



Negotiated Rulemaking Committee

Designation of Medically Underserved Populations and Health Professional Shortage Areas

Tess Kuenning, MSN, CNS, RN
Member, Negotiated Rulemaking Committee
Executive Director, Bi-State Primary Care Association

December 15, 2011

Agenda

- Introduction
- Conceptual Framework
- Rational Service Area (RSA)
- Population-to-Provider (P2P) Ratio
- Medically Underserved Areas (MUAs)
- Medically Underserved Populations (MUPs)
- Geographic Health Professional Shortage Areas (HPSAs)
- Population Group HPSA
- Facility HPSA
 - Exceptional MUP (EMUP)
- Impact Analysis
- Implementation

Introduction

- Legislative Authority
- Negotiated Rulemaking Committee (NRMC)
 - Procedure
 - Description/Members
- History of Health Professional Shortage and Medical Underservice Designation
 - Current MUA/P Designation Process
 - Current HPSA Designation Process
- National Health Service Corps Program

Introduction: Legislative Authority

- Patient Protection and Affordable Care Act enacted in March 2010 directed DHHS Secretary to establish negotiated rulemaking process to re-examine methodology for designating areas and populations that are experiencing medical underservice and/or health professional shortages

Introduction: NRMC Procedure

- Process governed by Negotiated Rulemaking Act of 1990, Public Law 101-648 [5 USC 561-569]
- Intent to form NRMC published in *Federal Register* on 5/11/10
- NRMC defined consensus as 70% comfortable with recommendation and 100% of members per recommendation
- In event NRMC reached full consensus, members agreed to support consensus by not commenting negatively on content of resultant Interim Final Rule
- In event consensus was not reached on some of issues presented, members were free to comment adversely on those areas of disagreement for which consensus was not reached

Introduction: NRMC Members

- Appointed by HHS Secretary in July 2010
- Members comprised of 28 organizations, representing 18 states and urban/ rural mix
- Representatives
 - 3 Primary Care Associations (PCAs)
 - 3 Primary Care Offices (PCOs)
 - 1 Community Health Center (CHC)
 - 1 National Association of CHCs
 - 1 HRSA
 - Other representatives credentials: MPH, MPA, JD, MD, FNP, CNS, PA, PhD health economist and data analyst
- Tess Stack Kuenning
 - Nominated by Senator Bernie Sanders (VT-I)
 - Represented CHCs and PCAs
 - NRMC Provider Workforce Subcommittee, Chair
 - NRMC Governors EMUP Subcommittee, Chair
 - NRMC RSA Subcommittee, Member
 - NRMC Facility Subcommittee, Member

Introduction: NRMC Description

- NRMC members included technical experts on indicators of underservice and shortage, workforce and data analysis, and methodologies for combining multiple indicators
- Bureau of Health Professions (BHP) in HRSA provided funding and administrative support
- Convened 14 times (36 days in person) over course of 14 months (does not include any Subcommittee research or analysis time)
- Statutory requirement to include indicators for determining health status, health barriers, ability to pay and P2P ratio
- Updated designation methodologies better delineate service areas and underserved population groups and facilities, as well as streamline designation application process

Introduction: History of HPSA & MUA/P Designation

- Critical Health Manpower Shortage Areas outlined in 1971 legislation created National Health Service Corps (NHSC)
- Initial MUA/P designations implemented in 1975 from 1973 legislation that established grant programs for Health Maintenance Organizations (HMOs) and CHCs that would serve MUPs
- Governor's Exceptional MUP created in 1986 with legislation that added population-level designation option if an MUP could be identified
- Two previous attempts (1998 and 2008) to revise regulations governing designations were both withdrawn after receiving large volume of public comments
- All or most major issues and concerns included role of Nurse Practitioners (NPs), Physician Assistants (PAs) and Certified Nurse Midwives (CNMs) in primary care; impact of methodological changes on rural/frontier areas; and impact on existing safety net

