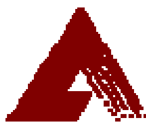

Arizona Hospital and Healthcare Association

May 20, 2008

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

Re.: Proposed Regulations on Designation of Medically Underserved Populations and Health Professional Shortage Areas

Dear Ms. Jordan:

Thank you for the opportunity to comment on the proposed rules to revise and consolidate the criteria and processes for designating medically underserved areas and populations (MUA/Ps) and health professional shortage areas (HPSAs). I submit these comments on behalf of the Arizona Hospital and Healthcare Association (AzHHA).

The federal HPSA and MUA/P designations are vital to the delivery of healthcare services in Arizona. These designations qualify our communities and healthcare providers for participation in a variety of state and federal programs that improve the delivery of medical services to underserved areas and populations, including the following programs:

- State J-1 Visa Waiver Program,
- National Health Service Corps,
- Medicare Provider Incentive Payments,
- Rural Health Clinics Act, and
- Arizona Medical Student Loan Program.

While all states utilize federal programs supported by the HPSA and MUA/P designations to one degree or another, these programs are critical to the delivery of services in Arizona where our physician supply is simply not keeping pace with the state's rapid population growth. In 2005, Arizona had 219 physicians per 100,000 persons, compared to the national average of 293/100,000. With this in mind, it is

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imperative than any changes to HPSA and MUA/P designation criteria and processes do not disrupt the delivery of current health care services provided by these programs nor impact our ability to keep pace with the state's rapid growth. AzHHA offers the following comments for your consideration.

Impact Analysis

The Health Resources and Services Administration (HRSA) based its impact analysis on 1999 data, which likely understates the impact of the proposed revisions. Analyses using more current data show the revisions jeopardize a much larger percentage of designations – approximately 25 percent of urban and 17 percent of rural areas compared to HRSA's estimated 10 percent. (Peter Shin, et al., "Analysis of the Proposed Rule on the Designation of Medically Underserved Populations and Health Professional Shortage Areas," Geiger Gibson/RCHN Community Health Foundation Research Collaborative, Research Brief #2, April 14, 2008). Calculations run by the Arizona Department of Health Services indicate a substantial number of Arizona communities currently receiving medical services under a HPSA or MUA/P designation program would be eliminated under the proposed revisions. These include medically underserved populations receiving primary care services in the Phoenix and Tucson metropolitan areas as well as rural communities receiving hospital services in regional medical centers. One rural hospital stands to lose 60 percent of its hospitalist practice under the proposed regulation. **With this in mind, AzHHA urges HRSA to reevaluate the impact of the proposed regulation before issuing a final rule.**

Population to Provider Threshold

HRSA proposes retaining the 3000:1 population to primary care provider (PCP) ratio currently used to designate HPSAs, which has been in effect for 30 years. Discussion in the *Federal Register* justifies this number based on studies from the mid-1990s that suggest a typical PCP patient caseload of 1,500 patients per provider. We question whether it is appropriate to establish a threshold that is two times the normal caseload cited in the *Federal Register*, particularly given recent increases in utilization rates. In 1996, HRSA itself defined an adequate ratio to be 2000:1. **We urge HRSA to reconsider the 3000:1 population to provider ratio, and replace it with a ratio that more adequately reflects current utilization trends.**

Provider Counts

We applaud HRSAs attempt to mitigate the "yo-yo" effect by establishing a two-tiered eligibility process, but disagree with the way provider exclusions are factored in. We believe all providers serving under a federal obligation (e.g., National Health

Services Corps or J-1 visa waiver program) should be excluded from the provider counts *under tier 1* until their obligations are complete. Because a substantial number of these providers leave an area when their obligation ends, it would be more appropriate to exclude these providers up front.

Additionally, providers working at rural health centers (RHCs) should be treated the same as providers working at federally qualified health centers (FQHCs). Since RHCs receive enhanced federal funding and provide safety net services similar to FQHCs, providers from both facilities should be excluded from the counts. Designation criteria should not be based upon data limitations at the time the model was developed. **We urge HRSA to exclude all federally obligated providers under tier 1 and exclude providers from RHCs under tier 2.**

Safety-Net Facility Designation

We appreciate HRSA's use of the safety-net facility designation as a final method of designation, but are disappointed the Centers for Medicare and Medicaid Services (CMS) will not recognize this designation for RHCs. RHCs serve the same populations and provide the same safety net services as FQHCs. We realize there is a distinction between the roles HRSA plays in the designation process and CMS plays in applying the designations to specific programs. Unfortunately, this distinction has the potential for disrupting the delivery of safety net services in many rural areas. While we are encouraged that the proposed rules integrate the six-year "grace period" for existing RHCs as prescribed by the Health Care Safety Net Amendments of 2002, the rules place future RHCs at a disadvantage. **We urge HRSA to more fully study the impact of the proposed regulations on existing RHCs, and develop, in partnership with CMS, an approach to protect safety net services delivered by future RHCs that would otherwise meet the safety-net facility designation.**

Designation Period

We fully appreciate criticism that existing MUA/P regulations do not require these designations to be updated, and thus some may be outdated. Having said this, we believe the proposed designation review period – three years – is too short. Basing the designation period on existing HPSA review requirements is intuitively understandable, but impractical in the current climate of physician shortages and modern recruitment practices. A number of hospital administrators who contract with J-1 visa physicians under the sate waiver program have expressed serious concern over the length of time it takes to recruit these physicians and the impact this will have on the ability to secure slots under the proposed three year designation period. Moreover, we question how this period will work, given these physicians must contract to work at an approved service site for at least three years. What

happens if the site is de-designated prior to the three year requirement? Under the current physician recruitment climate, hospital administrators have recommended that a ten year designation period is more appropriate. This would also assist with recruitment under the loan repayment and Medicare provider incentive payment programs. **We urge HRSA to replace the three-year designation review period with a time frame that is more in line with existing recruitment practices, such as ten years, but no less than five years.**

In summary, we thank HRSA for the opportunity to comment on the proposed regulations. We support the concept of blending HPSA and MUA/P designation processes to create a more streamlined methodology. However, we believe the impact of the new methodology on existing programs that rely on current HPSA and MUA/P designations is not fully understood. Moving ahead with the proposed revisions without this knowledge jeopardizes services to the most vulnerable populations we serve. If you have any questions or would like further information regarding our comments, please call me.

Sincerely,

John R. Rivers, FACHE
President and Chief Executive Officer