

Maine Primary Care Association
Summary of Comments Concerning The Proposed Designation Process for HPSA / MUP

Upon analysis by the Maine Primary Care Association and the Office of Rural Health and Primary Care, with the support of JSI, Inc., it appears that no FQHC in Maine would lose its underlying HPSA/MUP designation status under the new proposed rule making (NPRM). However, how the designations will be used, as well as some of the considerations behind the designations deserve comment. The comment period for the NPRM extends through 5/29/2008.

Currently all FQHCs in Maine are located in an MUA/MUP. All are also designated HPSAs – either due to a geographic designation or by virtue of the automatic designations created in 2002. Among the 18 FQHC grantees in Maine, there are currently (at least) 50 geographic locations of care. (Locations are considered to be minor civil divisions as distinct from “sites” which can overlap within an existing minor civil division.) Among these 50 locations, 17 are currently designated as geographic or population HPSAs (already discounting for the couple of locations identified for proposed withdrawal).

Applying the methodology to the best available local information (through the combined work of the ORHPC, JSI and MPCA), we find that among these 50 locations there are expected to be:

- Two (2) Tier 1 geographic HPSAs
- Twenty one (21) Tier 2 geographic HPSAs
- Seventeen (17) Tier 1 population HPSAs
- Seventeen (17) Tier 2 population HPSAs
- Three (3) Tier 1 MUAs
- Five (5) Tier 1 MUPs
- Thirteen (13) Tier 2 MUAs
- Thirteen (13) Tier 2 MUPs
- Fifteen (15) Facility level designations

Of the 18 FQHCs, the cascade of designations appears as follows:

- 44% are expected to have a Tier 1 population HPSA designation;
- 17% are expected to have a Tier 2 geographic HPSA or MUA designation; and
- 39% are expected to have a safety net facility designation only.

In general, the analysis of the proposed rule is that there are aspects of it that make it possible to preserve, and likely expand, designated areas and covered areas of Maine. The primary care analysis areas of Gorham, Jay, Kingfield, Gardiner, Dexter, Corinth, Old Town, Bucksport and Mars Hill – all of which are either currently not designated or proposed for withdrawal – are all expected to *gain* designation under the NPRM, most as Tier 2 geographic HPSAs. Only two PCAAs would lose designation status: Jackman and Ashland.

With this overall review of the anticipated impact of the NPRM, there are a number of questions and concerns with the rule that the Maine Primary Care Association advances for consideration.

They are addressed in these topic areas:

1. Impact of Tier 1 v. Tier 2 v. Safety Net Facility Designation
2. Meaning and value of Facility Level Designation
3. Methodology for Calculating the Score

Impact of Tier 1 v. Tier 2 v. Safety Net Facility Designation:

The Guidance says: “Both types of designations would be eligible for federal programs authorized to place resources in MUPs or HPSAs. *However, Tier 2 areas would typically be eligible only to maintain the approximate levels of federal resources already deployed, while Tier 1 areas could apply for additional resources.*” Federal Register, vol. 73, No. 41, p. 11247
This is of utmost concern to the safety net which is already saddled with significant clinical staff vacancies. Among the best recruitment tools available to safety net facilities is access to NHSC scholar placements and loan repayment. It would seem from the rules as stated that neither NHSC scholar placements nor loan repayment options would be available to FQHCs that are designated as Tier 2.

After the release of the NPRM, HRSA issued an update (released on 4/21/08) stating that “The proposed rule includes three methods for making funding eligibility designations - Tier 1, Tier 2, and Safety Net Facility. The proposed rule gives none of these three designations an advantage in determining eligibility for current, new or expanded health center funds. Entities designated under any of the three methods will be equally eligible to compete for new or expanded health center funds. *Similarly, all entities under the three designations will be equally eligible to compete for National Health Service Corps (NHSC) placements.*” [emphasis added]

There is a clear contradiction between the proposed rules as they appear in the Federal Register and the subsequent statement broadcast to health center grantees on April 21st. MPCA urges HRSA to follow through on its commitment to place all three types of designation: Tier 1, Tier 2 and Safety Net Facility on equal footing in the determination of resource allocation – both 330 funding and NHSC resources alike.

