

May 23, 2008

Elizabeth M. Duke, Ph.D.
Administrator
Health Resources and Services Administration
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: (HHS_FRDOC_0001-0007) Proposed Rule: Designation of Medically Underserved Populations and Health Professional Shortage Areas: Proposed Rule

Dear Dr. Duke:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Health Resources and Services Administration's (HRSA) proposed rule, "Designation of Medically Underserved Populations and Health Professional Shortage Areas." HRSA's proposal to revise and consolidate the criteria and process for designating medically underserved areas and populations (MUA/P) and health professional shortage areas (HPSA) will have a significant impact on the providers and programs that depend on these designations for federal funding and the communities they serve.

Underservice designation is used to prioritize the distribution of federal and state funds to provider shortage areas. In fact, more than 34 federal programs use these shortage designations for eligibility and funding criteria. In fiscal year 2005, almost \$3 billion in federal funds were distributed through programs that use the HPSA or MUA/P system to determine eligibility (GAO-07-84). In addition, designation as a MUA/P is critical for the receipt of community and rural health center grants, as well as cost based reimbursement for federally-qualified health center "look-alikes" and rural health centers.

In the proposed rule, HRSA recommends revising the methodology to determine the level of underservice to a single "index of primary care underservice." HRSA wants to:



- consolidate the procedures for making designations;
- simplify the system for facilities seeking designations; and
- use scientifically based criteria to minimize any disruption in the current designated underservice areas.

The proposed new method encompasses designations for geographic HPSA, population MUP and safety-net facility HPSA.

The new approach identifies geographic HPSA and population MUP designations using two tiers of shortage. Tier-1 designations are given to areas, populations and facilities that exceed the population-to-provider ratio threshold of 3,000:1 with all primary care clinicians counted. Tier-2 designations are given to areas and populations that exceed the threshold only when federally-sponsored primary care clinicians serving community health centers or National Health Service Corps areas are excluded from the calculation.

HRSA also proposes a new designation for safety-net facility HPSA which serve at least a certain percentage of Medicaid and uninsured patients. It is granted to health centers as long as 40 percent of their patients are Medicaid-eligible and uninsured in metropolitan areas; 30 percent in non-metropolitan, non-frontier areas; or 20 percent of all patients in frontier areas. The designation criteria also require that the uninsured account for at least 10 percent of patients.

The AHA has concerns regarding HRSA's proposed changes and the data used to analyze the impact of these changes. First, it is impossible to determine with any certainty what designation or funding level a health center, clinic, population or area will receive under the index of primary care underservice. Second, the rule's analysis uses nearly 10-year old data from 1999. Finally, the analytical model HRSA developed to assess the potential impact of these proposed changes has not been widely distributed – making it difficult for communities and facilities to adequately assess the impact of the proposed rule.

The Geiger Gibson/RCHN Community Health Foundation, in collaboration with The George Washington University, attempted to replicate HRSA's analysis using more current data from 2005. The groups' April report concluded that fewer health shortage areas and health centers will receive the designation of serving an underserved area or population, or facility-level designation. Further, the report finds that HRSA's new methodology would jeopardize the designation status of one in four urban areas and one in six rural and frontier areas. These findings clearly demonstrate that the proposed rule will have a more significant adverse impact than HRSA suggests.

The proposed rule's new "safety-net facility" designation for organizations serving high-need populations is intended to rank these facilities' "need" equitably with the designations scored in the other methods outlined in the proposed rule. However, the AHA is concerned that the "safety-net facility" designation cannot be modeled nor the impact measured. HRSA should test and refine this approach before moving forward with this policy change.

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The proposed rule sets strict timelines for review and notification of designation. It also encourages state and local government to increase their role in defining service areas, underserved populations groups and unique local conditions. Specifically, states are urged to define rational service areas used to designate underservice and shortage areas and be involved with identifying safety-net-facility primary care HPSAs and MUPs. Interaction with states and localities is important to achieving fair and equitable designations and may ameliorate the adverse impact of the proposed index. However, HRSA has not adequately assessed the added burden to states and local governments in meeting these new responsibilities.

On a more technical note, HRSA fails to exclude certain physicians when counting primary care physicians and determining an area's adjusted population-to-primary care clinician ratio for designation as a Tier-2 shortage area. The following physicians also should be excluded from HRSA's count: primary care clinicians working in rural health centers and federally-qualified health center look-alikes, members of the National Health Service Corps, physicians practicing under a J-1 visa waiver, and primary care clinicians who are providing services at a health center receiving a grant under Section 330 of the *Public Health Services Act*.

While HRSA proposes to phase-in the new methodology and provide automatic HPSA designation for at least six years for select entities, it falls short in its analysis of the impact of these proposed changes. **Therefore, the AHA urges HRSA to withdraw the proposed rule for further field testing and analysis and invite stakeholders to assist the agency in its goal to improve the designation process for HPSAs and MUA/Ps.**

If you have any questions about these comments, please feel free to contact me or John Supplitt, senior director for constituency sections, at (312) 422-3306 or jsupplitt@aha.org.

Sincerely,

Rick Pollack
Executive Vice President