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

RE: Notice of Proposed Rulemaking – Designation of Medically Underserved Populations and Health Professional Shortage Areas – RIN 0906-AA44, 73 Federal Register 11232 *et seq.* (February 29, 2008)

Dear Captain Jordan:

The Redwood Community Health Coalition is pleased to respond to the solicitation of comments from the Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA) on the proposed rule to revise and consolidate the criteria and the processes for designating Medically Underserved Areas and Medically Underserved Populations (MUAs and MUPs) and Health Professional Shortage Areas (HPSAs), which are used to determine eligibility for federal funding for a variety of programs, including community health centers (CHCs), National Health Service Corps providers, international physicians utilizing J-1 Visa Waivers, and Medicare Provider Incentive Payments.

Redwood Community Health Coalition (RCHC) is a network of ten Federally-Qualified Health Centers, one Rural Health Center, one Federally-Qualified Health Center affiliated with the Indian Health Service, and two Community Clinics. RCHC clinics and health centers operate 23 sites of care in Marin, Napa, Sonoma, and Yolo counties in California, and are the "Medical Home" for approximately 150,000 people in our region.

RCHC's service area is approximately 3,860 square miles, approximately the size of Connecticut. It is a mix of rural, suburban and urban communities with a total population of 1 million people. Our region is an area of great wealth and great disparity. The percent of the total population lives beneath the federal poverty level and 24% lives beneath 200% of the poverty level. The two most significant ethnic groups are white non-Latinos (68% of the population) and Latinos (24%), the fastest growing segment of the population. Sixty-four percent of RCHC's patients live below 100% of the poverty level and 92% below 200%; 40% have no insurance; 33% are White non-Latinos and 57% are Latinos, the vast majority of whom are mono-lingual Spanish speakers.

RCHC appreciates the goals of simplification and clarification of the Shortage Designation process which has motivated the current Notice of Proposed Rulemaking (NPRM) and its supplemental statement. We are, however, *deeply concerned* about the impact that this process will have on the ever growing number of uninsured and underinsured people in the state of

California, on those who lack access to care because of geographic isolation, and on the providers whose operations, stability and very existence is predicated on their continued designation under that process.

Ten years ago, HRSA decided to update the regulations governing shortage designations as they applied to MUAs/MUPs and HPSAs. After substantial debate and questioning, HRSA recognized that their efforts had potential to do significant harm to the network of providers serving those who provided access to uninsured and underinsured populations of America as well as those in rural and geographically remote locations. After at least 800 responses, they determined that the proposal needed to be more carefully tested and develop alternatives. Ten years later, the second NPRM has been published and appears to be *as potentially harmful* as the original.

We emphasize the concept of *potential* harm and note that, in principle, Redwood Community Health Coalition would not object to a simplification process *per se*. But, as discussed below, we are deeply concerned with what appears to be a far more complex, far less transparent, far more burdensome process that is being proposed. California faces perhaps the most difficult challenge in analyzing the impact of this proposed rule because we are one of four states that does not utilize counties as rational service areas (RSAs). Because of the size and population density of California counties, they cannot be utilized as RSAs. California counties average 2700 square miles in area, which cannot represent a rational service area under any assessment for shortage designations. In addition to concerns associated with utilizing counties as RSAs, California has the highest population density per county in the entire country, creating another area of concern in utilizing counties as RSAs.

Based on the level of complexity involved in analyzing the proposed NPRM at an RSA level and the limited timeframe provided for comments, California's Primary Care Organization (PCO) and Primary Care Association (PCA) could not complete a comprehensive analysis on the impact. California's PCO, the Office of Statewide Health Planning and Development, was able to complete a Tier 1 analysis. The limited timeframe provided by the available comment period resulted in California's PCA being forced to conduct an abbreviated Tier 2 analysis and a safety-net facility analysis for those health centers *located* in areas unable to secure a Tier 1 or Tier 2 designation.