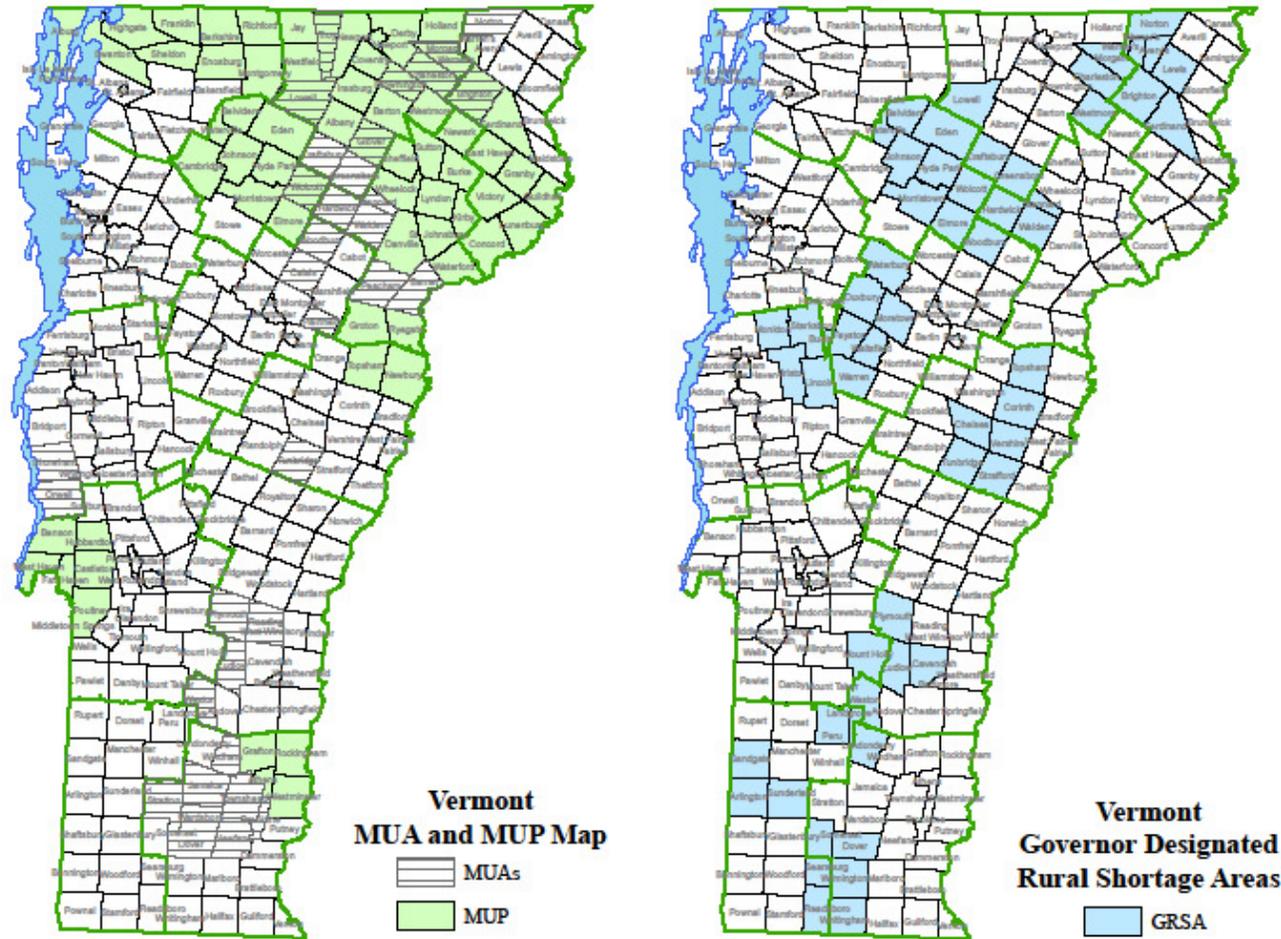
Introduction: Current MUA/P Designation Process

- Identifying MUA/Ps is computation of an Index of Medical Underservice (IMU), comprised of 4 components
 - Ratio of primary care *physicians* to population
 - Infant mortality rate
 - % of population age 65 and over
 - % of population with incomes below federal poverty level (FPL)
- MUAs:
 - Each of 4 IMU components calculated for entire population of geographic area
- MUPs:
 - Ratio computed based on members of undeserved population seeking designation and primary care providers serving that group

Introduction: Current HPSA Designation Process

- Established in law in 1978 under Section 332 of PHS Act
- Considers both ratio of available health professionals to number of individuals in area, or population group, and need for health services in area or population when establishing criteria for designations
- Geographic or population group HPSA designation
 - Natural catchment area for delivery of health services
 - P2P ratio of at least 3,500:1 (physician only)
 - Physician resources in contiguous areas must be overutilized, more than 30 minutes away or inaccessible
 - High need indicators: population with incomes below FPL and rate of infant mortality or low birth weight
 - Updated every 3 to 4 years

Medically Underserved Areas, Populations and Governor Designated Rural Shortage Areas



Source: Health Resource Allocation Plan for the State of Vermont 8-2-05

61 Elm Street, Montpelier, Vermont 802-229-0002



Conceptual Framework

- Evidence-Based and Data Driven
- Simplicity
- Reasonableness
- Consequences to Existing Safety Net
- Maintaining Separate HPSA and MUA/P Designations

Conceptual Framework: Maintaining Separate HPSA & MUA/P Designations

- NRMC recommended maintaining current distinction between the two major types of shortage/underservice designations
 - Health *professional* shortage
 - Health *service* shortage
- Legislative requirements for two designation types are similar but rooted in distinct legislative histories and each has unique practical applications

