Oregon

Theodore R. Kulongoski, Governor

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

RE: Notice of Proposed Rulemaking – Designation of Medically Underserved Populations and Health Professional Shortage Areas – RIN 0906-AA44, 73 Federal Register 11232 et. Seq. (February 29, 2008), RIN0906-AA44 (April 21, 2006)

Dear Ms. Jordan,

Oregon appreciates the HRSA effort to develop and adopt a new methodology to determine designations of Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps). We also understand federal statutory constraints that require that both types of designations remain. We note that the development of a simplified approach that is more scientifically based is a desirable goal.

We also appreciate the clarification made in the amendment to the federal register that extended the comment period 30 days and provided the clarification that each of the designation types remains eligible for new funds and NHSC. We believe the shift from "tiers" to "methods" is more consistent with the original intent of the Primary Care Offices who provided some of the conceptual framework nearly 10 years ago. The various methods now provide a more logical set of alternatives for communities to consider.

The original proposal was developed a number of years ago and, while it attempts to simplify methods, the Federal Register explanation has been confusing and incomplete. Given the degree to which states, communities, and many organizations use designations, it is important that a good understanding of the

proposed changes is shared broadly. In addition, it is unclear how the many comments HRSA has received will cause it to adjust the methodology. Therefore, while the 30 day extension is appreciated and has allowed some time for analysis, we believe it to be insufficient for the kind of analysis a change of this order requires.

We recommend that HRSA review comments to date, determine what changes need to be made based on comments then publish an interim document with more cohesive consistent language and provide an additional opportunity of at least 60 days for final comment. This is reasonable considering the length of time the methodology has been under development within HRSA. We believe the benefit of taking this step will mean much greater agreement nationwide on the intent, the methodology, and the impact.

In addition to this request, we offer a number of suggestions and concerns. Please let us know if you have questions based on the items we note below.
Thank you for your consideration of our recommendations.

1. We recommend that, consistent with the recent Federal Register changes, "method" language be used instead of "tier" language.

2. **Review Cycles:**

   HRSA and CMS designation review and update cycles should be aligned on a four year cycle. The current unaligned policies make it difficult for providers and for primary care offices. It is really a four year work load.

   We assume that, for the first year, only the HPSAs due for an update in that year are run by SDB, not all HPSAs as stated in the Federal Register.

   We recommend prioritizing MUAs by age and via agreement with each state. **It would be best for areas with both an MUA/P and a HPSA to be updated on the natural HPSA cycle. This would avoid an uneven work load and duplication. We then suggest updating MUA/Ps with no HPSA, over the three years.**

3. Some implications of the Safety Net Facility Designation are not clear – especially as they relate to rural health clinics and eligibility for CMS bonus payments. The Federal Register is largely framed through a community health center lens. In general we would like to see greater emphasis and clarity in regard to the rural health clinics as well.

4. The Safety Net Facility Designation criteria are problematic for rural health and school based health clinics. They require the clinic to be open full time. In some isolated rural areas and school based clinics this is not feasible and the policy would be detrimental to access.

5. In order to avoid the yo-yo effect for Rural Health Clinics, we advise removal of RHC providers similar to the adjustment for other federal resources (certified by CMS and reimbursed at enhanced rates).

6. Oregon recommends that the Safety Net Facility method allow for inclusion of for-profit private practices which meet the service requirements.

7. Oregon recommends that the medical resident FTE adjustment be eliminated because of data limitations due to their transient status and uneven impact across states.

8. Oregon encourages a standard .5 mid-level FTE adjustment regardless of state scope of practice rather that the proposed .5 to .8 range or make it more clear that states have the option to decide.

9. The 3000:1 population to primary care ratio, considered by many to be too high in the previous iteration of a new methodology in 1999, is still cause for concern. We recommend a ratio of 2200:1 as more reasonable.

10. Rational service areas "are assumed to be 40 minutes for a frontier area and 30 minutes for all other areas unless the provisions of paragraph (g)…are invoked by a State." 30 minutes is problematic in urban areas. Perhaps states need the option to develop rational service area plans for urban areas in addition to HRSA options for statewide and rural plans. We believe it is very important that states retain the option to make decisions in regard to RSAs.