RCHC's analysis of the Proposed Rule revealed that only two RCHC clinic sites would qualify for the Tier 1 designation, none of our clinics would qualify for the Tier 2 designation, eleven sites qualify for the safety-net designation, and one clinic sites is under the 40% threshold.

Local Analysis of HPSA Regulations

Tier 1 Designations

Clinic Site	Health Center	County	MSSA ID	MSSA Name	Underserved
ALEXANDER VALLEY REGIONAL MEDICAL CENTER	**Alexander Valley Regional Medical Center**	**Sonoma**	**206**	**Cloverdale**	**RHC – Tier 1**
SALUD CLINIC	**CommuniCare Health Centers**	**Yolo**	**245**	**West Sacramento**	**FQHC – Tier 1**

Local Analysis of HPSA Regulations
Safety-Net Designations

Clinic Site	Health Center	County	MSSA ID	MSSA Name	Underserved
BOLINAS FAMILY PRACTICE	Coastal Health Alliance	Marin	81	Bolinas	FQHC - Safety-Net Designation
POINT REYES MEDICAL CLINIC	Coastal Health Alliance	Marin	81	Point Reyes	FQHC - Safety-Net Designation
MARIN COMMUNITY CLINIC	Marin Community Clinics	Marin	83a	Greenbrae	FQHC - Safety-Net Designation
MARIN COMMUNITY CLINIC	Marin Community Clinics	Marin	83b	Novato	FQHC - Safety-Net Designation
COMMUNITY HEALTH CLINIC OLE	Community Health Clinic Ole	Napa	112.2	Napa	FQHC - Safety-Net Designation
ALLIANCE MEDICAL CENTER	Alliance Medical Center	Sonoma	205.1	Healdsburg	FQHC - Safety-Net Designation
OCCIDENTAL AREA HEALTH CENTER	West County Health Centers	Sonoma	210.2	Occidental	FQHC - Safety-Net Designation
RUSSIAN RIVER HEALTH CENTER	West County Health Centers	Sonoma	207	Guerneville	FQHC - Safety-Net Designation
SONOMA VALLEY COMMUNITY HEALTH CENTER	Sonoma Valley Community Health Center	Sonoma	208	Sonoma	FQHC - Safety-Net Designation
PETALUMA HEALTH CENTER	Petaluma Health Center	Sonoma	209.1	Petaluma	FQHC - Safety-Net Designation
PETALUMA HEALTH CENTER DENTAL CLINIC	Petaluma Health Center	Sonoma	209.1	Petaluma	FQHC - Safety-Net Designation

CHANATE HEALTH CENTER	Southwest Community Health Centers	Sonoma	210.1	Santa Rosa	FQHC - Safety-Net Designation
ELSIE ALLEN HEALTH CENTER	Southwest Community Health Centers	Sonoma	210.1	Santa Rosa	FQHC - Safety-Net Designation
SOUTHWEST COMMUNITY HEALTH CENTERS, INC	Southwest Community Health Centers	Sonoma	210.1	Santa Rosa	FQHC - Safety-Net Designation
SONOMA COUNTY INDIAN HEALTH PROJECT, INC	Sonoma County Indian Health Project, Inc.	Sonoma	210.1	Santa Rosa	FQHC (Indian Health Service) - Safety-Net Designation
WINTERS HEALTHCARE CLINIC	Winters Healthcare Clinic	Yolo	242	Winters	FQHC - Safety-Net Designation
DAVIS COMMUNITY CLINIC	CommuniCare Health Centers	Yolo	244	Davis	FQHC - Safety-Net Designation
PETERSON CLINIC	CommuniCare Health Centers	Yolo	246.1	Woodland	FQHC - Safety-Net Designation

Local Analysis of HPSA Regulations

Under 40%

Clinic Site	Health Center	County	MSSA ID	MSSA Name	Underserved
STINSON BEACH MEDICAL CENTER	Coastal Health Alliance	Marin	81	Stinson Beach	FQHC - Under 40%

