May 8, 2008

Honorable Michael O. Leavitt
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: *Designation of Medically Underserved Populations and Health Professional Shortage Areas; Proposed Rule Change*

Dear Secretary Leavitt:

On behalf of organizations listed below, we would like to provide the following comments on the proposed rule, *Designation of Medically Underserved Populations and Health Professional Shortage Areas,* which was released on February 29, 2008. We appreciate the extension of the comment period until May 29.

In the proposed rule, the Health Resources and Services Administration (HRSA) would change how the agency designated Medically Underserved Areas and Populations (MUA/Ps) and Health Professional Shortage Areas (HPSA). Specifically, the rule is a major attempt to revise and consolidate the process for making these designations. It follows a failed proposal in 1998, attempts to correct problems in the current designation process and address perceived shortcomings of the earlier approach. As you know, in 1998, HRSA received 800 public comments on the proposal, principally citing concern over the negative impact on existing safety net programs. As a result, the agency withdrew the rule to perform further testing and revision. In our view, the proposed rule is both unnecessarily complicated and is ambiguous regarding its effects on medically underserved areas. Consequently, our recommendation is that you withdraw the rule.

Background

Currently, a geographic area can be designated as a primary care HPSA if it 1) is a rational service area (RSA) for the delivery of primary care, 2) has less than one primary care physician (PCP) per 3,500 people, or less than PCP per 3000 people with unusually high needs for primary care services or insufficient capacity of nearby providers, and 3) its contiguous areas are overutilized or too distant to meet local needs. Roughly 24 percent of US counties are RSAs that currently qualify for whole-county HPSA status, but smaller qualifying RSAs (homogenous neighborhoods, communities or population clusters) are found in an additional 40 percent of US counties.

Medically Underserved Areas are geographic areas (contiguous county areas or smaller) that reach a certain score or lower on the Index of Medical Underservice (IMU), which is a summary of weighted values for four characteristics of these areas: 1) the ratio of primary medical care physicians per 1,000 population, 2) infant mortality rate, 3) percentage of the population with incomes below the poverty level, and 4) percentage of the population age 65 or over. The same criteria can be applied to underserved population groups within an area of residence to declare a Medically Underserved Population (MUP). There are approximately 1,435 whole county MUAs and 1,090 counties with subcounty MUA or MUP designations.

According to information in the Federal Register, the goals of the proposed rule are the following:

- To establish a uniform HPSA and MUA designation process and criteria.
- To enable greater universal application by using national data, thus reducing the need for independent data collection (state/local data and population group data can be submitted if national data does not result in designation).
- To automate the scoring process, thus minimizing state and local efforts in gathering data and updating designations.
- To expand the state role in defining rational service areas and identifying underserved populations and unusual local conditions.
- To reduce the need for population group designations, which typically are more resource-intensive, by adjusting an area's base ratio, which should increase the designation of areas with concentrations of underserved populations.

Concerns with the Proposed Rule

Despite the stated goals of the proposed rule, we are concerned that as formulated, it will have a significant impact on access to health care and primary care providers in this country. More importantly, however, it is entirely unclear which medically underserved areas will be affected, positively or negatively, and yet the effect on primary care physicians and on state and federal programs would be enormous.

More than 34 federal programs depend on these shortage designations for eligibility and funding preference purposes. For example, the Medicare Provider Incentive Payments are made to physician practices in HPSAs and physician loan repayment programs are dependent on service in HPSAs. The rule does not specify how these programs administered by the department or agency will be affected.

According to a preliminary analysis by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care (attached to this letter), approximately 600 HPSAs, containing nearly 32,000 primary care physicians and 32 million people, could lose designation under the rule, jeopardizing access to care for underserved people. It also could de-designate more than 900 MUAs, which contain 38,000 primary care physicians and 31 million people. We believe that it may have negative consequences for more than 10,000 family physicians who practice in HPSAs and MUAs, which may be de-designated in the proposed rule. We would expect a similar situation affecting general internists as well. In addition, however, under some scenarios, a handful of states may benefit in some ways from the rule change. Nonetheless, the lack of transparency about the process and data to be used make it uncertain what the rule would do.

In addition, other organizations have tried to analyze the proposed rule and have found it highly confusing and indeterminate. Specifically, a report from the School of Public Health and Health Services at George Washington University estimates preliminarily that urban areas and northeastern and northwestern states would be particularly hard hit. Specifically, the School has found that under the proposed rule, fewer areas and health centers would receive designation of underservice. As the School points out in its analysis, the loss of MUA/P and HPSA designation may have broad implications for the nation's health care safety net. Additionally, it may be that HRSA s using the HPSA redefinition to shift certain types of poverty to benefit different regions.

Recommendations

At a time when the health care safety net is severely frayed and the shortage of primary care physicians has been growing concern, as documented most recently by the Government Accountability Office, we believe it is unreasonable for HRSA to hurriedly push this revision without more extensive consideration of its effects and the impact on patient care in this country.

We recommend strongly that HRSA withdraw the proposed rule, and suspend updating current HPSAs and MUAs. The Agency should use this time to more extensively examine the implications of this change on patient access to primary care services in consultation with family physicians, general internists, community health centers and others and determine a method of designation that is not detrimental to patients, physicians, and other health care services.

Sincerely,

Rick Kellerman, MD, FAAFP
Board Chair
American Academy of Family Physicians

Scott Fields, MD
President
Society of Teachers of Family Medicine

Mark Robinson, MD
President
Association of Family Medicine Residency Directors

Allen Dietrich, MD
President
North American Primary Care Research Group

Michael K. Magill, MD
President
Association of Departments of Family Medicine

David C. Dale, MD, FACP
President
American College of Physicians

Lil Anderson
Board Chair
National Association of Community Health Centers

CC: Health Resources and Service Administration
Department of Health and Human Services
Attention: Capt. Andy Jordan
8C-26 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857