



Designation of Frontier Health Professional Shortage Areas

Summary

HPSA designations matter to safety net providers including those serving populations in frontier areas. The criteria currently in place as well as anticipated proposed methods do not provide meaningful results in areas with sparse or geographically isolated populations. “Frontier” is here defined for HPSA as a geographic area with fewer than 7 people per square mile across a service area, within which the time and/or distance to primary care is excessive for the residents, and exceeds the national goal of 30 miles or 30 minutes.

Examples of “excessive time and distance” that are related to geography and/or seasonal weather conditions include:

1. Lack of a consistently accessible road (due to water, mountain, desert or tundra barrier) to an access point in the frontier area from communities in the area;
2. Where there is a consistently accessible road, residents of some communities must travel more than 30 miles or 30 minutes to a primary care access point; or if there is no frontier access point, they must travel more than 30 minutes or 30 miles to a contiguous area for primary care services.
3. The distance/time from a “frontier access point” within the service area to the next accessible source of primary care is more than 30 miles or 30 minutes via a consistently accessible road.

Such areas should qualify as frontier HPSAs whose populations are experiencing excessive time or distance to primary care, oral health, vision and mental health care. These service areas are generally without public transportation. Some experience dramatic seasonal fluctuations in population either for employment or recreation, and many have seasonal weather barriers to travel.

Background

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

Frontier areas are characterized by the following:

1. Frontier areas generally do not have population centers that can support the range of healthcare services, even for primary care, services of the type that are available in areas that are either more dense or have easier access for populations to such population centers
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 are generally lower income than their rural and urban counterparts; 48% of frontier counties are classified as “high poverty”

Targeted Federal Programs

HPSAs have been used by over 30 federal programs in the prioritization and distribution of resources. For the purposes of this paper, the Frontier Designation for HPSAs is designed to benefit the following federal programs:

1. CHC/330
2. National Health Service Corps
3. CMS: rural health clinic designation and bonus payments
4. J-1 VISAs

Principle Issues

1. **Lack of Access:** Geographic barriers typical of frontier areas can be taken into account by using a matrix that includes both distance and time to reach primary care services that are available to the general population, or that uses either distance or time as part of the definition. Population density can be a criterion used in conjunction with time and distance to services.
2. **Inadequate System of Care:** Given their comparatively fragile infrastructure overall, frontier areas generally lack the capacity to develop and sustain a comprehensive system of care.
3. **Population-to-Provider Ratio:** For frontier areas meeting the other criteria, a ratio of 1450:1 or lower is recommended.
4. **Adequate Provider Staffing:** Notwithstanding the ratio criterion recommended above, it is recognized that frontier areas cannot easily sustain solo practitioners. Two providers are the minimum necessary for frontier areas even if this reduces the population-to-provider ratio below 1450:1. This is because ratios of providers-to-population based on effective service delivery for large populations do not apply in a meaningful way in frontier areas because providers do not come in fractions of FTEs. For example, it is not feasible to operate a clinic and cover call 24/7 with only one provider. 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 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.

Proposed Criteria

1. **Population Density:** Population density less than seven persons per square mile within the service area
2. **Distance and/or Time for Population to Access Care is Excessive**
 - a. Distance/Time for Population to Access Service Point in 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 Nearest Accessible Source of Primary Care—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
3. **Population/Provider Ratio:** service area has a population to primary care provider ratio of 1450:1 or higher. Physician and non-physician provider FTEs will be calculated in the same manner as other HPSAs. If an area otherwise meets the preceding two criteria, but has less than a 1450:1 ratio, the area will still be designatable if there are 2.0 or fewer primary care provider FTEs.

Waiver and/or Reconsideration Process

Need for Waiver Process: There must be a HPSA waiver and/or reconsideration process for those communities which do not meet the national HPSA eligibility criteria. There must be a process for organizations, state and local government, tribal leaders and other relevant entities to make the case for programmatic eligibility despite being excluded by the use of a single national criterion or set of criteria.

Precedence: There is a long history of federal legislation and policy to include such procedures. Examples include:

1. **Example 1:** 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.
2. **Example 2:** 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).
3. **Example 3:** More recently 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. It stated:

“The chief executive of a state, in consultation with the state Office of Rural Health and other relevant agencies, or the highest elected official of a federally-recognized tribe should be provided the opportunity to recommend additions or deletions of designated frontier areas if they find that these areas should have been either included or excluded initially from the list of designated frontier areas as a result of inaccuracies in the analyses that produced the original list (e.g., mistakes in mapping programs, calculation of mileage or travel-time). The reason for requesting reconsideration must be specified and documented in the request as to why an exception should be made to the designated list related to the published criteria. Among the reasons for reconsideration, states and tribes may include rationales such as seasonal fluctuations in travel time related to the time of year, island locations, topography, or other unique characteristics of their state or tribe.” (source: Expert Panel Report: Defining the Term “Frontier Area” for Programs Implemented through the Office for the Advancement of Telehealth, Center for Rural Health, University of North Dakota, May 2006).

Conclusion

There is ample precedence for recognizing the limitations of national-level criteria, and further, for establishing a process for reconsideration or appeal of specific designations. No methodology is perfect and no set of local conditions can always be adequately described using estimates and models; a responsive system is thus required which encourages feedback and enables corrections wherever necessary.

Policy adopted October 2007.

Government Affairs Office
1108 K Street NW, 2nd Floor
Washington, DC 20005
(202) 639-0550

You can access this document online at <http://www.nrharural.org>.