In addition, MPCA would like to see:

- Exclusion of Rural Health Clinic Providers in Tier 2: The proposed rule does not permit Rural Health Clinic providers that are certified by CMS and currently eligible as NHSC placement sites to be excluded from the Tier 2 FTE calculation (p. 11276). This will prove problematic for areas that rely on this program for designation. This class of provider should be included to the extent that they are CMS certified and provide a sliding fee scale for all patients below 200% FPL.
- Use a Single Exclusion Category for Tier 2: On a 4/3/08 technical assistance call, it was indicated that the federally-linked provider count would be reported separately for each program-class of provider (ie. NHSC providers separate from FQHC providers, etc), with the idea that different programs could selectively back out different groups of linked providers. While the goal of such flexibility is understandable, the practical implications of such an approach will be cumbersome to implement and communicate to communities and providers seeking assistance. Rather than a designation simply being a Tier 1 or 2, this approach would give a different tier for each program category. Also, any given provider may be covered by a combination of programs (NHSC and J-1 providers can work at FQHC's) making the reporting of FTE in this way impossible to add to obtain an overall count.

Meaning and value of Facility Level Designation

Beyond placing Safety Net Facility designation on an equal footing with other designation types, there must also be a methodology for arriving at a Facility Level Designation Score. As stated in the NPRM: “This new method will result in a measure of the degree of underservice, not just a yes/no answer. The resulting “SCORE” will serve to rank the areas in terms of greatest need, as required by the NHSC and also used for some other programs. This replaces the current two step designation and then scoring process, which has caused much confusion and anxiety as scores have become more important in targeting limited resources.” Accordingly, the Safety Net Facility Level Designation also needs a scoring methodology that is derived on a consistent scale with the other designation types. More specifically, the proposed rules should:

- Modify Safety-Net Facility Designation Criteria (Part 5-j, p. 11251): The criteria governing eligibility for Safety-Net facility designation status are not applicable in areas where the FQHC represents the major provider in the community. Any grantee that can show that they serve more than 2/3 of the population in their immediate area should, by definition, be considered a safety net provider. This information is readily accessible via the UDS service area analysis of users by zip code. Two FQHCs in Maine failed this test for safety net facility designation even though they serve virtually all of the population in their immediate area. While both FQHCs retain designation as Tier 2 geographic HPSAs and Tier 1 population HPSAs, there are other instances where the safety net facility designation screen is the only designation available. Otherwise, should demographic swings occur, a designation could be lost regardless of whether the facility is the major or even only provider for that community.
- Clarify the ‘AND/OR’ Criteria for Facility Designation (p. 11251): The ability to designate facilities as ‘safety net’ MUPs state two potential criteria for meeting the requirement - 10% on Sliding Fee or 20-40% on Medicaid and Sliding Fee combined. It is not clearly indicated if the facility must meet either of these criteria or both of these criteria. We suggest the rule should be modified to interpret the logic for this designation as ‘OR’ rather than ‘AND’.
- Clarify Role of UDS in Safety Net Facility Designations: The ‘safety net’ facility MUP states that documentation of patient insurance status must be presented. Will the latest UDS report submitted by CHC grantees and/or by NHSC provider sites be considered documentation for this purpose? The caveat to this question is that these reports count ‘Uninsured/Self Pay’ patients, *but does not make a distinction between those that qualify for sliding fee discounts as a subset of that group*. Maine’s FQHC patient population is categorized by a high percentage of working poor, often with some form of high-deductible insurance. For this population that is effectively uninsured for primary care, the sliding fee for primary care services reduces the economic barrier to care. Please also clarify if these will be considered equivalent terms for designation purposes.
- Clarify What Tier Safety Net Facility Designations Be Considered To Be In: It is not clear if all Safety Net Facilities will be required to also designate as a Tier 1 shortage area in order to apply for additional resources. It will, for example, be necessary for these facilities to replace lost NHSC providers and fill open vacancies that exist, as well as request new resources to meet changing community needs.