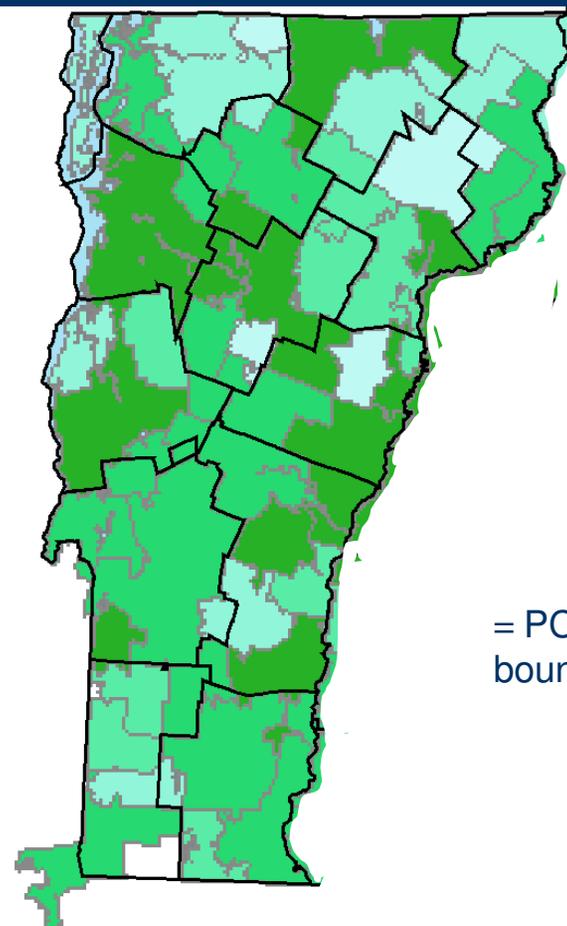
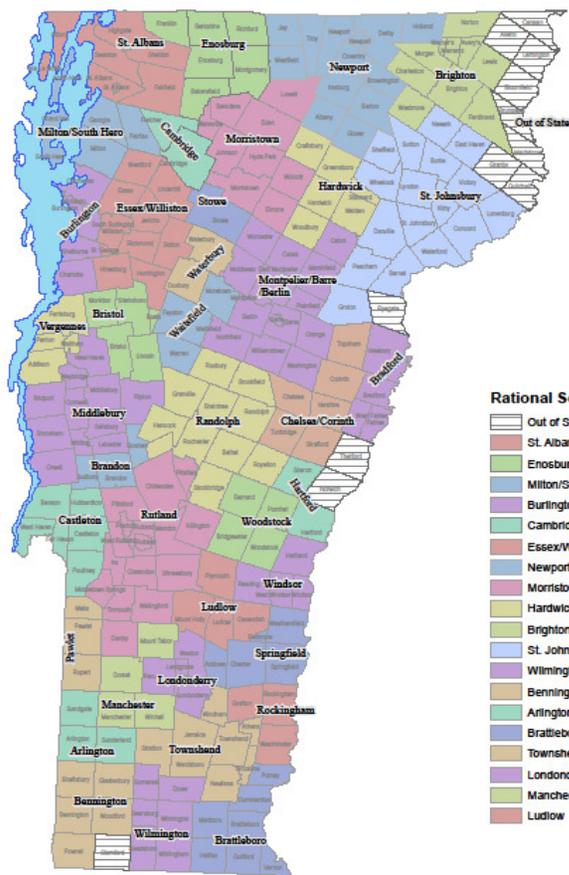
Conceptual Framework: Maintaining Separate HPSA & MUA/P Designations

- MUA/P Designation
 - Determines eligibility for grants for CHCs
 - Determines eligibility for certifications as FQHC or FQHC Look-Alike and cost-based Medicare/ Medicaid reimbursement
 - Targets federal resources to areas and populations with poor health status, low ability to pay, limited primary care providers, and barriers to accessing care
 - Presently based on IMU score
- HPSA Designation
 - Tied to NHSC program
 - Offers recruitment incentives in form of scholarship and loan repayment support to health professionals committed to providing care in areas with health professional shortages
- NRMC recognized overlap but should remain distinct to emphasize statutorily defined purposes for separate designations and differences in interventions

Rational Service Area (RSA)

- NRMCM recommended:
 - Maintaining requirement that all geographic HPSAs and MUAs by RSAs
 - Population group HPSAs and MUPs generally be defined within population RSAs
 - Applicants be allowed to use Geographic Information System (GIS) tools to measure travel distances, travel times and geographic isolation
 - RSA defined as area that meets 4 criteria
 - RSAs must be made up of discrete defined geographic base areas
 - RSAs should be located in continuous areas
 - Different parts of RSA must be interrelated
 - RSAs must be distinct from adjacent contiguous areas
 - Petition for statewide RSA plan