While we appreciate recent action by HRSA extending the initial sixty day comment period by an additional thirty days, we remain concerned that ninety days was insufficient given the sheer complexity of the methodology. Given the lack of information and time available to analyze the impact of these changes on the people and programs in our service areas and the potential for great harm that this proposal carries with it, we strongly urge the withdrawal of the proposed NPRM and enter into a Negotiated Rule Making (NPM). This process will allow HRSA and relevant stakeholders to discuss and resolve significant areas of concern and allow California as

well as other states in similar situations the time to fully analyze the impact of any proposed changes.

Recommendation: **Redwood Community Health Coalition strongly urges HRSA to withdraw the Proposed Rule, and to enter a Negotiated Rule Making under 5 U.S.C. §§ 561 – 570, in which HRSA and relevant stakeholders can participate in a collaborative effort to discuss and resolve remaining concerns arising from the Proposed Rule. We also recommend that because of the complexities involved in deriving shortage designations at a RSA level, representatives from California be included as a stakeholder in the Negotiated Rule Making.**

Not a Rational Threshold.

The NPRM bases the entire new process on the idea that we can set a threshold of patients per provider (3000:1) that triggers eligibility. In fact, there is no *rational* justification for setting the limit at 3000. HRSA begins by asserting that a ratio of 1500:1 is appropriate for clinical physicians (750:1 for mid-level providers). It then argues, that in Community A, with 3000 (adjusted) individuals served by only one physician, it is reasonable to use HRSA resources to add a second physician. That is because it is appropriate to act to bring the ratio back to 1500:1 and one additional physician could do that.

From this intuitive example, the regulation proposes to project the formula to all communities –a dangerous process. It proposes, for example, that in Community B, with 4500 individuals, there would *not* be a need for HRSA resources, even though one additional physician is needed. And in Community C, with 30,000 residents served by ten providers, *where their own formula suggests 10 more providers are needed,* HRSA suggests that no resources are justified. Community C has ten times the need exhibited by Community A. Community A gets support, Community C does not.

This is critical because, in the State of California, the average number of individuals in a rational service area (RSA) is nearly *67,000.* Indeed, nearly 200 of the RSAs in the state have in excess of 100,000 residents. We are being told that Community D, which might lack 30 or more providers – which has 45,000 or more residents who lack access to care, *is not worthy of federal support* not because their need is too low, but because their community is too large. Community D, with a shortage of resources which leaves 45,000 individuals potentially unserved, does not justify support, but Community A, with a potential of 1500 underserved should be given a federal grant.

The patient to provider ratio, a mathematical construct being used to represent a shortage of resources, has become more important than the reality of individuals who lack services. The same concept could be used to measure, not the ratio, but the resources needed (Community A needs 1 provider, Community B needs 1 provider, Community C needs 15 providers). This far more direct measure of need could then be used to set a threshold. In a new NPRM, HRSA should say that anyone with a need greater than 1 is eligible for resources.

Recommendation: **Redwood Community Health Coalition recommends that, if HRSA is going to use a single provider to population ratio to designate underserved areas – using adjusted or unadjusted populations - that it recognize as underserved, and hence as eligible for resources, any community which has a demonstrated need for at least one additional provider.**

Oversimplification.
HRSA describes the new process as intended to simplify the securing of shortage designations. "Simple" is most justified by the fact that a single variable – the ratio of patients to providers – is emphasized. However, the new process engages in substantial complex machinations to "adjust" the simple ratio. The emphasis on this single ratio dramatically changes the basis for analysis of shortage designation areas and *places the emphasis in the wrong area.*

The current MUA/MUP process makes use of four separate and distinct variables, only one[1] of which is the ratio of patients to providers. In doing so it recognizes the importance not only of the resources available to provide care, but the evidence of lack of care and the exacerbating characteristics of the population at risk. These (MUP) designations are used to set basic eligibility standards for more than $2 billion dollars in direct federal funds and at least[2] $1 billion in associated FQHC funds in an $8 billion dollar currently program serving in excess of 16 million[3] Americans. In contrast, the HPSA designation *does* make use of a single population to provider ratio. This designation, which defines eligibility for National Health Service Corps resources, is associated with just over $100 million in federal funds – *less than 5% of that dependent on MUP designation* and yet this is where the new designation process takes us.