- Clarify Unit of Safety Net Facility Designation: Will the Safety Net Facility HPSA be done at the organization level – covering all service delivery sites, or will separate designations be required for each site within an existing FQHC. It should be noted that payor mix data is not readily available at the site level for many FQHCs.

Methodology for Calculating the Score

Given HRSA’s statement that Tier 2 designations will be given full and equitable consideration for NHSC resources that are consistent with Tier 1 designations (4/21/08 email to grantees), then there needs to be a new process for identifying scores for Tier 2 designations that back out all area providers because all area providers are federally supported. In this instance, which occurs in 8 of 22 HPSAs and 4 of 42 MUAs/MUPs, the score is otherwise infinite and defies ranking amongst themselves, let alone a process for allocating resources between those infinite scores and others. In short, how will the new system rank ratios with a Tier 2 denominator of zero?

More generally, several of the most ‘beneficial’ factors seem to be based on calculations and logic that distort the underlying analysis of need, and may actually be flaws in the application of the intended policy principles. Moreover, we have concern that seemingly small ‘technical’ corrections to these issues may dramatically change the impact assessment. We strongly suggest, therefore, that any change in the following 3 aspects of the rule be accompanied by a new opportunity to assess impact through a new proposed rulemaking process before a final rule is published:

- a) The calculation of the Barrier Free population (Step 1), which currently produces an across-the-board increase in the population used in the ratio for all areas.
- b) The ability to apply sub-population specific rates to the Step 4 High Need score calculation, which currently greatly reduces the effective threshold for designation, particularly for a Low Income population group.
- c) The application of High Need scores which currently lower the effective threshold for designation, even for communities with the most ‘positive’ demographics.

We also point out a range of other areas where the rule should be clarified to more explicitly delineate the policy intent. Also, there are a number of areas where we feel that alternative methods or additional factors should be considered to account for specific situations that are not adequately captured in the proposed rule as it is written. Specific comments are as follows:

- Clarify Relationship of New Designations to Existing Categories: The rule states that the Index of Primary Care Underservice ‘will replace the existing MUP and HPSA criteria and procedures, while maintaining the two separate designations in order to meet the legislative requirements of the relevant statutes.’ It is not clear if this means that any area or organization designated under these proposed rules will now have BOTH an MUA and a HPSA designation for program participation purposes. In particular, with respect to Subpart D – Designation of facilities as ‘safety-net’ HPSAs... will existing FQHCs that provide the required level of service to the low income population continue to be considered to have an MUA/P designation necessary to maintain their grant funding? Section V-I (p.11251) seems to indicate that there is a new MUP category for the patients of safety net

facilities designated as primary care HPSAs.... Will this require a separate designation process for the MUP using the proposed sub-population rules or will qualifying the facility suffice directly for participation in the FQHC program?

