

October 2006

HEALTH PROFESSIONAL SHORTAGE AREAS



Problems Remain with Primary Care Shortage Area Designation System





Highlights of [GAO-07-84](#), a report to congressional committees

Why GAO Did This Study

To identify areas facing shortages of health care providers, HHS relies on its health professional shortage area (HPSA) designation system. HHS designates geographic, population-group, and facility HPSAs. HHS also gives each HPSA a score to rank its need for providers relative to other HPSAs.

The Health Care Safety Net Amendments of 2002 required GAO to report on the HPSA designation system. GAO reviewed (1) the number and location of HPSAs and federal programs that use HPSA designations to allocate resources or provide benefits, (2) available research on HPSA designation criteria and methodology, and (3) the impact of a 2002 provision that automatically designates federally qualified health centers and certain rural health clinics as facility HPSAs. GAO obtained and analyzed HHS's data on primary care HPSA designations as of September 2005 and January 2006 and identified reports on HPSA criteria and methodology through a literature search of peer-reviewed journals and other reports published since 1995.

What GAO Recommends

GAO recommends that HHS (1) remove the designations of HPSAs that no longer qualify by publishing a list of designated HPSAs in the *Federal Register* and (2) complete and publish HHS's proposal to revise the HPSA designation system. HHS concurred with both recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-07-84.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600 or aronovitzl@gao.gov.

HEALTH PROFESSIONAL SHORTAGE AREAS

Problems Remain with Primary Care Shortage Area Designation System

What GAO Found

GAO identified more than 5,500 HPSAs designated throughout the United States as of September 2005; multiple federal programs relied on these designations to allocate resources or provide benefits. GAO estimated that slightly more than half of the HPSAs were designated for geographic areas, such as counties or portions of counties, or population groups, such as migrant farmworkers. The remaining HPSAs were designated for facilities, such as rural health clinics. In fiscal year 2005, more than 30 federal programs relied on HPSA designations, and in some cases HPSA scores, to allocate resources or provide benefits. The use of the HPSA designation by numerous federal programs to allocate resources or provide benefits is an incentive for obtaining and retaining a HPSA designation.

Published reports have pointed to shortcomings in the methodology used for designating HPSAs. These reports' observations were consistent with findings in GAO's 1995 report, *Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved*, ([GAO/HEHS-95-200](#), Sept. 8, 1995), including that HHS's methodology did not account for certain types of primary care providers already serving in a HPSA, which can result in an overstatement of the provider shortage. Recognizing the shortcomings of the current methodology, HHS has been working since 1998 on a proposal to revise the designation system. In addition, some HPSAs that no longer meet the criteria have retained their HPSA designation and possibly received benefits from federal programs that rely on that designation. HHS has not complied since 2002 with the statutory requirement to annually publish a list of designated HPSAs in the *Federal Register*—which would remove the designations of those HPSAs that are no longer listed.

Many federally qualified health centers and rural health clinics did not benefit from automatic designation as facility HPSAs because they were located in geographic or population-group HPSAs. In addition, most of the more than 1,600 federally qualified health centers received HPSA scores associated with the automatic designation that were too low to qualify them for certain federal programs that required a minimum HPSA score in 2005, although they qualified for other programs that did not have such a requirement. Of the 590 rural health clinics that chose to certify that they would treat anyone regardless of ability to pay and, as a result, received automatic designation as facility HPSAs, most also received associated HPSA scores too low to qualify for benefits from certain federal programs that required a higher HPSA score.

Contents

Letter		1
	Results in Brief	5
	Background	8
	HPSAs Are Located in Every State and Are Used by Multiple Federal Programs	14
	Research Points to Shortcomings with Designation Methodology Many Health Centers and Rural Health Clinics Did Not Benefit from Automatic HPSA Designation	25
	Conclusions	29
	Recommendations for Executive Action	34
	Agency Comments	35
Appendix I	Scoring of Health Professional Shortage Areas	38
Appendix II	Medically Underserved Area or Population Designations and Medically Underserved Community Definition	41
Appendix III	Scope and Methodology	45
Appendix IV	Federal Programs Using Health Professional Shortage Area and Other Designations of Underservice	49
Appendix V	Comments from the Department of Health and Human Services	55
Appendix VI	GAO Contact and Staff Acknowledgments	59

Related GAO Products

60

Tables

Table 1: Number of, Population in, and Physicians Needed in Geographic and Population-Group HPSAs, September 2005	15
Table 2: Programs and Administering Agencies That Used HPSA, MUA, MUP or Other Designations to Allocate Resources or Provide Benefits in Fiscal Year 2005	49