Recommendation: **RCHC recommends that HRSA develop a process that is not dependent solely on the concept of an adjusted ratio of patients to providers, and that it consider other critical variables in expanding the basic four MUP variables to include uninsured populations.**

Unduly Budensome Process.
The NPRM repeatedly describes the new proposed process as "simple". The fact that the process is not, in fact, a simple one, is perhaps best demonstrated by the need for the Agency to post "supplementary information"[4] to clarify some of the issues raised by the initial 51 page announcement which explained this process.

HRSA Desk Review.
"Simple" in HRSA's approach is partially justified by the fact that the *initial* analysis of shortage designation areas will be conducted by HRSA and not require input from third parties. And indeed, for some the task should be very simple. But, as discussed below under "Burden," for

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[1] The other three, geriatric patients, infant mortality rate and poverty rate, are included directly or indirectly along with six other variables in the "simplified" process.
[2] The 2006 UDS reports on just over $650 million in wrap-arounds and reconciliations, but many states pay their increased FQHC rate through a process which is not identifiable in the UDS.
[3] Current estimates from incomplete 2007 USD data.
[4] Federal Register 73-77. April 21, Page 21300.

many, the initial analysis may not provide a score adequate to permit the assignment of NHSC resources. For these areas, the review is complex *and the entire burden falls on them!* Using HRSA's data, the proportion of health centers (we do not have comparable data for "Look-Alikes because HRSA did not run these data,) who will fail at one or more designation level is variously reported as being from 8% to 25% to 30%. The proportion of *patients* is even higher with estimates running as high as 63 million.

All that notwithstanding, HRSA has stated "that it is impossible to predict the exact final impact on specific communities and states because of the iterative process built into the system."[5]

Use of County-level Data.
HRSA found it simple to perform its analysis as long as it was able to make use of county data, which is sufficient in states that have many small counties. As mentioned previously, California has counties that are larger (geographically) than many states. Using county data in California to determine shortage designations would be severely inaccurate. HRSA has clearly stated that concerned individuals, groups or grantees may take it upon themselves to do all of the work required to obtain the data needed for a better presentation, but the burden clearly falls on those who would need to revise the figures.

Questionable Data.
The variables which are proposed for this process are based on data which are questionable.

1. **Providers.** The number of physicians and midlevels is a question which neither HRSA, CPCA, nor the state of California have been able to arrive at. This most critical variable is one which cannot be ignored:
   - **a.** **Physicians.** Physicians to be counted are taken from the membership lists of professional organizations. Yet these lists include significant numbers of physicians who are:
     - **i.** Administrators (not practicing)
     - **ii.** Academics (not practicing or with very limited practices including those who are precepting residents)
     - **iii.** Interns and residents (who, *if we can identify them)* may be discounted, but identifying them is almost impossible
     - **iv.** Retired (a critical problem in rural areas with retirement communities)
     - **v.** Semi-retired or working a reduced schedule. (many providers are now working two or three day weeks)
     - **vi.** Practicing at an address other than that listed in their membership
     - **vii.** Practicing at multiple addresses
     - **viii.** Practicing within closed health delivery systems

     These issues are known to impact different areas in very different ways, but without extensive surveying, it is difficult if not impossible for a health center to provide more accurate data. HRSA implies that adjustments may be made[6] but places the onerous responsibility for this on the applicant and is silent on the

[5] Federal Register 73-41. February 29, Page 11259.
[6] Federal Register page 11276.