- Extend Transition Period for New Rules: Regarding the Health Care Safety Net Amendments of 2002, the rules note that the Automatic HPSA status will extend for ‘*at least 6 years*’ and give organizations a legislatively required ‘smooth transition period.... to allow plenty of time to adapt to the new designation criteria’ (p. 11234). This ‘minimum’ 6-year transition period should be extended to account for the lengthy delay in releasing these new criteria. Without such a period, the automatic designation will expire just as the new criteria are released, which seems to violate the legislative intent of the ‘grace’ period.
- Clarify and Reconsider Process for Population-Based Designations: We have many concerns regarding the stated intent to “Reduce the Need for Population Group Designations” (p. 11236). While the proposed rule does seem to maintain the option for using such an approach, it is unclear how the proposed rules will be adopted for ‘sub-population’ purposes, and there seems to be an intent to do away with such designations over time. Specific concerns are as follows:
 - Without using a low-income approach, the proposed rule essentially ignores the critical question of access for the low income population. Based on the general method, two communities with similar demographic profiles and overall provider:population ratios would score the same even if one community had no providers willing to see Medicaid or Sliding Fee patients, while the other had many providers willing to do so. It is often the case in our region that there are many providers in an area, yet the low income residents continue to experience severe and persistent issues accessing care. The majority of our designations have been for the low income population in areas where the designations fail at the geographic level. We expect this type of need to persist. The adjustment factor (step 4) related to the low income population does nothing to correct for the issue noted above, as implied at several points in the application. The presence of a low income population, particularly on a percentage basis, has no relevance to whether that group has medical access. In the example above, the inclusion of need indicators would have no net effect between these two communities. It is often the case in our area that the low income % in a community has fallen below the 30% cutoff for designation under the existing rule, despite the fact that they represent tens of thousands of people with a proven lack of access. This rule further compounds that problem. A community with 20,000 low income people, representing 10% of the population would score lower than a community with 5,000 low income people representing 40% of the population – regardless of whether both groups faced the same access issues.
 - It is not clearly spelled out how the Step 4 High Need scoring factors will be applied to a low income population designation under this new process. In Section 5.202(b)(3) (p. 11277) the rule states that the high need indicators should be based on the values for the applicable population group... using such approximations as the Secretary may allow. Applying this approach, a low-income population designation would necessarily be able to claim a 100th percentile score for the Low Income % of the population – equating to nearly 1400 of the 3000:1 required ratio. Combined with the high likelihood of the low-income group being unemployed as well, it is

conceivable that such designations would score a nearly 2000:1 ratio before actual providers are ever assessed. If the area were also very sparsely populated it could likely qualify without ever counting actual providers. This clearly and substantially increases the potential for obtaining and expanding Low Income designations with a Tier 1 eligible score. The use of population-specific values in calculating high-need indicators was confirmed by Andy Jordan on a 4/2/08 call, sponsored by the National Association of Rural Health Clinics, and is a key premise for our assessment of the proposed rule. We strongly feel that any change to this aspect of the rule would require a new evaluation and comment period.

- It is not stated that the Proposed Rule will employ any minimum percentage requirement for the portion of the population represented by the low income group, similar to the 30% requirement in place for the current HPSA and MUP designations? These rules were problematic for areas such as New England with a high cost of living, and prevented designations for several populations with significant access barriers from being submitted. We urge that no minimum percentage threshold be applied for population designations, or that such thresholds take the size of the population and/or cost of living into account. This should be explicit in the rule and not subject to subsequent policy restrictions from within HRSA.
- Re-visit Steps One and Four: There are two potential issues with the way the Proposed Rule impacts the designation threshold that are worth noting. The intent of Steps 1 and 4 seems to be a means of factoring in community characteristics that may influence the level of demand – a desirable goal. It is, however, troubling both of these factors seemingly imply increased ‘need’ in nearly every possible community in the country. As they serve to decrease the threshold for designation, they are therefore favorable to maintaining and expanding designated areas and form a key basis for our evaluation of the potential impact. As such, while we suggest that there may be a reason to revisit these calculations, we are also concerned that they may be revised in a way that will require re-assessment of the potential impact of the final rule. We suggest that any fundamental changes to Steps 1 and 4 should be accompanied by a new assessment and comment period. Specific issues are as follows:
 - Based on our demographics, Step 1 results in an age/sex adjustment that is positive in every city/town in New England, with the increase running from 3% - 42% and averaging about 17% overall. New Mexico has also noted a similar across-the-board increase to the total population on a technical assistance call. One would normally expect some communities to be adjusted down if the goal was to adjust to a ‘normal’ population based on likely utilization, with an average adjustment of 0 at the national level. It should also be noted that the footnote on Table IV-1 states 3.471 instead of the 3.741 used in the sample calculations. The lower denominator would further skew the resulting population upward.
 - Looking at the tables in Step 4, nearly every percentile in every ‘high need’ category will produce an increase in the population:provider ratio (and therefore decrease in the designation threshold) over what is observed in the community, with the exception of high population density which adjusts down though it would be thought to potentially equate to the greatest need adjustment). While the weight scores are applied logarithmically to apply the greatest impact at higher levels, one must still question whether communities at the 1st percentile for these factors should accrue a

positive 'high need' score above the Barrier-Free utilization rate. One would expect communities with rates well below the national median for these factors to have 0, or even a negative adjustment. Only the Non-White and Population Density factors seem to roughly follow this pattern.