VT State RSAs vs. PCSAs



= PCSA boundary

Source: Health Resource Allocation Plan, Adopted August 2, 2005
6-6-06p

Population-to-Provider (P2P) Ratio: Overview

- Counting Primary Care Providers
 - Counting Primary Care Physicians
 - Counting NP, PA and CNMs
 - Counting Full-Time Equivalency (FTE)
 - Counting Providers for Population-specific Designations
 - Excluding Certain Providers from the Counts
 - Additional Provider “Backouts”
- Counting Population
 - Adjustments for Age and Gender
 - Transient Populations
 - Institutional and Group Quarters Populations
- Calculating P2P Ratio

P2P Ratio: Counting Primary Care Providers

- NRMC recommended:
 - Significant revisions to process of counting primary care clinical providers
 - Broadening definition to include NPs, PAs and CNMs who provide primary care
 - Revising types of activities that count toward full-time practice

P2P Ratio: Counting Primary Care Providers

Type	Current	Proposed
MD and DO: general family physicians, pediatricians or internists as 1.0 FTE based on 40 hour work week	✓	✓
MD and DO: adolescent medicine and geriatrics (1.0 FTE)		✓
OB/GYN	1.0 FTE	0.25 FTE
NP and PA: primary care (0.75 FTE)		✓
CNM: (0.25 FTE)		✓
Exclude: hospitalists and ER-only physicians	✓	✓
Exclude: physicians suspended under Fraud and Abuse Control programs	✓	✓

P2P Ratio: Counting NPs, PAs & CNMs

- Significant expansion over past decade of NPs, PAs and CNMs practicing in primary care settings
- Including them in counts of primary care clinicians essential to validity of revised designation process
- NRMC recommended HRSA apply 0.75 FTE weighting to NPs, PAs and CNMs relative to primary care physicians
- National and state data for NPs, PAs and CNMs are problematic

P2P Ratio: Additional Provider “Backouts”

- NRMCM recommended:
 - Continue and expand practice of backing out providers associated with federal programs to avoid “yo-yo” effect
 - Continue to exclude NHSC scholars, Loan Repayment recipients and J-1 VISA waiver physicians
 - New exclusions:
 - State Loan Repayment Program recipients and those with state service obligations
 - Organizationally program affiliated providers who work at HRSA grant funded health centers (section 330 of PHS Act), FQHC Look-Alikes and hospital-based or independent RHCs offering sliding fee scale

Medically Underserved Areas (MUAs)

- NRMC addressed 4 statutory components of MUA/P designation methodology: P2P, health status, barriers to care and ability to pay
- NRMC developed revised index (Index of Primary Care Needs – IPCN) to distinguish it from Index Medical Underservice (IMU)
- NRMC utilized available evidence including literature reviews and data analysis to select indicators for inclusion
- NRMC recommended threshold for designation be set such that highest scoring 1/3 or 33% of population would be eligible for designation under revised methodology

FINAL MUA MODEL

Component	Factor	Weight
Population-to-Provider Ratio	Count at 1.0 = MDs/DOs in GP, FP, General IM, General Pediatrics, Geriatrics, Adolescent Medicine Count at 0.25 = OB/GYN Count at 0.75* = Primary Care PAs and NPs, CNM (1) Do not count CHC, RHC, Look-alike, NHSC, J-1 visa practitioners	15%
Health Status	<ul style="list-style-type: none"> •SMR (weighted at 50%) •LBW Rate or Diabetes Prevalence (50%) 	20%
Barriers to Care	Two of the following barriers: <ul style="list-style-type: none"> • Percent of the Population with LEP or Hispanic Ethnicity • Percent of the Population that is of a Racial Minority • Population Density (Urban/Rural) or Travel Time • Percent of the Population with a Disability • Uninsured and under 400% of Poverty 	20%
Ability to Pay	Poverty (200%)	45%

10/24/2011

1

MUAs: Threshold for Designation

- NRMC recommended threshold of 33% of population with greatest need as measured by indicators of weighting or components
 - NRMC ranked all RSAs from highest to lowest need
 - NRMC discussed whether threshold should be based on designation process that tightly targets highest need communities for potential consideration in government expenditure decisions or on a process that identifies communities in need of additional resources and health services that gives federal programs the ability to further target actual resources
 - In absence of threshold “break point” NRMC made decision to establish threshold at worst scoring 1/3 of population

Medically Underserved Populations (MUPs)

- Created in recognition that certain population groups within geographic areas may not have access to primary health care equal to that of general population in area
- Currently, MUP process mirrors MUA process with applicants utilizing data specific to population group in order to calculate P2P
- NRMC recommended:
 - Closely replicating the proposed new MUA model for MUP methodology but with different weighting formula for 4 index components used for MUAs
 - Allowing applicants to submit data specific to population group for each of 4 MUP components where locally available
 - Create two separate paths to MUP designation: regular and streamlined application process
 - Exclude clinicians supported by certain HRSA programs that provide primary care to underserved populations

MUPs Overview

- Eligible Population Groups
- MUP Regular Application Process
 - P2P (20%)
 - Health Status (20%)
 - Barriers to Care (40%)
 - Ability to Pay (20%)
- Local Data Options
 - Weighting
- Streamlined Application Process
- Thresholds