evaluation of these adjustments.

b. **<u>Mid-level providers.</u>** In addition to the same issues raised for physicians above (and there are probably even higher proportions of nurse practitioners (NPs) in administrative work), there are multiple issues with identifying midlevel providers:
   i. In some areas NPs are going back to work as RNs simply because the income differential has all but disappeared. This is especially true here in California where a state mandated staffing ratio for hospitals has driven the cost of an RN close to that of an NP in larger metropolitan markets.
   ii. The nurse practitioner data are based on a seven year old survey which may or may not have accurately reflected the population at the time.
   iii. There are *<u>no</u>* consistent reliable lists of Physician Assistants.
   iv. Even if they are noted by license, there is no way to tell if a licensed NP is in primary care or in some subspecialty including mental health nurse practitioners.

c. **<u>Tier Two adjustments.</u>** Regulations clearly suggest that adjustments are to be made for health center providers, J-1 Visa Waiver providers and NHSC members, but no provision is made to identify who those individuals are. *Despite the fact that HRSA is in possession of this information,* applicants will find it difficult if not impossible to obtain this information.

2. ***<u>Unemployment</u>.*** While the basic concept is sound, the devil is in the details and the details for the unemployment measure really make it quite untenable.
   a. **<u>Age of Data.</u>** The data, at ten years old, are outdated and unusable. Utilizing updated data may also be of no value given the precariousness of the current economy.
   b. **<u>No Longer in the Work Force.</u>** Unemployment data do not include individuals who are no longer seeking employment, also sometimes referred to as "discouraged workers." Their inability to get work during a recession is as much a barrier to their ability to accessing health care as it is for those who are actively looking. While unemployment compensation requires one to search for a job (thus ensuring that they remain counted) once unemployment benefits run out there is often no incentive.
   c. **<u>Geographic area.</u>** Unemployment data are almost always generated for much larger geographic areas than the RSAs utilized in California. (County level data are to be available in the near future.) Even more important, there is no way identify sub-county regions in the unemployment data. (Note – programs which serve a specific racial or ethnic group might be able to better approximate the unemployment for that group if permitted to use these sub-samples of data in the process.)

3. ***<u>Health Status</u>.*** These data are also outdated, and, again, will be impossible to at a sub-county level. Note again that racial, ethnic or other data might possibly help to narrow down the target population.

4. ***Closed Health Systems*.** The proposed rule does not take into consideration that providers in closed health care systems, such as Kaiser Permanente, do not provide primary care services to non-members, including underserved populations. Consequently, communities with multiple closed health care systems, will appear not to have primary care shortages because of the large number of primary care providers employed by closed systems. As a result, many areas in our region, which includes Marin, Sonoma, Napa and Yolo counties, may not qualify for underserved designations even though there is a shortage of primary care providers for people who are not part of closed systems.

5. ***Private Practice Providers who do not serve Underserved Populations***. Currently, HRSA, based on physician registration at state or with a medical society, determines whether the supply of primary care physicians in an area is adequate or inadequate. However, HRSA has yet to develop a methodology to automatically discount providers who do not significantly care for underserved populations. Due to the low Medicaid reimbursement rate in California, it is our experience that a growing number of private practice physicians in our region serve very few underserved patients. California health centers must conduct burdensome surveys of local private providers to appeal HPSA determinations. RCHC asks that HRSA incorporate the Medicaid/Medicare billing history of physicians (volume per year) into HPSA formulas. Primary care providers with few Medicaid/Medicare visits, in proportion to their practice volume, should automatically be discounted. This would greatly decrease the burden on community health centers.

Recommendation: **RCHC recommends that HRSA target a release of a revised NPRM for mid- 2011 (following the release of the latest census data) and, in the interim, work with constituency groups such as primary care associations to develop more reasonable approaches to the data, especially approaches to data elements which could meaningfully be developed at the sub-county level.**

The revised NPRM should *explicitly* permit the use of stratified data to the extent that they are available and to the extent that it will better reflect the RSA being applied for. At a minimum use of variables like race and ethnicity and age of mothers should be permitted in stratifying unemployment and health data.

