NRM Committee Recommends

NEW CRITERIA AND METHODOLOGIES

for Designating Medically Underserved Areas and Health Professional Shortage Areas

By Dan Hawkins

After more than a year of meetings, the Negotiated Rulemaking (NRM) Committee established under the Affordable Care Act (ACA) concluded its efforts this October to develop new methodologies for designations of Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUAs/Ps). Although the Committee's 28 appointed members were unable to reach the desired full consensus on proposed new methodologies for both HPSA and MUA/P designations, the Committee nevertheless gave overwhelming approval to recommendations for a new process, criteria, and methodologies for designating MUAs, MUPs, and HPSAs.

The work of the NRM Committee covered the following designations: geographic, population, and facility primary care HPSAs; MUAs; MUPs; and Governor-requested-Secretary-certified exceptional underserved designations.

I was proud to represent NACHC on the Committee and was joined by several others representing health centers and primary care associations, including: Tess Kuenning, Director of the Bi-state (NH/VT) Primary Care Association; Jose Camacho, Director of the Texas Association of Community Health Centers; Beth Geisting, then Director of the Hawaii Primary Care Association; and Sherry Hirota, Director of Asian Health Services in Oakland, CA.

All of us voted with the majority as the final report of the Committee to HHS Secretary Kathleen Sebelius was approved by a vote of 21-2 (with five members not present). However, because full consensus was not achieved, the report will only provide guidance to the Secretary and HRSA in developing a new rule for the HPSA and MUA/P designations, and will not bind her to follow the Committee's recommendations. The hope is that, in developing the new rule, the recommendations of the majority will guide HRSA so that the rule developed will capture the will of the majority, if not the whole, of the Committee. (Note: A summary of the Committee's final recommendations can be found at: www.nachc.com/regulatory-issues.cfm.)

Of particular importance to health centers, the proposed methodology maintains the existing automatic HPSA designation

for Federally Qualified Health Centers (FQHCs) and certain Rural Health Clinics (RHCs). It also creates a new "Facility HPSA-Dependent MUP Designation," which would apply to a facility that loses its previous MUA/P designations under the new methodology and that:

- Meets the criteria for a safety-net facility HPSA (defined as serving a certain percentage of low-income – or publicly-insured and uninsured – populations); AND

- Is a health center that was either (i) funded under Section 330 and continues to comply, or (ii) certified as a FQHC Look-Alike because it was located in or served a designated MUA/P, but whose MUA/P would no longer qualify for designation under the new methodology.

Also, for both HPSA and MUA/P designations, the counts of available primary care workforce in an area/population WILL include Nurse Practioners, Physician Assistants and Certified Nurse Midwives weighted at .75 FTE, but will NOT include NHSC-assigned, state Loan Repayment, or J-I visa waiver providers, nor will they include providers working at FQHCs, RHCs, or at Government, Military, or Veterans Affairs facilities.

While some members disagreed with this recommendation, questioning the need to "back-out" these providers, the overwhelming majority (18-3) of the Committee was concerned that including these providers could result in a "yo-yo" effect, under which an area that is designated is assigned resources (grants or NHSC placements), who are then counted and result in the loss of the designation, once again making the area once again eligible for designation.

Importantly, the Committee's final recommendations reflect the understanding 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 HRSA, consistent with the manner in which such decisions have been made for the past 35 years.

In this respect, the Committee's view was that 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.

That issue assumed great importance in the selection of a designation threshold for MUAs and MUPs. 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 threshold under which areas containing one-third of the U.S. 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 (set at the median score for all counties). This decision is supported by a host of recent studies and reports that underscore the appropriateness of that 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.
- Latest Census figures document that more than a third of the U.S. population is low income (below twice the federal poverty line), with racial/ethnic disparities widening. More than 1 in 5 children – and more than 1 in 3 minority children – lives in poverty (at or below the federal poverty line).
- 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.
- 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.

In the Committee's view, it is clear that the one-third threshold for MUA and MUP designations, which was supported by an overwhelming majority of the Committee, is appropriate – it is evidence-based, easy to explain, and reasonable given the purpose of designation and the data available.

HHS Secretary Sebelius is expected to take the Committee's report and its recommendations into consideration in developing an Interim Final Rule setting forth the new MUA/P and HPSA designation methodologies sometime next spring. The new rule will be effective immediately, but public comments will be invited, with the possible result that the methodologies may be revised based on the comments received. NACHC will closely follow and keep its members apprised of developments in this regard.