

The Negotiated Rulemaking Committee (NRMC) on the Designation of Medically Underserved Populations and Health Professional Shortage Areas

Summary of Recommendations

November 1, 2011

The Negotiated Rulemaking Committee (NRMC) on the Designation of Medically Underserved Populations (MUPs) and Health Professional Shortage Areas (HPSAs) was appointed in July 2010. The Committee was established pursuant to the Affordable Care Act (ACA) of 2010 to consider and develop new methodologies for designating medically underserved communities and those with shortages of primary care health professional. On October 13, 2011, after 14 months of work, including review and assessment of extensive data, analyses and research, the NRMC voted 21 to 2 (with 5 members absent) to endorse their full package of recommendations. A final report describing those recommendations was submitted to the Secretary of Health and Human Services on October 31, 2011.

The Committee is confident that its recommendations and supporting documentation will lead to significantly improved methodologies for identifying underserved communities and those in need of additional primary care providers. The Committee urges that those recommendations for which complete consensus was reached be implemented by the Secretary as recommended, and that the Secretary seriously consider the other recommendations, all of which were overwhelmingly endorsed by the Committee.

Rational Service Areas (RSAs)

- All geographic HPSAs and MUAs must be rational service areas (RSAs). Population group HPSAs and MUPs must also generally be defined within RSAs applicable to the population group.
- An RSA is defined as meeting the following criteria:
 - Composed of discrete geographic basis areas (i.e. CTs, MCDs, ZCTAs, counties, or PCSAs);
 - Are continuous (no “holes” or other spaces between component areas);
 - Different parts of the RSA must be interrelated (demographically or otherwise); and
 - Must be distinct from adjacent contiguous areas.
- The threshold ratio indicating over-utilization for the contiguous area is defined as 80% of optimal provider capacity (2000:1).

Population to Practitioner Ratio (P2P)

These recommendations on how to count and calculate the P2P ratio would apply to all designation categories, including geographic and population HPSAs, MUAs, MUPs, and facility designations.

- Primary care physicians (MDs and DOs) included shall be family physicians, general internists, pediatricians, geriatricians and adolescent medicine physicians at 1.0 full-time equivalent (FTE) for those working full time.

- Hospitalists (providing inpatient care) shall be excluded.
- Obstetric/gynecological (OB/GYN) physicians working full time shall be counted as 0.25 FTE for those working full time due to time spent in surgery and hospital based follow up.
- Nurse practitioners (NPs), physician assistants (PAs) and certified nurse midwives (CNMs) working with primary care physicians or in independent practice of primary care shall be counted at 0.75 FTE for those working full time. This 0.75 relative weight for shortage designation purposes only, is based on productivity studies and does not represent the general or relative value of NPs, PAs and CNMs.
- PAs specializing in OB/GYN will be counted as .25 FTE
- The following practitioners will be excluded or “backed out” from counts of local resources:
 - National Health Service Corps (NHSC) scholars and loan repayment recipients;
 - J-1 visa waiver physicians;
 - Federal/State Loan Repayment Program (SLRP) recipients (jointly funded by Federal and state funds);
 - Providers who work at HRSA grant-funded (Section 330) health centers;
 - FQHC look-alike providers;
 - Providers at hospital-based or independent RHCs that accept patients regardless of ability to pay;
 - Practitioners with a state or local time limited service obligation;
 - Indian Health Service (HIS) physicians with scholarship or loan repayment obligations; and
 - Provider time spent working exclusively for Governmental facilities, VA facilities, corporate health facilities and correctional institutions. This is a continuation of current practice.
- The Committee recommends continuing the current practice of counting the population based on the resident civilian count in an area, adjusting for utilization by age and gender, counting transient populations (with certain tourist adjustments), and excluding institutionalized individuals in geographic area and population group designations, although such populations are counted for the purposes of some facility HPSA designations.

