where poverty is the norm may have significant difficulty in assembling an application using existing data sources. As a result, if more areas are competing for at least the same level of funding (and predictably, a lower level of funding), and less needy places may be competitive for these funds because they have more resources, then the outcome of committee's decisions could be less targeting of needed resources than is optimal or desired. It is even possible that the targeting of future resources could be less desirable than the current distribution. In addition to the targeting of HRSA resources expanding the designated areas and people may undermine the intended incentive created by the Medicare bonus. An incentive acts an inducement only if earning it requires a certain response. In this case, the incentive to practice in needier areas could be weakened by the ability to earn the same bonus by practicing in less needy areas, another paradoxical response to the totality of the committee's decisions.

The proposed threshold for Medically Underserved Areas (MUAs) raises similar concerns. The committee selected a threshold so that one-third of the US population was designated as underserved. The rationale offered was that this threshold is less than the one-half of the population designated in the original rule 35 years ago. This argument has no face validity. The notion that the committee is acting conservatively by designating 33 percent of the country instead of the 50 percent designated in the 1970s is specious. In particular, medical care delivered in the U.S. today bears little resemblance to that delivered in the 1970s. In 1975, health care spending was 8 percent of GDP as compared to almost 18 percent today. The per capita supply of providers has increased significantly as well. The number of generalist physicians per capita increased 19 percent in non-metro areas and 11 percent in metro areas from 1991-2001.[11] . In addition, there has been a 24 percent growth in the number of primary care practitioners per capita (defined as primary care physicians, nurse practitioners and physician assistants) between 1995 and 2005.[12] Finally, the committee

[11] US GAO, PHYSICIAN WORKFORCE:Physician Supply Increased in Metropolitan and Nonmetropolitan Areas but Geographic Disparities Persisted. Washington, DC. GAO-04-124, October 2003.

[12] GAO 2008 is US GAO, PRIMARY CARE PROFESSIONALS: Recent Supply Trends, Projections, and Valuation of Services, Washington, DC GAO-08-472T, February 2008.

reviewed evidence (from the Medical Expenditure Panel Survey) early in its deliberations that demonstrated a relatively low percentage of individuals report not receiving or delays in receiving needed care.

> *We believe it is important for the Secretary to try to identify a valid empirical basis for defining the underservice threshold and consider substituting it for the committee's 1/3 threshold. We* believe that a far more detailed analysis of the impact of the HPSA designation approach on the Medicare incentive payment is needed to inform the final decision. *We further believe it is important for HRSA to examine the potential for locally defined RSAs to increase the amount of the Medicare bonus payments and at a minimum, consider adjusting the HPSA thresholds to maintain the Medicare bonus payments at current levels, in particular to meet the committee's goal of targeting resources to the most needy in the safety net. We also ask the Secretary to consider whether the current method of fixing the thresholds in the rule which does not allow adjustments over time for the level of available program resources should be modified to help assure better targeting of program resources to the neediest areas.*

Concern about Designating the Right Areas or Populations

We have concerns about a number of committee decisions that affect which areas or groups of people will be designated. They include:

- Conceptual model used to define underservice
- Backout of federal physicians
- Weights assigned to poverty
- Designating HPSAs with intermediate population to provider ratios
- Structure of the index of underservice

Conceptual model used to define underservice. The Committee spent a great deal of time determining a conceptual framework for capturing medically underserved areas. A spirited discussion of methods and models consumed considerable time and effort by the committee, with sincere and useful contributions made by many members of the committee. Nevertheless, the inevitable disagreements between well-intentioned individuals with differences of opinions led to some difficulty in determining a final conceptual framework or model upon which to base the final measure, especially one that can be supported with a rigorous external evidence base outside of the committee's work, which notably, is an important criteria the committee itself set for the policy decisions to be made.

What was eventually recommended by the Committee was to use an index of underservice, analogous to current practice. Underservice by definition implies a deficiency or difference. In this context, underservice might be considered as the difference in service need for an area or population and the supply of services available to that area or population. The underservice index recommended by the committee majority is a weighted sum of measures of need and the services available. Again while this index is similar to current practice, that does not mean it is a conceptually valid framework for measuring underservice. While it may be desirable to give higher weight to need proxies in defining underservice, it is important to assess whether the recommended index so heavily discounts the available service levels to the point of their being ignored. This type of impact analysis was not conducted during the committee's deliberations.