MUPs: Eligible Population Groups

- NRMC expects population groups widely recognized in national reports as experiencing health disparities be considered for population HPSA and MUP designations
 - Low income and uninsured
 - LGBT
 - People with HIV
 - People with mental health, physical, sensory, cognitive or developmental disabilities
 - Individuals with low English proficiency
 - Incarcerated populations
 - Immigrants and refugees

FINAL MUP MODEL

Component	Factor	Weight
Population-to-Provider Ratio	Count at 1.0 = MDs/DOs in GP, FP, General IM, General Pediatrics, Geriatrics, Adolescent Medicine Count at 0.25 = OB/GYN Count at 0.75* = Primary Care PAs and NPs, CNM (1) Do not count CHC, RHC, Look-alike, NHSC, J-1 visa practitioners <i>(Using data specific to the population seeking designation)</i>	20%
Health Status	<ul style="list-style-type: none"> • SMR (weighted at 50%) • LBW Rate or Diabetes Prevalence (50%) • Option to substitute up to 2 disparities in health outcomes 	20%
Barriers to Care	Two of the following barriers: <ul style="list-style-type: none"> • Percent of the Population with LEP or Hispanic Ethnicity • Percent of the Population that is of a Racial Minority • Population Density (Urban/Rural) or Travel Time • Percent of the Population with a Disability • Uninsured and under 400% of Poverty • Optional Unique Local Barrier 	40%
Ability to Pay	Poverty (200%)	20%

MUPs: Local Data Options & Weighting

- Local Data Options

- NRMC recommended allowing for flexibility with respect to type of data that can be submitted for population group designations
- Unique local data option exercised only in cases where nationally compiled data for local area is not available
- Applicants using unique local data option would be required to specify data source, coverage years, geographic area, population group and methodology used

- Weighting

- NRMC recommended following general MUA approach to weighting of components with certain adjustments
- NRMC recommended adjusting weighting among 4 components in MUP model because barriers to care are frequently the most significant issue affecting primary care access for specific populations

MUPs: Streamlined Application Process & Thresholds

- MUP applicants can use “streamlined” process to designate certain population groups and involves describing boundaries of service area involved and providing local population count with respect to population group
- Following population groups chosen based on statutory language identifying them as special underserved populations and/or populations with well recognized health status or access problems:
 - Federally recognized Indian Tribes and Alaskan Natives; “special medically underserved populations” named in Section 330(g)(h) and (i) of the PHS Act such as migrant and seasonal farmworkers, homeless and public housing residents
- NRMC recommended MUP threshold representing 33% of population in manner consistent with MUA model

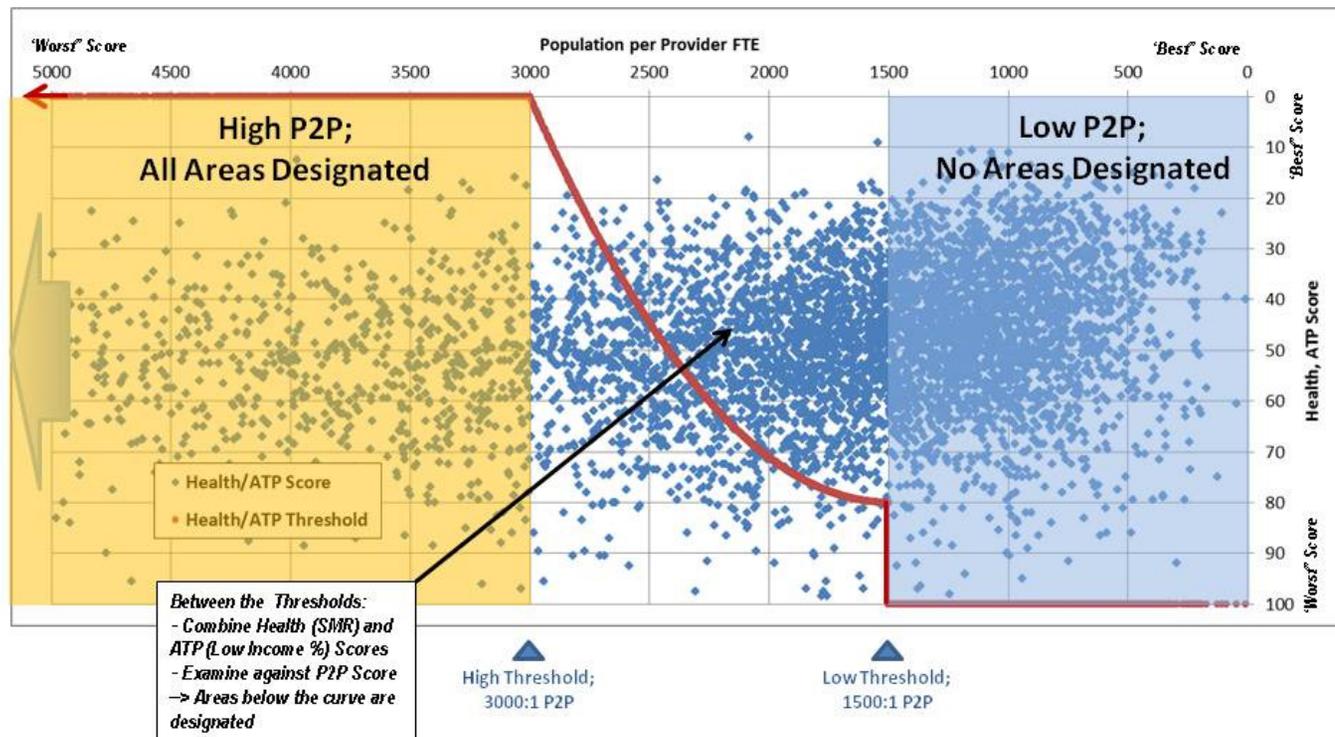
Geographic Health Professional Shortage Areas (HPSAs)