Medically Underserved Areas (MUAs)

- The Committee recommends that new indicators be used for each of the four statutory components for determining eligibility as an MUA:
 - ***Health status***: A combination of standardized mortality rate (SMR, at 50%) and the greater of either low birth weight (LBW) or diabetes prevalence (at 50%);
 - ***Availability of health professionals***: The P2P ratio as described above;
 - ***Access barriers to care***: Communities will have the flexibility to select two of following five possible barriers:
 - population density of the area (whether urban or rural), or the travel time from a frontier or other rural area to the border of the nearest urbanized service area;

- percent of the population with limited English proficiency (LEP) or with Hispanic ethnicity;
 - percent of the population that is of a non-white racial group (as defined by the Census);
 - percent of the population with a physical, sensory, cognitive, or developmental disability; and
 - percent of the population that is both uninsured and has incomes at or below 400% of the Federal Poverty level.
- **Ability to pay:** The percentage of individuals at or below 200% of the Federal Poverty Level will be used.
- The Committee considered a wide variety of possible relative weightings for the four components, including equal weighting, and conducted impact tests of many possible approaches. Ultimately, the Committee selected a weighting of 20% for health status, 15% for availability, 20% for access barriers, and 45% for ability-to-pay.
- The Committee recommends that the threshold for MUA designation be set so as to cover the worst scoring one-third (33%) of the U.S. population.

Medically Underserved Population (MUP)

The Committee expects that population groups to be considered for MUP and population-group HPSA designation would include groups identified in *Healthy People 2020* including, but not limited to, the following:

- Low income and Medicaid populations;
- Individuals with low English proficiency (LEP);
- People with HIV infection;
- People with physical, sensory, cognitive, or developmental disabilities;
- Native Hawaiians;
- Lesbian, gay, bisexual and transgender (LGBT) populations; and
- Immigrants and refugees.

The Committee has defined the content for the four statutory components determining eligibility as an MUP to be similar to that of the MUA, except that applicants must submit data specific to the population group rather than for the area within which the population group resides, to the extent possible. Unique local, state, or tribal data may be submitted in the event that data from a nationally recognized data source is unavailable.

- **Health status:** In general, the health status components identified for MUAs will be used for MUPs as well. However, applicants have the opportunity of submitting up to two other available direct measures of health status for the MUA indicators, if the available data on the latter does not reflect the significant health disparities of the population group requested to be designated.
- **Availability of health professionals:** The P2P method for a MUA will be used counting only those providers servicing the population group seeking designation. In addition to the general back-outs for providers, population-specific designations will also back out

clinicians supported by other HRSA programs to target primary care to underserved populations will be backed out, where appropriate (e.g., providers of Ryan-White services for HIV/AIDS populations).

- ***Access barriers to care:*** The method to determine accessibility of care will be similar to that used for an MUA, i.e. the applicant can choose from the five alternative barriers listed for MUA. *Alternatively, MUP applicants may substitute a population group specific local barrier for which local data are available as one of the two barrier choices. (These data would need to be sourced and reviewed by HRSA-OSD to determine applicability.)*
- ***Ability to pay:*** The ability to pay method defined for n MUAs will be used.
- The Committee decided that the relative weighting for the four statutory components should be different for MUPs than for MUAs. Access barriers are frequently cited as the most significant issues affecting primary care access for specific population groups. The weighting ultimately selected was 40% for access barriers and 20% for each of the other components.
- A streamlined MUP process is included for legislatively recognized special populations such as American Indian/Alaskan Natives, Migrant and Seasonal Farm Workers (MSFWs), homeless, and public housing residents. These groups need only to identify the service area involved and perform a local population count for designation.
- The Committee recommends a threshold for MUP designation that parallels the MUA threshold; that is a threshold score which would designate the third of the population with the highest need. Because of time constraints, the Committee requested that HRSA determine the threshold score that represents 33% of the population.

Geographic HPSA

- Applicants are eligible for a geographic HPSA if their P2P exceeds 3000:1 or falls between 3000:1 and 1500:1.
 - Applicants demonstrating P2P above the 3000:1 threshold will be designated without consideration of additional data.
 - Applicants with P2P falling between the two P2P thresholds will be scored on an index of SMR and the percentage of the population with income at or below 200% of the Federal Poverty level.
 - A curved threshold function has been selected for use between the two P2P thresholds so that, as the supply of practitioners improves, the weight given to health status (SMR) and low income measures will increase, allowing designation of areas that would not qualify on P2P ratio alone.
- Frontier areas will have one P2P threshold of 1500:1 for designation, without the need for consideration of additional data or indicators. This reflects lower levels of primary care practitioner productivity in very sparsely populated areas.