HRSA should not include data that will lack veracity such as mid-level provider data. California does not have licensure data that clearly identifies the practice of mid-level providers as "primary care." We understand HRSA's interest in including these providers in the NPRM, accurate data on these providers that can be included in any calculation is simply unavailable.

RCHC recommends that HRSA develop a methodology to automatically discount providers who do not significantly care for underserved populations. RCHC also urges HRSA to take into consideration that providers in Closed Health Systems do not provide primary care for non-members.

Safety Net Facility Designation.
HRSA proposes to establish a "Facility Designation Method,"[7] designed to designate those programs serving an at-risk population who fail to meet the criteria of Tier 1 or Tier 2 of the proposed rule. The process is spelled out (at paragraph 5.301.(b)(2)) as including two criteria:

1. Having at least 10% of all patients "indigent uninsured" receiving services on a sliding discount
2. Having 20, 30 or 40% of their patients who are on "Medicaid or who receive services free or on a discounted sliding fee scale)

There appears to be some confusion as to whether both criteria are required or just one, but we see no way to read it other than that both are required. A number of problems arise based on a poor understanding of how these concepts actually work in a health center.

1. **Indigent Uninsured.** Many health center patients who have insurance (as reported to BPHC on the UDS report) have deductibles of as much as $1000 per family member. As such, while probably covered in-patient, they are carried by the health center on their sliding discount program for all or virtually all of their services. These individuals are excluded by the definition.
2. **Paid by Medicaid.** Ironically, Medicaid is the best payor at most health centers. Those who are in need include patients who are covered by S-CHIP (whose reimbursement is lower and not boosted by FQHC provisions) and especially those who receive services through other federal programs including, but not limited to, Title X Family Planning, Breast and Cervical Cancer Control Program, and EPSDT.
3. **Patient Mix.** Not only are these *clearly needy, clearly appropriately targeted* individuals not included in the "numerator" of the equation, they ***are*** included in the denominator. The result is that a facility seeking designation must carefully question whether it sees beneficiaries of these other federally mandated programs. For example, a health center might have to drop all S-CHIP patients in order to get the denominator small enough to ensure continued funding and/or receipt of FQHC prospective payment.

Recommendation: **RCHC recommends that HRSA modify the methodology for facility designation to include as "appropriate" target patients all patients whose services are paid for by other programs of DHHS.**

Burden to Health Centers Underestimated.
HRSA believes that the level of effort for this new process will be relatively low. They point to such tremendous time savers as electronic submission (which so far has only lengthened submission times for other HRSA activities). And no doubt, if all that is required is accepting the numbers from HRSA, a HPSA resubmission will be much simpler. Based on the limited

[7] Ibid. Page 11251

analysis California's PCO was able to conduct on the NPRM, many health centers will be unable to simply utilize the numbers from HRSA and therefore, the level of effort stated in the burden statement is invalid. While not having had access to the raw data used to come up with the figures, we suspect that much of the level of effort calculation is predicated on the assumption that there will be a lot of "zero effort" centers. We feel that this assumption is probably erroneous. When it is suggested that a safety net facility designation – the designation that will require an applicant to first attempt to qualify as first a Tier 1 and then a Tier 2 applicant – will take only "2.6 hours", this estimate is clearly inaccurate.

***MUA/MUP Applications*.**

In the more than 30 years that many health centers have been serving their communities they have ***never*** had to submit a new application. We are now talking about repeating the process every three years. HRSA estimates 27 hours to submit a Metro area request, 10 hours for a non-Metro area. Although we agree the number of hours may be limited for many, in metropolitan areas where clinician time surveys are needed the amount of time may well be significantly longer and we believe may be excessive. There is no suggestion anywhere that current grantees are not serving an appropriate population and, indeed, HRSA goes out of its way to say that, even with no recertification having occurred for a period of 30 years or more, they should all be qualified. Tri-annual re-certification, whether it takes 27 hours every three years or for some possible over 100 hours every three years is an undue burden and should be eliminated.