Given the difficulty encountered in finding an underlying framework or theory to use for setting the index, the committee also resorted in the end to using "expert opinion" for setting the weights used in the formula for the MUA index. Some committee members, including those who have signed this Minority Report voiced many concerns for months about using expert opinion rather than an empirical basis for setting weights, but the concerns went unheeded. So in the end, the final index was determined not by empirical evidence nor from evidence obtained from the literature, but instead was determined by a vote of the committee. This leads to a decision that can be difficult to explain or justify when implemented. In particular, an outside party affected by the decisions of the committee might

ask the basis for the decisions made, and suggest that if they are based on the unique set of participants on this committee, why wouldn't a different committee, otherwise configured come up with a different index and weights?

> *We recommend that the Secretary seek rigorous, defensible evidence-based analysis to support the development of a conceptual model underpinning the MUA index, and that the weights in the index be also supported by empirical analysis, peer-reviewed literature or other published analysis. We further recommend that when these decisions are made that they be made while closely following the spirit of the recommendations made by the full committee, and using the variables the committee decided were important to consider in the development of the index, to the extent possible, defensible, and desirable.*

Backout of federal physicians. In the current rule, certain physicians supported by federal funding are not counted in determining population to provider ratios. The rationale is that these physicians may only reside in a community on a temporary basis and counting them will lead to a yo-yo effect in terms of designation and de-designation. While recognizing the disruption caused by such a yo-yo effect, steps to prevent one must be weighed against the distortions created in the measured provider capacities of different communities. Communities with uncounted federal providers will be treated the same as communities with fewer providers. The committee decided to expand the types of physicians receiving federal support that are to be excluded. The same rationale, a potential yo-yo effect, was offered. However, there was no evidence presented of the extent of any potential yo-yo effect and how the extent may vary by type of federal support. In fact, in very early discussions of this topic, some members of the committee disputed the presence of a yo-yo effect citing the long tenure in single locations of some physicians that would be excluded.

> *We believe it is important for HRSA to assemble data to affirm the presence and extent of a yo-yo for the different types of physicians or other providers that might be excluded and potentially adjust the committee's backout decision so that communities are treated equitably over time.*

Weights assigned to poverty. There is no dissent on the conclusion that persons in poverty are more likely to be in ill health and to have more difficulty accessing health care services. From the outset, the committee recognized the importance of taking the extent of poverty in communities or populations into account as a proxy for health status or access. However, it became clear that there were two important issues with using poverty as a proxy for lack of access to health services. The first is that it is widely recognized that the current measurement of poverty in the US, the Federal Poverty Level, is substantially flawed. The second is that the circumstances of persons in poverty, particularly access to health care, may vary considerably across the U.S. due to range of reasons that include cost-of-living, government policies, and other local considerations.

The problem of measuring economic well-being was recognized by the committee early on. Current poverty measurement does not take into account the significant geographic variation in the cost of living or purchasing power. Persons in higher cost areas with incomes nominally above the federal poverty level may be significantly worse off than persons with income below the federal poverty level in low cost areas. The committee spent considerable time trying to determine if there were better measures of economic well-being that would adjust of geographic differences in costs of living. It was concluded that while the problem of measuring poverty is recognized, no alternative measure of poverty that would remedy this problem exists at this time. However, the Final Report supported by the committee does not adequately express the long-term concerns about the poverty measure, nor recommend the Secretary monitor the development of alternative poverty measures by the Census Bureau and others for potential use in future revisions of this rule.

Despite the concerns raised about the poverty measure, the committee subsequently decided to limit the variables used to define need in order to simplify the designation process, a decision which led to assigning very significant weights for poverty status in the determination of HPSAs, MUAs, and MUPs. The importance of poverty as a proxy for health and access may be sufficient reason to use federal poverty status, despite flaws in the measure. At a minimum, however, it is important to understand the impacts of the inaccuracies in the measure. For example, it was observed that unless the threshold for MUAs was set at a level of one-third of the population, certain areas of the country would

have no MUAs. While this suggested a need to examine whether this result occurs because of flaws in the poverty measure, as opposed to low scores on other measures of underservice, this analysis was not explored by the committee

A final concern in this area is the very significant relationship between poverty status and eligibility for government programs, in particular Medicaid. Although this relationship is not uniform of course, the fact that states set eligibility rates as varying percentages of poverty for different eligibility categories only serves to exacerbate the problems of measurement of true access problems among persons with incomes below the federal poverty level. For example, if in one area of the country the Medicaid eligibility level for most populations is close to 100 percent of the poverty line (e.g., New York), then in fact the access problems faced by low-income persons in that state will be lower than they would be in a state that sets its eligibility levels very low as a percent of poverty (e.g., Missouri). None of these issues were explored to any depth by the committee even after they were raised by some committee members.