- HPSA designations reflect the adequacy, availability and accessibility of health professional workforce to meet needs of population in an area
- Measures supply relative to need and demand for health care providers
- Currently to qualify, applicants need only demonstrate they are located in a RSA for primary care and have a P2P ratio above 3500:1
- NRMC felt that health status and potentially other access and/or ability to pay components could help indicate problems in areas with 'marginal' but less than adequate P2P rates where barriers to accessing available providers might be higher

Geographic HPSAs Overview

- Geographic HPSA Model
- Issues Relating to Establishment of HPSA Thresholds
- Frontier Areas

FINAL GEOGRAPHIC HPSA MODEL



Geographic HPSAs: Issues Relating to Establishment of HPSA Thresholds

- Federal representative advised NRMC of potential added cost implications resulting from new HPSA designation methodology
- By law, MIP must pay 10% bonus to all physicians, NPs, PAs and clinical nurse specialists in geographic HPSAs if they receive fee-for-service reimbursement for Medicare services
- Two specific concerns:
 - Lowering HPSA threshold: majority of NRMC emphasized it was their primary responsibility to identify needs of all communities and populations including some in the mid-range of P2P ratio with reduced health status and/or ability to pay issues that affect their ability to get care
 - Setting the curved threshold: majority of NRMC were comfortable delegating to HRSA the discretion to set the arc of the curve so long as the arc emphasized areas with high P2P ratios and worse health and ability to pay

Population Group HPSAs

- Current population-based HPSA designations are modeled upon geographic HPSA process with a few key differences
 - Lower P2P threshold ratio for designation (3000:1)
 - Computation of P2P ratio based on number of persons in population group relative to number of primary care clinicians serving that specific population
 - Automatic designation for American Indians and Alaska Natives
- NRMC recommended **revising designation** process by building in data flexibilities and creating two different paths to population group HPSA designation
 - Regular application process
 - Streamlined application process

Population Group HPSAs Overview

- Eligible Population Groups
 - NRMC expects populations listed in MUP and/or others would be considered for population group HPSA, as well as MUP designation
- Regular Application Process
 - Data Flexibility
- Streamlined Application Process

Population Group HPSAs: Streamlined Application Process

- Similar to process NRMCC recommended for streamlining specific groups for MUP designation, HPSA applicants serving certain established population groups need only perform local population count with respect to population group
- Streamlining application process would save HRSA, PCOs and local applicants considerable time and resources
- Established population groups that can apply under streamlined population group HPSA designation include:
 - Federally recognized Indian Tribes and Alaskan Natives; populations named in Section 330(g)(h) and (i) of the PHS Act such as migrant and seasonal farmworkers, homeless and public housing residents

Facility HPSAs

- NRMC recommended *revised criteria* for facility HPSA designation by creating *new pathways* to:
 - Magnet facilities (facilities used predominantly by a single population such as HIV, deaf or hard of hearing, persons with disabilities, limited English proficiency, etc.)
 - Safety net providers
 - Essential primary care providers in a community
- NRMC recommended expanding types of correctional institutions eligible for designation
- NRMC recommended creating a facility independent MUP designation for populations served by certain facility HPSAs

Facility HPSA Overview

- Automatic designations
 - FQHCs and RHCs meeting requirements of NHSC statute for availability of services would remain automatically eligible for designation as facility HPSAs as is statutorily required
- Continuation of the current process for public and non-profit private facility designations
- Correctional facility HPSA designation
- Facility-specific MUP designations
- New pathway for and add new facility designation
 - Magnet clinic; safety net provider facility designations; essential primary care providers in community; and insufficient provider capacity
- Exceptional MUP (EMUP)