Figures

Figure 1: HPSA Designation Request and Review Process, 2005	9
Figure 2: Types of HPSAs and Criteria Used to Designate Them, 2005	10
Figure 3: U.S. Counties with Geographic and Population-Group HPSAs, January 2006	16
Figure 4: Types of Facility HPSAs, September 2005	19
Figure 5: Distribution of HPSA Scores among Health Centers Automatically Designated as Facility HPSAs, September 2005	31
Figure 6: Distribution of HPSA Scores among Rural Health Clinics Automatically Designated as Facility HPSAs, September 2005	34
Figure 7: Scoring of HPSAs, 2005	39

Abbreviations

CMS	Centers for Medicare & Medicaid Services
COGME	Council on Graduate Medical Education
HHS	Department of Health and Human Services
HPSA	health professional shortage area
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
MUA	medically underserved area
MUP	medically underserved population
NHSC	National Health Service Corps
USCIS	U.S. Citizenship and Immigration Services
VA	Department of Veterans Affairs

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



United States Government Accountability Office
Washington, DC 20548

October 24, 2006

The Honorable Michael B. Enzi
Chairman
The Honorable Edward M. Kennedy
Ranking Minority Member
Committee on Health, Education, Labor,
and Pensions
United States Senate

The Honorable Richard Burr
Chairman
Subcommittee on Bioterrorism and Public
Health Preparedness
Committee on Health, Education, Labor,
and Pensions
United States Senate

The Honorable Joe Barton
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

Many Americans live in areas, such as inner-city neighborhoods or isolated rural locations, where obtaining health care is difficult because health care providers are in short supply. To identify areas facing a critical shortage of providers, the Department of Health and Human Services (HHS) relies on its health professional shortage area (HPSA) designation system.¹ Originally created in 1978 to identify areas in need of physicians and other health care providers from HHS's National Health Service Corps (NHSC) programs, HPSA designation is now used by a variety of federal programs—including programs that provide grants for health professions

¹Throughout this report, we use the term *HPSA* to denote health professional shortage areas for primary care, which HHS considers to include medical specialties of general or family practice, general internal medicine, pediatrics, and obstetrics and gynecology. In addition to primary care HPSAs, HHS designates HPSAs for fields other than primary care, including dental and mental health.

education and training or bonus payments under Medicare for physician services—to allocate resources or provide benefits.²

A HPSA can be a distinct geographic area (such as a county), a specific population group within an area (such as low-income individuals), or a specific health care facility. Facility HPSAs include federal or state correctional institutions, as well as federally qualified health centers—facilities that provide primary care services in underserved areas³—and certain rural health clinics—facilities that provide outpatient primary care services in rural areas.⁴ HHS’s Health Resources and Services Administration (HRSA)—the HHS agency that manages the HPSA designation system—designates HPSAs based on the ratio of population to the number of primary care physicians and other factors.⁵ HRSA then

²HPSAs can be located in all states and the District of Columbia, as well as in American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, Puerto Rico, the Republic of the Marshall Islands, the Republic of Palau, and the U.S. Virgin Islands.

³Federally qualified health centers, referred to as *health centers* in this report, include (1) health centers that receive a grant or funding from a grant under the consolidated health center program authorized under section 330 of the Public Health Service Act; (2) facilities, called look-alikes, that are determined by the Secretary of Health and Human Services to meet the requirements for receiving such a grant; and (3) outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act. Health centers are located in both urban and rural areas and are required to treat everyone regardless of ability to pay. According to data from HHS’s Health Resources and Services Administration (HRSA), the agency that administers the consolidated health center program and certifies look-alikes, there were over 1,600 health centers as of September 2005.

⁴Rural health clinics are located in rural areas and, unlike health centers, are not required to provide services to all individuals, regardless of their ability to pay. According to data from HHS’s Centers for Medicare & Medicaid Services (CMS), the agency that certifies these clinics as rural health clinics for purposes of the Medicare and Medicaid programs, there were over 3,600 rural health clinics as of September 2005.