> *We recommend that additional analysis is needed to explore and disentangle the relationship between poverty status, government insurance eligibility levels and the relationship of these to need/access to safety net services. We further recommend to the Secretary that HHS work with other agencies to improve on the poverty measures, and local poverty data that can be used for the purposes of shortage designations. Finally, when such improved poverty measures are available that they be considered for incorporation into future revisions of the shortage designations rule,*

Designating HPSAs with intermediate population to provider ratios The committee recommended that an area be designated a HPSA if its population-to-provider ratio exceeded 3000:1 or in the case of rural frontier areas, exceeded 1500:1. For non-rural frontier areas, it also recommended that some areas with a population-to-provider ratio between 1500:1 and 3000:1 be designated. The designation decision for these areas with intermediate population to provider ratios is to be based on an area's population-to-provider ratio and an index based on area mortality and poverty. The recommended designation decision involved creating a two dimensional graph of these two variables and drawing an exponential curve between the two thresholds 3000:1 and 1500:1. Areas falling to the left of the curve would be designated and those to the right not.

The initial drafts of the Final Report raised several concerns about the selection of the particular exponential curve which is simply one of an infinite number of possibilities. Some of these concerns were partially resolved in the last two days the committee met, but a full resolution was not achieved. In particular, this important decision must meet three tests, and be explained thoroughly in the report: what method was chosen by the committee for this decision; what specific line was chosen (that is, mathematically, what is the formula for the line); and finally, specifically why did the committee make these decisions, using what evidence-based criteria?

To the committee's credit, revisions to the Final Report now include an explanation of the specific line chosen, and the method used for computing this line (as noted, a complicated exponential curve). But two major concerns remain. First, the committee was presented with no evidence from any peer-reviewed literature or other evidence base to justify the decision of the specific curve chosen (over all other possibilities). Discussion suggested while the shape of the curve was determined by variables in the equation, the positioning of the curve was set by a budget constraint based on Medicare spending available (as noted in the Final Report). Second, the final curve chosen fails the simplicity test set by the committee for all policy decisions, which was clearly recognized by the committee in its deliberations. These two points lead to a major concern for implementation of the policy. If the policy is not simple enough to be understood by those affected by it, and if the decision to choose one curve over the many other alternatives is not justified or explained then those communities who do not qualify for federal funds as a result of the setting of the curve based on one function can rightly argue that the decisions made were arbitrary and not justified, and thus a remedy is needed.

We recommend that additional analysis be undertaken to explore the impacts of decisions about HPSA designation of areas between the two thresholds has on communities. For example, an analysis could be conducted that compared

areas "just designated or close to the curve" to those that were "close but not designated" to determine if there are meaningful differences between these areas in terms of the concepts being measured. In this way, a final shape of this curve could be arrived at with more confidence that it is drawn in such a way to maximize its ability to distinguish areas more in need from those that are less so. We feel that the committee, and the statistical consultant was proceeding with due diligence on analyses before the Final Report was completed, and that the intent of the committee is clear, but that adequate analysis was not completed before final decisions were made. We finally feel that evidence (particularly published evidence if possible) should be found to justify any policy decisions made about the selected thresholds and the curve defining designations between the thresholds. Finally, we believe that the final decision about the criteria defining designations between the thresholds should be a simple enough formula that will meet a standard of reasonableness in the eyes of the broader community affected by these decisions. A suggestion is that the excellent work completed by the committee to date be used as a starting point for setting the final criteria, even if these are a more simple function, or step functions that approximate the more elegant and complex function discussed by the committee and approved in its Final Report.

Final Comments

This Minority Report lays out the major concerns of the two undersigned members of the committee, Timothy McBride and William Scanlon , who decided that they could not support the Final Report, in large part because they did not support any of the major decisions of the committee on thresholds for HPSAs, MUAs, MUPs, and HPSA-special populations. It should be reiterated though that we believe that the committee created a major body of excellent work that can be built upon before the Secretary determines a final rule. The decisions made by the committee have not been adequately tested to the point where they can be defended when presented to the populations affected. But with further work, and additional analysis, the committee's excellent work to date can be respected and enhanced to the point where it can lead to implementation of an improved rule. We believe that the very high percentage of the committee who supported the final report demonstrates to the Secretary a significant and widespread and rather remarkable level of support of the principles reflected in the Report.
We sign and present this Minority Report, however, in the spirit that the excellent work of the Committee can best be respected and fulfilled with further work by HRSA reflecting the concerns we express here. We understand that HRSA may appoint an Advisory Committee to complete the work of the NRPM, keeping true to the spirit of what the committee proposed. Most significantly we firmly believe that the well-being of the wide array of people and providers affected by the decisions made by this committee, as well as taxpayers, can best be preserved and enhanced with due diligence to the concerns raised in this Minority Report, and that this will in the end lead to stronger support of the Final Rule proposed by the Secretary.

Minority Report respectfully presented and supported by:

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