



Designation of Frontier Health Professional Shortage Areas

Introduction

The additional resources available to communities that are designated as Health Professional Shortage Areas (HPSA) are critical to allow safety net providers, including those serving populations in frontier areas, to serve their patients with adequate support staff, up to date equipment, and appropriate medications. The HPSA criteria currently in place do not ensure access to federal resources in areas with sparse or geographically isolated populations, which often experience the greatest challenges to recruiting health care professionals. According to the Patient Protection and Affordable Care Act¹, the term frontier health professional shortage area means an area with a population density less than six persons per square mile within the service area; and with respect to which the distance or time for the population to access care is excessive. Specifically, the time and/or distance to primary care is considered excessive for the residents by exceeding 30 miles² or 30 minutes³.

Areas whose populations are experiencing excessive time or distance to primary care, oral health and/or mental health care should qualify as frontier HPSAs. These service areas are generally without public transportation and some experience dramatic seasonal fluctuations in population either for employment or recreation. Many have seasonal weather barriers to travel with poor roadway maintenance and /or inoperable personal transportation due to high poverty levels in proposed frontier HPSAs.

Data

The purpose of establishing a frontier-specific designation for HPSAs is to acknowledge geographically marginalized communities with fragile health care delivery systems as areas with a high need for health care professionals.

¹ 124 STAT page 591 of the Patient Protection and Affordable Care Act. PUBLIC LAW 111–148—MAR. 23, 2010

² Current criteria for HPSA geographic or population group designation the rational service area involved must be natural catchment area for the delivery of health services, including provider resources in contiguous (or adjoining) areas must be more than 30 minutes travel time away, or otherwise inaccessible.

³ The Final Report to the Secretary by the Negotiated Rulemaking Committee on the Designation of MUPs and HPSA (10/31/2011) proposes to define a RSA as an area that meets four criteria, including RSAs must be distinct from adjacent contiguous areas. Service areas would be considered distinct from adjacent service areas if: 1) the service area population is isolated from the nearest source of accessible care by at least 30 minutes of travel time, on public roads, under travel conditions normal to the service area.

Frontier areas are unique from rural areas because of the following characteristics:

1. Frontier areas generally do not have sufficient population to support a range of healthcare services, including necessary primary care services, unlike rural or more densely populated areas that typically have a broader range of services.
2. People who live in frontier areas are more likely to lack health insurance than other rural and urban citizens.
3. People who live in frontier areas generally have lower incomes than their rural and urban counterparts; 48% of frontier counties are classified as “high poverty”.
4. Frontier areas typically have a higher percentage of older adults and therefore require more health services per person than other identified populations.
5. Given their comparatively fragile infrastructure overall, frontier areas generally lack the capacity to develop and sustain a comprehensive system of care.

Targeted Federal Programs

HPSAs have been used by over 20 federal programs in the prioritization and distribution of resources. The frontier designation for HPSAs is designed to particularly benefit the following federal programs:

1. National Health Service Corps Placements and Loan Repayment programs
2. CMS: Rural Health Clinic designation and bonus payments for physicians
3. J-1 VISAs

In the development of new rural delivery and payments systems, the Frontier HPSA may open opportunities to increase the availability of healthcare.

Policy Recommendations for Frontier HPSA

1. **Geographic HPSA.** Under the current HPSA designation process applicants must demonstrate that any geographic service area they wish to designate (or use as the basis for a population group HPSA designation) is a rational service area (RSA), based on a defined set of criteria in terms of geographic units, distance and travel time, and boundary/contiguous area placement. The geographic HPSA designation methodology should be revised to allow for a scoring adjustment that addresses the unique needs of frontier areas. Such needs are not adequately captured by any of the current HPSA designation or RSA methodologies. Most models leave out a substantial number of frontier areas, which are likely to be much more sensitive to the number of providers than to other criteria such as income levels, mortality rates, or other health status indicators. To adjust for this, it is recommended to eliminate the requirement to measure Standardized Mortality Rates (SMR) and the percent of low income in the middle population-to-provider (P2P) ratio for frontier areas, effectively establishing a

P2P threshold of 1500:1 for frontier areas. Under this approach, all frontier areas with P2P ratios above this threshold would be designated as geographic HPSAs along with all areas below this threshold if there are 2.0 FTE or fewer primary care provider FTEs (including primary care physicians, NPs, PAs, and CNMs). A lower threshold for frontier areas is justified on the basis that clinicians (whether physicians, NPs, PAs, or CNMs) working in frontier communities cover large territories and cannot be as efficient as clinicians located in urban areas (a position supported by health center Uniform Data System Reports⁴). Additionally, the loss of even one primary care clinician in a frontier community has the potential to be particularly devastating, since these communities often rely on a very small number of clinicians.