***HPSA or HPSA+MUA/MUP Applications*.**

It would appear from the process being described that, on a regular three year basis, HRSA will evaluate each designation and indicate whether or not it will be automatically renewed. For those whose application will not automatically be renewed, there will be a significant level of effort involved in obtaining re-designation. Adequate time and resources must be supplied if the burden is to in any way approach a reasonable level.

Recommendation: **RCHC recommends that HRSA allow grantees that wish to use their designation only for eligibility for health center grant funds should be given the option of submitting one application every ten years with the application due in the year following the completion of the census.**

OTHER CRITICAL CONSIDERATIONS.

We request that HRSA to modify or expand on their proposed rule based on the comments below.

Support Continuity of Care

While HRSA believes it is unlikely, there is still the possibility that one or more California health center will lose its MUA and with it, its eligibility for its 330 grant.

Recommendation: **Redwood Community Health Coalitions urges HRSA to "grandfather" all existing FQHCs. Health Centers should not lose their designation**

as result of these changes to the Proposed Rule. Our communities depend on our health centers to provide services to underserved communities, and our health centers depend on 330 funds to meet the growing primary care needs in our region.

Migrant and Homeless Populations

Census data from 2000 were only marginally effective in counting Migrant and Homeless persons and we do not know, but have little faith in, the methodology used by Claritas and others to count this population which is of so little interest to marketing departments.

Recommendation: **RCHC recommends that HRSA modify its population counts to include HUD estimates of homeless populations and estimates of migrant populations made by other branches of government.**

Site versus organization.

We note that, despite the attempt to clarify the matter, the question of whether site or organization data will be used is unclear. HRSA makes clear that their analysis for continuing eligibility was based on the requirements for a MUA and MUP: "This analysis was conducted at the grantee level consistent with HRSA's health center policy that states: 'The statutory obligations of serving an MUA or MUP is an organizational level obligation, not a site specific requirement.'"[8] But eligibility for HPSA determination has always been site (or group of sites) specific. The analysis failed to review impact of the new rules on individual sites. This complex issue was skipped over, but there is no indication that the new rule will simplify it or how. If it is organization wide, will a site need to be separately designated? The supplement states: "To determine a Safety Net Facility designation, HRSA will need data on the proportions of the applicant organization's patient population that are low-income uninsured as well as Medicaid-eligible (see 73 FR 11251 of the proposed rule)."[9]

Recommendation: **RCHC recommends that any revised NPRM should include options for organizational and site designations and that clear and explicit rules should be established for the designation of a site, especially in terms of new BPHC attempts to define the service area of specific sites.**

Redwood Community Health Coalition acknowledges that certain features of the Proposed Rule are improvements over the methodology proposed in the first NPRM issued in 1998. However, we find that there are serious flaws and shortcomings regarding the Proposed Rule.

At a time when we face a severe fraying of the health care safety net and a shortage of primary care physicians, we find it unreasonable for HRSA to hurriedly push this revision without more extensive consideration of its effects and the impact on the safety-net and the patients we serve. As such, Redwood Community Health Coalition strongly urges that HRSA withdraw the Proposed Rule and enter into a Negotiated Rule Making with stakeholders from California present to discuss and resolve concerns.

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[8] Federal Register 73-77. February 29, Page 21301.

[9] Ibid

Thank you for the opportunity to comment on the Proposed Rule. We appreciate your consideration on these comments. If you have any further questions, please do not hesitate to contact Pedro Toledo, Director of Community and Government Relations at (707) 326-7551, or via e-mail at ptoledo@rchc.net.

Sincerely,

Nancy Oswald, Ph.D.
Redwood Community Health Coalition