- Revisit Underlying Premise of Step 4: We believe that the application of the underlying research in the manner proposed in Step 4 of this process is inconsistent with the nature of the data. The use of the underlying research to adjust for local conditions seems to confuse correlation with causality and attempts to reverse-generalize the findings; applying broad national relationships between population characteristics and provider availability as though they apply uniformly in local circumstances. They also seem to assume a static situation, in which pent-up or repressed demand exists in perpetuity. While, for example, predominately Hispanic communities may face access barriers in general compared to largely non-Hispanic communities, it is both conceivable and likely that it is the Hispanics living in communities where they represent a small minority of the total population that face barriers based on discrimination and culture, even though these communities don't show adverse provider ratios overall. Providing greater weight to minorities as their % of the population rises may be reasonable at the national level, but undermines the concept of minority status locally, as does assuming that the Hispanic proportion of a community will always require more resources. Also, applying these factors to sub-population groups seems to invalidate the premise on which the tables were created. Lastly, the relatively high weight of these purely demographic factors seems to overwhelm the true need uncovered by a current assessment of access via a survey of providers (as in the policy example), assuring that some communities will qualify for designation in perpetuity, even if provider access is largely resolved and utilization patterns begin to approximate those of a barrier-free population.
- Revise Table IV-6: The number of significant digits for Unemployment on Table IV-6 is not sufficient to determine which percentile each community falls into. For example, both the 6th and 7th percentile for unemployment is 2.40%.
- Clarification of Poverty vs Low Income: The conversion tables (IV-6 and (IV-7) label the first column as 'Poverty', while the intent seems to be that this represents the level of Low-Income or <200% of poverty population. The levels shown would be highly skewed if they represented the % poor.
- Consider Newer Information on Population:Provider Ratio: In Step 5, the justification for the ratio adopted cites unpublished BPHC data from 1999 as demonstrating that 1,439 medical patients per FTE is typical. The UDS data is now published annually, and the most recent data, from 2006, shows a national average of 1,106 medical users per provider FTE and a median of 1,092 per FTE. This figure is nearly 25% lower than the 1,493 statistic and 27% below the 1,500 figure basis. NHSC 2006 average for sites offering primary care services is 1,325/FTE. Admittedly all of these figures focus on users of health services, and not the underlying population, but the lower user volumes for providers in underserved areas should be reflected.
- Clarify Medicaid Designation Method: Section V-I (p. 11251) – the section mentions the inclusion of the Medicaid population as a designation group. In the past it was possible to determine the FTE serving the Medicaid population using a ratio of 5000:1 of Medicaid visits. It is not clear if this option is still available under the new rules. This option permits

the availability of Medicaid providers to be directly compared to the Medicaid population at the local level without additional data collection, and assures the validity of the results as they are based on actual claims and utilization. As 5000 visits per year is a high practical level of productivity for care to an underserved population, this method seems reasonable and worthy of continuing.

- Clarify Role of IMU vs HPSA Score: Will the concept of HPSA scores be preserved in any way, or will the Index of Medical Underservice be used as a direct proxy for the degree of need in terms of prioritizing placements? The heavy influence of Step 4 seems to make the direct use of the IMU problematic as areas with favorable demographics will dominate the higher scores, despite potentially similar access issues.
- Clarify Basis for Full-Time Service: Reducing FTE for part-time practice is an important factor in our area. The rule suggests that FTE may be reduced when there is “evidence of less than full-time practice, in which case their actual FTE in the area is used based on guidance set by the Secretary”. (p.11240) The rule does not state what that guidance is. Will the 40 hour basis for determining full-time practice be preserved? Will other forms of evidence be acceptable, such that a survey would not be required? – a stated goal of the ‘simplified’ process.