Facility HPSA: Public & Non-Profit Private Facility Designations

- NRMC recommended continuing current process of allowing public and non-profit private facilities not located in designated geographic or population HPSAs but serving residents of these HPSAs to apply for facility designations provided they can demonstrate service to existing designated areas or population groups
 - Applicants must demonstrate that significant numbers of their patients come from nearby HPSAs
 - Applicants must produce data indicating they are located in socio-demographically similar area, eliminating access barriers
 - Applicants must demonstrate there is insufficient capacity of primary care clinicians at facility to adequately service the community

Facility HPSA: Proposed Additional New Facility Designation Process

- NRMC recommended additional new facility designation process
- To qualify, applicants would be required to show that they:
 - Serve a community or population group that is eligible for, but did not meet the threshold for, geographic or population-based HPSA designation
 - Function as a public or non-profit private facility offering services to everyone, regardless of insurance coverage or ability to pay
 - Function as either a magnet clinic, safety net clinic or essential primary care provider in a community
 - AND have insufficient provider capacity to meet the needs of population served by facility

Facility HPSA: Proposed Additional New Facility Designation Process

- Magnet Clinic
 - Draws patients from long distances seeking culturally sensitive care
 - >50% of encounters provided by primary care clinicians to 1 or 2 population groups nationally recognized and experiencing health disparities
- Essential Primary Care Providers in Community
 - Facilities located in RSA providing primary care services to at least 70% of population in that area, including underserved and uninsured populations
- Safety Net Provider Facility Designations
 - Deliver significant percentages of their primary care services to low-income individuals $\leq 200\%$ FPL, uninsured, have Medicaid or CHIP coverage or American Indians or Alaskan Natives
 - To qualify, certain percentage of facility's patients must be in one of population groups below:
 - 40% if in metropolitan area
 - 30% if in rural (non-frontier) area
 - OR 20% if located in frontier area

Facility HPSA: Proposed Additional New Facility Designation Process

- Medical facility could demonstrate insufficient provider capacity by satisfying at least 2 of 4 criteria:
 - P2P ratio exceeds 1500:1 counting all patients seen in facility during last year
 - Wait for appointments is >14 days for new patients; 7 days for established patients; or closed to new patients
 - Patient encounters per clinician exceed 4400 per year
 - Average patient care hours per clinician exceed 40 hours per week
 - OR There is excessive use of ER facilities for routine primary care

Facility HPSA: Correctional Facility HPSA Designation

- For federal and state correctional institutions and youth detention facilities, NRMC recommended:
 - Revising current regulations to include all security levels if facility houses at least 200 internees and the ratio of number of internees to primary care providers serving the institution is at least 1000:1
 - Broadening security level to include minimum security correctional facilities since correctional facilities no longer differentiate between security levels
- For county correctional institutions, NRMC recommended:
 - Permitting them to apply for facility HPSA designation using methodology described above

Facility HPSA: Facility-specific MUP Designations

- NRMCM recommended creating facility-specific MUP designation to address concerns that some safety net facilities might be located in areas that no longer meet MUA/P criteria
- Two paths to facility-specific MUP designation recommended:
 - 1) Populations served by magnet facility HPSAs would be eligible for MUP designation so long as facility complies with FQHC requirements in Medicaid in force as of 1/2/11 or previously funded as a health center under Section 330 of the PHS Act and continues to comply with the Medicaid FQHC requirements
 - 2) Populations served by facilities designated as safety net facility HPSAs and populations served by safety net facilities can qualify for designation under this process only if they no longer qualify for community-level MUA/P designation under regulation and policies in effect at time they seek such a designation

Facility HPSA: EMUP

- EMUP designation allows populations that face “unusual local conditions which are a barrier to access to or the availability of personal health services” to apply for shortage designations even though they may not satisfy established MUA/P criteria
 - Definition of EMUP Service Area
 - Guidance for EMUP Designations
 - Unusual Local Conditions
- In deviation from current practice, NRMC recommended EMUP designations be updated every 5 years

Facility HPSA: EMUP Definition

- EMUP service area does not need to be existing RSA or PCSA as defined in geographic designations
- EMUP may have own unique service area boundaries if unusual local conditions that form basis of barriers to access or availability of personal health services, cross boundaries (or subset) of existing RSA or PCSA
- EMUP service area boundaries must define an area both small enough in size that population can reasonably access services provided and large enough in population to support state and/or federal resources assigned or allocated to serve that population

Facility HPSA: EMUP Guidance

- EMUP applicants must describe unusual local conditions, access barriers and/or availability indicators to demonstrate need
- NRMC recommended continuation of current approach and that HRSA specifically require the following of EMUP applicants:
 - Must show they do not qualify for designation under regular MUA/P criteria
 - Must show that unusual local condition limits access to local resources available to area residents
 - Must provide information explaining why area or population group is “exceptional” by identifying what makes it stand out from other similar areas, surrounding areas and state; and should provide comparison of local, regional, state and/or national data for factors involved
 - Governor or Chief Executive of requesting state must certify area/ population group involved is underserved due to unique circumstances

