

ARIZONA RURAL HEALTH ASSOCIATION
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May 26, 2008

Ms. Andy Jordan
Health Resources and Service Administration
Department of Health and Human Services
8C-26 Park lawn 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 Rural Health Association.

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.

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 imperative that 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.

Based on our initial review, we have identified a number of adverse effects of these proposed rules on rural Arizona communities. In fact, we believe these proposed rules could have a catastrophic effect on our Rural/Frontier Hospitals. We believe the following considerations need to be made to mitigate the loss of medical services posed by these rule changes.

Border Communities and Undocumented Populations

While the basis of the proposed regulations only addresses trended 1999 United States Census counts, Arizona's population growth in documented and undocumented populations is significantly understated. The current 1011 Program recognizes the adverse affect that undocumented populations pose to hospitals and border communities. The primary authority on illegal immigration within the United States (Urban Institute and Pew Hispanic Center¹) has identified that 40% of the undocumented population (4.4 million) have been in the United States less than five years. Additionally, 80% of these populations are crossing the US/Mexico border and are from Mexico and other South American countries. Border proximity is a major factor in undercounting of population and need. In addition each of our hospitals and rural health clinics are accessed by patients who live in the large population centers in Mexico. The current federal policy of compassionate entry and free border access to shop creates a demand unrecognized in your model. **We urge HRSA to include a population adjustment to for undocumented residents relative to boarder proximity. Specifically, we recommend that communities within 50 miles of the US/Mexico border factor an increase in their Hispanic population counts by (100%).**

Frontier Hospital / Specialist - Penalty

It is recognized that access to medical care is a function of primary care and emergency care providers. Specialists provide little (if any) care to affect infant mortality, immunization coverage, preventive health, and health maintenance in general. Additionally, the fact that these specialist rotate through a rural community hospital should not penalize that community. A rural / frontier hospital's ability to balance a community's primary care providers with specialists and maintain expensive emergency services is not congruent with current provider counting. **For this reason we urge HRSA to exclude specialists in Rural/Frontier/ Safety Net Hospitals from the provider count.**

FTE Volatility – Hospital Coverage

The most time consuming and resource intensive component in determining the RSA score is the identification and FTE estimating of providers. This factor leads to the increased probability of error. Because the lower number of providers in a community increases the FTE sensitivity, an error of .3 FTE could equate to a 100+ point drop in RSA score. Stated differently, a 10% estimation error in provider FTEs could be greater than a 100% error in any of the demographic variable scores. Additionally, Nurse Midwives, Nurse Practitioners, and Physician Assistants are not Physicians and therefore cannot provide medical oversight and physician-call in Rural / Frontier hospitals. The practicality of recruiting/retaining only one physician (regardless of the number of other types of providers) is unrealistic simply for the quality of life considerations with taking call, continuing education, or providing respite for other physician colleagues. It is universally recognized that the number of FTEs needed for 24/7 coverage 365 days a year is 4.2

¹ <http://pewhispanic.org/files/reports/61.pdf>

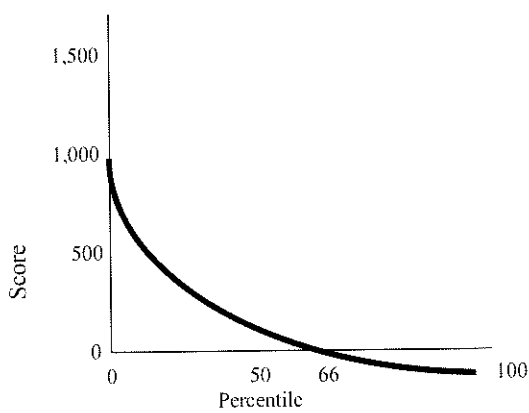
FTE. For these reasons we urge HRSA to place a 4.2-FTE physician provider exemption in Rural/Frontier RSAs with a hospital.

Safety-Net Facility Designation

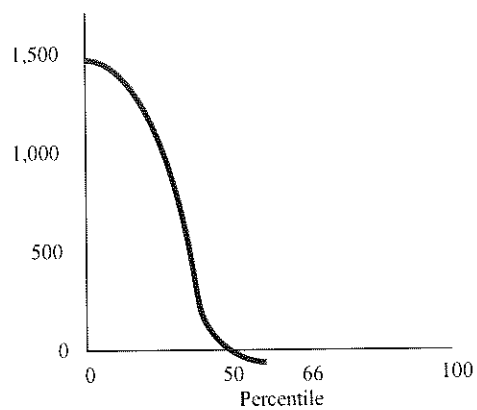
We appreciate HRSA’s use of the safety-net facility designation as a final method of designation, but are disappointed the Centers for Medicare and Medicaid Services (CMS) will not recognize this designation for RHCs. RHCs serve the same populations and provide the same safety net services as FQHCs. 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.**

Adverse Effect of Density Cap on Frontier Communities – Bias to Metro Areas Greater Than 50th Percentile

The current methodology rewards metro areas that have a density greater than the national average up to the 66th Percentile. Any points allocated above the 50th percentile for population density is a *metropolitan bias* and a flaw of the model. Conversely the proportionality variance assigned to Frontier communities below the 20th Percentile produces an unrealistic scoring of need. Whether there are .5 people per square mile or 2 people per square mile is not significant enough to warrant a drop of 380 points. In both scenarios these are extremely rural and frontier communities and they are very likely bordered by RSAs that have little-to-no medical care and have similar densities. A cap of 995 points (which can only be scored for the top 1 Percentile nationally) undermines the importance and role geographic barriers play in health professional shortage. Every aspect of this logarithm is flawed. The graphs below show current and recommended scoring graphs.



Current Scoring Curve



Recommended Scoring Curve

We urge HRSA to modify the Density Scoring Logarithm with the following modifications: 1) The maximum score for this variable needs to equal at least 1,500 to assure rural/frontier area considerations are met. 2) No points should be awarded to populations with a density greater than the 50th percentile. 3) The Logarithm needs to be transposed to a slower rate of decreasing points and variability for rural and frontier communities.

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.

Given the complexity of the issues that must be addressed in applying the proposed formula, we recommend that CMS consider dropping the revisions for HPSA designation. We are concerned that the revisions in the regulations do not adequately support the continued delivery of health care in rural Arizona.

If you have any questions or would like further information regarding our comments, please call me.

Sincerely,

A handwritten signature in black ink that reads "Rick Swanson". The signature is fluid and cursive, with a long horizontal line extending from the end of the name.

Rick Swanson
President
Arizona Rural Health Association