11. Rules should not be set up so that Method 2 Geographic competes with Method 1 Population designations as would happen if a Medicare bonus was offered under Method 2 Geographic.

12. Safety Net Facility Designations should meet both the total low-income criteria AND the "indigent uninsured" criteria. Under-insured patients should be considered in the total percent, but not via the indigent uninsured criteria, which are pretty minimal.

13. We request that the clarification provided by HRSA, that special population and simplified designations are also HPSAs and MUAs, be explicitly stated in the new rules.

14. Federal analysis did not take into consideration contiguous area analysis. This issue has given Oregon problems in the past and could be more problematic than the HRSA analysis suggests.

15. There is uneven application of the contiguous service area rule. States with a plan do not have to do any contiguous area analysis and states with individual Rational Service Areas do. This is an unequal definition of need.

16. A process for dealing with areas where there are no providers needs to be developed. (PCO involvement recommended.)

17. A scoring process is needed for all the new designations. (PCO involvement recommended.) See scoring section below…

18. All references to the RCP (resident civilian population) should be dropped. It skews age and gender application.

19. Oregon recommends that the number of providers not be taken into account for areas with fewer than 1000 people.

20. An appeal process is needed to sort out disagreements.

21. The effective population or the total population should be used, which ever is greater. We believe it was an unintended consequence that the effective rate is sometimes lower than the total population.

22. No mention is made of a minimum response rate, nor policy to apply FTE to non-responders.

23. The original band of 16 intended for there to be a menu of variables to choose form. The rules create 8 fixed variables. This has the result of diluting the contribution of any one variable, making it possible for pockets of high need to become less apparent. Oregon suggests a state should be able to choose 7 out of 8 variables. Some choice currently exists between LBW and IMR. Adjustments may need to be made in the final score as a result of this change in the number of variables.

24. Rules should make clear that survey data can be applied to the mid-level FTE. This reduces the chance of a mid-level working at multiple sites being over counted.

25. Urgent requests should be limited to come from the state entity responsible for designations only.

26. Precision and Clarity of Data:

    a. Because state data may be so critical to certain designations, it is important to know how flexible the federal automated system will be to allow for unique state data.

    b. It will be important for states to know how often federal data will be updated.

    c. It is important now and in the future for HHS to clearly describe the data sets, assumptions, and definitions employed for each variable.

    d. Any change in variables should require a public process.

    e. Data for analysis is different than published data – also unemployment tables have an error. These data points are rounded and should be spelled out to two decimal places for states to calculate their points. Accurate data needs to be published for comment.

    f. States need to know the year and source of data used for all regression analysis. A schedule of updates to the regression analysis needs to made public, each with the year and source of data used. New tables need to be shared with states.

    g. The age and gender cohorts as well as mean visit rate should not be updated too often, such as annually. This exposes HPSA applications to a moving target and is an uneven application of policy. Perhaps a three year cycle would reduce frequent variation.

Scoring Issues

1. The process needs to be developed through a partnership with states.
2. Scoring criteria should not be published in a final Federal Register without an interim rule and comment.
3. Clinic Population to Clinic Provider FTE should be a variable.

4. Sliding Fee Scale and Medicaid percent over the Safety Net Facility Designation minimum should be developed as a variable.
5. Because of the difficult populations served by CHCs, many having culture and language issues complicating visits, CHCs deserve extra points by virtue of being a CHC.
6. Because of culture and language issues, distance to the next source of care is not a reasonable measure for urban clinics. It's unreasonable to assume private providers see these populations. Perhaps a measure for urban clinics could consist of percent of patients that have a special barrier such as language, homelessness, Native American culture, other culture or group with specific health complications such as the Marshallese. Perhaps a special population variable could be developed.
7. Rural Safety Net Facilities should have a distance factor associated.
8. Sole Community Provider should get bonus points.

Sincerely,

Joel Young
Manager, Health Systems Planning
Director, Primary Care Office

cc: Jill Canino, Senate Committee on Aging
Eva DuGoff, Office of Senator Ron Wyden
Scott Ekblad, Oregon Office of Rural Health
Craig Hostetler, CEO, Oregon Primary Care Association
Oregon Community Health Center CEO's