Facility HPSA: EMUP Unusual Local Conditions & Updates

- Unusual local conditions are:
 - Barriers to accessing primary care or an indication of medical underservice not covered by regular MUA/P criteria
 - Documented data showing high disease or mortality rates for requested population group
 - AND/OR significant negative changes in community profile such as high unemployment, high increase in school lunch program enrollment, high increase in WIC program enrollment, closure of major employer, etc.
- In deviation from current practice, NRMC recommended EMUP designations be updated every 5 years

Impact Analysis

- NRMC reviewed extensive array of analyses of national impact on proposed new designation methodologies on both designation status of existing services areas and proposed service areas
- Universal RSA estimates utilized
- Impact testing examined anticipated effect of proposed methodological changes on existing geographic HPSA and MUAs and on universal RSA
- NRMC views that aggregate results of impact analysis represent reasonable approximation of likely results
- NRMC anticipates impact estimates are likely to be a conservative estimate
- Not possible to run full impact testing of population group designation methodologies or facility designation methodologies
- Partial impact test was run for low income population group

Impact Analysis of MUA Model

Geography	Existing Designations (Not Universal RSA, Not Revised Model Scoring)	Universal RSAs	Currently Designated Areas
Total Pop Designated	70,715,969	102,583,355	54,918,772
Metro Pop Designated	40,418,301	63,351,782	29,882,904
Non-Metro Pop Designated	28,989,371	37,758,633	24,045,887
Frontier Pop Designated	1,308,297	1,472,940	989,981
FQHC Sites Designated	3,045	3,303	2,610
RHC Sites Designated	2,363	2,905	1,990

Impact Analysis of Geographic HPSA Model

Geography	Existing Designations (Not Universal RSA, Not Revised Model Scoring)	Universal RSAs	Currently Designated Areas
Total Pop Designated	33,381,824	41,834,136	21,353,191
Metro Pop Designated	17,798,960	21,689,791	11,030,158
Non-Metro Pop Designated	14,297,518	18,684,597	9,732,017
Frontier Pop Designated	1,285,346	1,459,748	591,016
FQHC Sites Designated	1,473	1,459	864
RHC Sites Designated	1,423	2,061	1,000
10% Medicare Charges Designated	\$268,526,413	\$260,841,021	\$134,419,190

Implementation

- NRMC recommended:
 - Process to implement new designation regulations utilizing state PCOs and establishment of a plan to ease transition between old and new regulations
 - After publication of interim final rule, HRSA submit to PCOs anticipated results of applying criteria in interim rule for each currently designated MUP and primary care HPSA
 - HRSA support communications activities relating to explaining revisions
 - PCOs for each state act as lead entity for submission of applications for designation as HPSAs and MUA/Ps

Implementation: Role of State PCOs

- NRMC recommended:
 - HRSA continue to require state PCO to coordinate processing of applications for designation of communities in its state with other interested state entities
 - HRSA provide regional face-to-face training, and subsequent periodic training, in interactive environment to provide interested parties detailed understanding of changes and requirements of each new shortage designation methodology

Implementation: Transition Plan

- NRMCM recommended:
 - HRSA re-evaluate 25% of existing HPSA and MUA/P designations each year over 4-year period starting with oldest first
 - Requiring PCOs to submit Action Plans every year for HRSA's review and approval containing a plan for evaluation of a minimum 25% of existing HPSA and MUA/P designations each year for 4 years to equal 100% review over 4-year period after publication of Interim Final Rule
- Currently, no required review and update of MUA/Ps, so this will be major change for MUA/Ps, while maintaining previous schedule for annual review of HPSAs more than 3 years old
- PCOs failing to complete required reviews on schedule should request extension and approval from HRSA to maintain compliance

Implementation: Annual Reviews & Frequency of Publication

- Consistent with current statutory requirement for HPSAs, NRMCC recommended:
 - Under revised MUA/P and HPSA regulations, Secretary should conduct annual reviews of both MUA/Ps and HPSAs
 - A review and update of every MUA/P and HPSA at least every 4 years with more frequent reviews of some areas conducted based on significant local changes as appropriate
- In cases where review results in proposed withdrawal of designation:
 - HPSA statute requires Secretary to afford interested persons and groups in affected area an opportunity to submit data and information concerning proposed action before finalized
 - MUP statute requires Secretary to consult Governor, PCO and PCA, and Secretary may request entities to provide data and information as necessary to evaluate particular requests for designation or withdrawal
 - PCOs to be in charge of coordinating responses from relevant agencies
- Urgent review of designation possible

Contact

Tess Stack Kuenning, MSN, CNS, RN

Executive Director

Bi-State Primary Care Association

525 Clinton Street, Bow, NH 03304

(603) 228-2830, extension 112

tkuenning@bistatepca.org

www.bistatepca.org



Link to Proposed Recommended Rule: NRMC Report to the Secretary 10/31/11

<http://www.hrsa.gov/advisorycommittees/shortage/>