Population Group HPSA

- Population groups listed in the MUP section above and/or others could be considered for population group HPSA designation.
- The methodology for designation of a population group HPSA would mirror that of a geographic HPSA but will utilize data specific to the applicant population.
- Data should be from available national data sets, or, if unavailable, unique local data can be substituted if the data set meets HRSA standards.
- The population group HPSA thresholds will set at a point 15% lower than the geographic HPSA consistent with current practice (Upper 2550:1; Lower 1250:1).
 - Special population groups with P2P ratios above 2550:1 would be designated without having to submit data on non-P2P indicators.
 - Population groups with ratios between 1250:1 and 2550:1 would need to submit data on SMR and percent pop with incomes below 200% of poverty
- A streamlined population group HPSA process is included for recognized special populations: American Indian/Alaskan Natives, MSFWs, homeless and public housing residents. These groups need only to identify the service area involved and perform a local population count of the special population for designation.

Facility HPSA

- Public or Non-profit Private facilities not located in designated geographic HPSAs will be permitted to apply for facility designations provided that they can demonstrate:
 - Service to existing designated areas or population groups (e.g. applicants can demonstrate that significant numbers of patients come from nearby HPSAs).
 - Insufficient capacity at the facility to adequately serve the area or pop group HPSA.
- New types of facility HPSA designations were developed including:
 - ***Magnet clinic***: more than 50% of encounters are provided by primary care clinicians to one or two specific population groups which may include, but are not limited, to those listed in the MUP section
 - ***Safety net providers***: facilities delivering significant percentages of their primary care services to:
 - low-income individuals;
 - those who are uninsured, or have Medicaid or SCHIP coverage;
 - American Indians or Alaskan Natives receiving services through either the Indian Health Services or Tribal health programs.
 - ***Essential primary care providers in a community***: Facilities located in an RSA providing primary care services to at least 70% of the population of that RSA including underserved and uninsured populations.

- ***Correctional Facilities:*** All security levels of Federal and State correctional institutions and youth detention facilities will be eligible to apply for designation as a facility HPSAs upon meeting the following criteria:
 - The facility houses at least 200 internees, *or*
 - The facility is designed to incarcerate specific categories of individuals, and the ratio of the number of internees to primary care providers serving the institution is at least 1000:1.
 - The Committee recommends that eligibility be expanded to include county jails as applicants.

- A ***new MUP designation*** has been developed for populations served by certain facility HPSAs:
 - Magnet facility HPSAs: The facility serves population groups such as HIV/AIDS or LGBT populations that come from a wide area, due to the expertise and/or culturally-sensitive care provided at the facility to the pop group involved. Such facilities must comply with the FQHC requirements in Medicaid/Medicare statutes, *or* the facility must have been previously funded as a health center.
 - Safety net facility HPSAs: This could include facilities previously funded as health centers *or* were certified as an FQHC federally qualified health center under section 1905(1)(2)(B) of the Social Security Act and which no longer qualify for MUA/P designation.

Exceptional Medically Underserved Population (EMUP)

- The Committee recommends that HRSA continue the current requirements for EMUP applications and recommends certain revised guidelines for them. The Committee also recommends that EMUPs be updated at least every 5 years.

Implementation

- The Committee recommends that HRSA continue requiring PCOs to coordinate the processing of designation applications from their states to HRSA, and that HRSA and the PCOs re-evaluate 25% of the existing HPSA and MUA/P designations each year over a four year period starting with the oldest first.
- Urgent Requests: The Committee recommends that if a clinician dies, retires, or leaves an area that is not already designated as HPSA or MUA/P with no or limited notice, causing a sudden and dramatic change in primary medical care services available to that area’s population, PCOs be allowed to submit an urgent request to the Secretary for immediate evaluation (within 30 days of receipt) of the affected community for designation as a HPSA or MUA/P. Such urgent requests would be limited to no more than five percent per year of the total number of designations in the State.

Other Recommendations

- The Committee recommends requiring the use of five-year American Community Survey (ACS) estimates [where this data source is utilized] as part of the process of determining eligibility for HPSA and MUA/P designation.

- The Committee recommends that HRSA convene and work with a technical advisory committee before the Rule is implemented to address several outstanding methodological questions.
- Federal programs that use these designations should ensure that additional program requirements and processes further target new resources to the areas and populations of greatest need. The designation methodology itself, which identifies relative need, provides data elements which may be of assistance in such targeting.
- The Committee recommends that HRSA consider reviewing HPSA and MUA/P scaling and data every five years with a full review of the entire HPSA and MUA/P designation process every ten years.