The following should be taken into consideration when determining distance and time criteria for RSAs that include frontier areas:

- a. Distance/Time for population to access the next closest service point in a frontier area: Residents must travel greater than 30 miles or 30 minutes via a consistently accessible road, or lack access via a consistently accessible road, or
 - b. Distance/Time from frontier access point to next closest accessible source of non-HPSA primary care, which is more than 30 miles or 30 minutes via a consistently accessible road, or not accessible via consistently accessible road, from the population center of the service area.
- 2. Population-to-Provider Ratio:** Primary Care HPSAs are currently based on a physician to population ratio of 1:3,500. The primary care needs of frontier communities are influenced by factors such as a severe lack of physicians, sparse population, low income and uninsured patients and the age of the community's population. Therefore, under the frontier HPSA it is recommended that the service area has a population to primary care provider ratio of 1500:1 or higher, which will include primary care Nurse Practitioners (NPs), Physician Assistants (PAs) and Certified Nurse Mid-Wives (CNMs). This recommendation aligns with that of the Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and HPSAs, where in the Final Report to the HHS Secretary the Committee recommended that for the first time NPs, PAs, CNMs and physician assistants specializing in OB/GYN who practice in primary care settings be included in the primary care provider count.
- 3. Adequate Provider Staffing:** Notwithstanding the provider to population ratio criterion recommended above, it is recognized that frontier areas cannot easily sustain solo practices. Two providers are the minimum necessary for frontier areas even if this reduces the population-to-provider ratio below 1500:1. This is because ratios of providers-to population

⁴ Data from Community Health Centers reveal lower average productivity for frontier health centers, roughly 73 percent of the productivity of health centers in metropolitan areas.

ratios are based on effective service delivery for large populations with multiple providers. For example, it is not feasible to operate a clinic and cover call 24/7 with only one provider. Some remote clinics must have coverage for nights and weekends. The population of frontier service areas is often under 3,000, the expected maximum patient base for one primary care provider. For areas with smaller populations, recognition of the population need for access options should warrant providing a frontier designation for the area and giving priority to providers who might serve the region with a combination of facility staff, itinerant practitioners, community health workers, transportation services, and/or telemedicine.

4. **Waiver and/or Reconsideration Process:** An opportunity for a HPSA waiver and/or reconsideration process for those frontier communities which do not meet the national Frontier HPSA eligibility criteria should be considered. A process for organizations, state and local government, tribal leaders and other relevant entities is encouraged to be added for programmatic eligibility when excluded by the use of a single national criterion or set of criteria.

There is significant precedence of federal legislation and policy to include such reconsideration procedures. Examples include:

- The Rural Health Clinic Act of 1983 mandated that the HRSA create a waiver for small National Health Service Corps freestanding sites and small Community and Migrant Health Centers from paying fees to the federal government for NHSC personnel assigned to these sites.
- In 1986 a process was established for designating medically underserved populations outside of existing criteria. It stated: “The Secretary may designate a medically underserved population that does not meet the criteria established under paragraph (4) if the chief executive officer of the state in which such population is located and local officials of such state recommend the designation of such population based on unusual local conditions which are a barrier to access to or the availability of personal health services.” (source: Public Law 99- 280, (100 Stat. 399), Section 2. Medically Underserved Populations, (6), April 24, 1986).
- In 2006, a detailed reconsideration procedure was established in response to S.1533 Health Care Safety Net Amendments of 2002, Subtitle B—Telehealth Grant Consolidation, SEC. 330I. TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS. This legislation required the Secretary (of HHS) to issue a regulation on defining “frontier” for the purposes of telehealth grant programs. The Office for the Advancement of Telehealth within HRSA convened a group of experts to recommend a process to the Secretary. The earliest point of consensus reached by the group was the absolute necessity of a procedure whereby sites designated ineligible could submit a request for reconsideration.

Conclusion

HPSA designation criteria are critical designations to safety net providers, the primary provider of frontier primary care services. The current HPSA criteria do not ensure adequate access to federal resources in frontier areas, which often experience the greatest challenges to recruiting health care professionals, offer the highest risk patient populations and have the most difficult issues with transportation. It is critical that HPSA criteria take into account the unique characteristics and challenges of sparsely populated and geographically isolated areas. A separate designation of frontier HPSA will address many of these issues. It is recommended that the frontier HPSA take into consideration the following criteria:

1. When defining frontier, HPSA criteria should consider the time and distance it takes to access primary care services, in addition to population density.
2. The service area for frontier communities are often vast and with little or no backup for providers.
3. Physicians, together with non-physician primary care provider FTEs (including NPs, PAs, or CNMs, all who typically serve frontier areas) should be calculated in the same manner as other HPSAs.
4. If a frontier HPSA designation is not approved, consideration of a waiver and/or reconsideration process should be available for unique situations.

The recommendations of this brief will allow appropriate designation, improve access to care and assist in attracting teams of health care providers to improve outcomes.

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