⁵In addition to the ratio of population to primary care physicians, HPSA designation is based on other factors, such as health care resources available in neighboring areas. For those geographic HPSAs that have their HPSA designations on the basis of having unusually high needs for primary care services, the HPSA designations are also based on at least one of three other factors: the area’s infant mortality rate, the percentage of the population with incomes below the poverty level, or the area’s birth rate. See HRSA, Bureau of Health Professions, “Health Professional Shortage Area Primary Medical Care Designation Criteria,” <http://bhpr.hrsa.gov/shortage/hpsacritpcm.htm> (downloaded May 15, 2006). HRSA also automatically designates health centers and certain rural health clinics as facility HPSAs; these facilities are not required to meet a ratio of population to primary care physicians for HPSA designation.

assigns each HPSA a score on the basis of specific criteria that ranks its shortage of primary care providers, or need, relative to other HPSAs.⁶ Some federal health care programs, such as NHSC programs, allocate their resources on the basis of HPSA scores, not just HPSA designations.

HHS's criteria and methodology for designating HPSAs has remained unchanged since October 1, 1993.⁷ In 1998, in an effort to improve the way underserved areas were designated, HHS published a proposal to revise the HPSA designation system.⁸ The department received more than 800 comments on its proposal from individuals and organizations, including individual physicians, state primary care organizations, and university or research organizations. These comments raised several issues, such as whether or how to count nonphysician providers, such as physician assistants, in the total number of practitioners serving a population; the potential number of HPSAs that would lose their HPSA designations because of changes in the designation criteria; and the incorporation of certain population factors, such as the percentage of elderly and uninsured individuals, which reflect a population's ability to access care. In response to these comments, HHS withdrew its 1998 proposal, and left the existing HPSA designation system in place while it began working on another proposal.

The Health Care Safety Net Amendments of 2002 required that we report on the HPSA designation system and on a provision included in the act that automatically designates health centers and certain rural health

⁶Four factors, including factors used for HPSA designation, determine a HPSA's score—ratio of population to primary care physicians, percentage of the population with incomes below the poverty level, infant mortality rate or low birth weight rate, and time or distance to the nearest source of primary care. Each HPSA is scored on a scale of 0 to 25, with higher scores indicating greater relative need for primary care providers. See appendix I for additional information on HPSA scoring.

⁷Since 1995 we have reported on shortcomings of the HPSA designation system. See GAO, *Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved*, GAO/HEHS-95-200 (Washington, D.C.: Sept. 8, 1995), as well as "Related GAO Products" at the end of this report.

⁸63 Fed. Reg. 46538–55 (Sept. 1, 1998). The proposal included provisions to combine the HPSA designation system with HRSA's other designations of underservice: the medically underserved area (MUA) and medically underserved population (MUP) designations. See appendix II for more information on the MUA and MUP designations.

clinics as facility HPSAs.⁹ As discussed with the committees of jurisdiction, this report discusses (1) the number and location of HPSAs and the federal programs that use HPSA designations to allocate resources or provide benefits, (2) available research on the criteria and methodology used to designate HPSAs, and (3) the impact of the automatic HPSA designation on health centers and rural health clinics.

To conduct our work, we examined relevant laws, regulations, and HHS documents related to the HPSA criteria in effect in 2005—criteria that had remained unchanged since 1993—and reviewed our prior work on the HPSA designation system. To determine the number of HPSAs, we interviewed officials from HRSA, who reported that precise, accurate, historical data on the total number of HPSAs were not available. Therefore, to estimate the number of HPSAs designated as of September 2005, we designed a methodology that used data from HRSA, including summary statistics on geographic and population-group HPSA designations and data files on the facilities that were automatically designated as HPSAs. We also analyzed a more detailed database of geographic and population-group HPSAs as of January 2006 in order to identify (1) the counties in which geographic and population-group HPSAs were located and (2) the HPSAs that were proposed for having their designations withdrawn because they no longer met the criteria or did not provide updated data in support of their designations. After taking steps to eliminate potential duplications or inconsistencies in the data we used, we determined that the data were sufficiently reliable for our purposes. To obtain information on HPSA designations and federal programs that use HPSA designations, we reviewed *Federal Register* notices and other documents obtained from HHS agencies—including HRSA, the Centers for Medicare & Medicaid Services (CMS), and the Indian Health Service (IHS)—and reviewed our prior work on these programs.

