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MISSISSIPPI PRIMARY HEALTH CARE ASSOCIATION

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May 29, 2008

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Health Resources and Services Administration
Department of Health and Human Services
Attention: Dr. Elizabeth Duke
Rm: 1405 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

RE: Notice of Proposed Rule Making (NPRM) – 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 Dr. Duke,

Mississippi 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). The Primary Care Office (PCO) and the Mississippi Primary Health Care Association (MPHCA), 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. On this basis, the PCO and MPHCA have jointly drafted this letter regarding the referenced NPRM.

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.

Upon our initial testing of the proposed NPRM calculators, it appears as though all 21 FQHC main sites and satellite clinics will meet the criteria at “Tier 1” and “Tier 2”. However, we cannot determine what designation or funding level a Community Health Center (CHC), clinic, population or area will receive under the index of primary care underservice. Second, the rule’s analysis uses nearly 10-year old data from 1999. Finally, the analytical model HRSA developed to assess the potential impact of these proposed changes has not been widely distributed – making it difficult for communities and facilities to adequately assess the impact of the proposed rule.

We are concerned that the proposed rule will have a more significant adverse impact than HRSA suggests. 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,

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.

One recommendation that we offer concerns the 3000:1 population to primary care ratio. We believe that the ratio is too high under the current methodology and that a ratio of 2000:1 is more reasonable.

Another recommendation concerns rational service areas. Rational service areas (RSAs) "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.

Third, 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.

Fourth, federal analysis did not take into consideration contiguous area analysis. This issue has given Mississippi problems in the past and could be more problematic than the HRSA analysis suggests. 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.

Thirty-four federal programs base allocation decisions on shortage designations. While some, such as the National Health Service Corps, look at the numeric score for the area, others, such as the Medicare Incentive Payment, are based on the category of designation, not the score. Currently, the PCO with input from MPHCA determines whether an area can be designated as a geographic area and, if not, to repeat the analysis for populations.

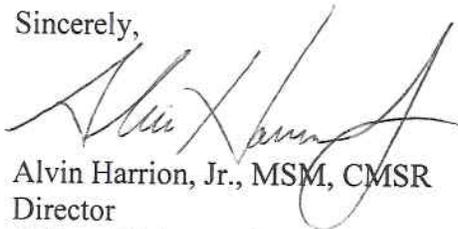
The proposed rule introduces another layer of complexity by creating two tiers for each category. Yet, no hierarchal process for reviews is proposed. This runs the risk of placing PCOs in the unwelcome position of adjudicator between the very providers the designation is intended to benefit. One specific example of confusion from the NPRM is that there is real potential for conflict among FQHCs, RHCs and private providers and PCOs when areas do not qualify for a Tier-1 geographic HPSA. FQHCs and RHCs will probably want to pursue a Tier-1 population HPSA to be eligible for new federal resources (330 funding, NHSC placements, etc.) while private providers will probably want to pursue a Tier-2 geographic HPSA which requires a geographic designation for the eligible Medicare HPSA payment.

This is a no-win position for the PCO and MPHCA, regardless of the efforts to obtain some designation for the area being surveyed. Because an area may qualify for Tier 2 geographic and

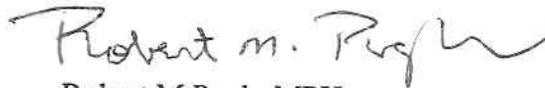
Tier 1 Low Income, it is important for HRSA to clarify the order of review or to indicate that an area can have multiple designations.

The proposed rule sets strict timelines for review and notification of designation. It also encourages state and local government to increase their role in defining service areas, underserved populations groups and unique local conditions. Specifically, states are urged to define rational service areas used to designate underservice and shortage areas and be involved with identifying safety-net-facility primary care HPSAs and MUPs. Interaction with states and localities is important to achieving fair and equitable designations and may ameliorate the adverse impact of the proposed index. However, HRSA has not adequately assessed the added burden to states and local governments in meeting these new responsibilities. Neither MPCHA nor the PCO have resources to dedicate staff for these additional duties.

Sincerely,



Alvin Harrion, Jr., MSM, CMSR
Director
Office of Primary Care Liaison



Robert M Pugh, MPH
Executive Director
MPHCA

cc: Ms. Andy Jordan, HRSA
Ms. Rozelia Harris, MSDH Office of Rural Health