To identify available research on the criteria and methodology used to designate HPSAs, we conducted a literature search of reports, including those published in peer-reviewed journals, issued from January 1, 1995, through November 1, 2005. We identified other published reports discussing the HPSA designation methodology, including one by the Council on Graduate Medical Education (COGME). Of the more than 340

⁹Pub. L. No. 107-251, § 302(a)(1)(A), (e); 116 Stat. 1621, 1643–1645. Under this act, health centers and those rural health clinics certifying that they serve all individuals, regardless of ability to pay, automatically receive designation as facility HPSAs.

articles, studies, and reports—which we refer to as reports—identified in the search, we identified 7 that addressed the relationship between key elements of the HPSA designation criteria, such as income, and primary care physician supply or shortages, or that addressed factors related to the HPSA designation methodology. We also interviewed researchers who have studied primary care provider shortages, as well as HRSA officials knowledgeable about the HPSA designation system. To review the impact of the automatic designation on health centers and rural health clinics, we analyzed HRSA’s data on automatic HPSA designations, including the HPSA scores associated with automatic designation, and interviewed HRSA officials and officials from associations representing these types of facilities. We performed our work from August 2005 through September 2006 in accordance with generally accepted government auditing standards.¹⁰

Results in Brief

We identified more than 5,500 HPSAs designated throughout the United States as of September 2005; multiple federal programs relied on these designations to allocate resources or provide benefits. We estimated that slightly more than half of the HPSAs were designated for geographic areas or population groups, and these geographic and population-group HPSAs were located in all 50 states and the District of Columbia. Facility HPSAs, which accounted for slightly less than half of the total number of HPSAs, were also located in every state and the District of Columbia. In fiscal year 2005, more than 30 federal programs—including programs administered by HRSA, CMS, and federal agencies outside of HHS—relied on HPSA designations and, in some cases, HPSA scores, to allocate resources or provide benefits. These included NHSC programs that award scholarships or educational loan repayment to students and health professionals in exchange for a commitment to practice in HPSAs for at least 2 years. Other programs relying on HPSA designations to allocate resources or provide benefits included programs that pay physicians bonus payments for services provided to Medicare beneficiaries in geographic HPSAs and programs that waive certain requirements for foreign physicians if they agree to practice in HPSAs or other underserved areas of the United States. The use of the HPSA designation by numerous federal programs to allocate resources or provide benefits is an incentive for obtaining and retaining a HPSA designation.

¹⁰See appendix III for additional information on our scope and methodology.

Of the seven reports we identified that discuss the criteria and methodology used to designate HPSAs, one supported a relationship between a key element of the HPSA criteria and primary care physician supply, while the remaining six pointed to shortcomings in the methodology. The one report we identified that supported a key element of the criteria found that areas with higher incomes had more primary care physicians than areas with lower incomes. The other six reports included observations that were consistent with what we reported in 1995, including the fact that the HPSA designation methodology does not account for the presence of certain types of primary care providers in a HPSA, which can result in an overstatement of the shortage of primary care providers. Researchers have highlighted other problems in the methodology used to designate HPSAs, such as relying on geographic boundaries that do not necessarily reflect areas' health care needs. Recognizing the shortcomings of the current methodology, HHS has been working since 1998 on a proposal to revise the HPSA designation system, which, as of September 2006, was in the department's clearance process. In 1995, we reported on an additional problem involving the timeliness with which HRSA identified and removed the HPSA designations of those areas, population groups, and facilities that no longer met the HPSA criteria—a problem that has continued in recent years. For example, in 2005, the HHS Office of Inspector General reported that, as of 2003, HRSA had not reviewed HPSA designations in a timely manner. In addition, we found that since 2002, HHS has not complied with the statutory requirement to annually publish a list of designated HPSAs in the *Federal Register* or otherwise remove the HPSA designations for those HPSAs that either no longer meet the criteria or have not provided updated data in support of their designations. As a result, some HPSAs that no longer meet the criteria have retained their HPSA designations and possibly received benefits from federal programs that rely on the designation for allocating resources.

Automatic HPSA designation of health centers and certain rural health clinics as facility HPSAs provided little or no benefit for many of these facilities. For health centers and rural health clinics located in geographic or population-group HPSAs before implementation of the 2002 provision, automatic designation as a facility HPSA resulted in no added benefit unless the HPSA score associated with the automatic designation was higher than the score for the geographic or population-group HPSA in which the facility was located. Although precise data were not available, HRSA officials estimated that many of the more than 1,600 health centers—all of which received automatic designation as facility HPSAs—were located in geographic or population-group HPSAs before 2002. Of the

more than 3,600 rural health clinics, 590 had certified they would treat everyone regardless of ability to pay and, as a result, received automatic HPSA designation as of September 2005; however, data were not available to determine how many of them were located in geographic or population-group HPSAs before receiving automatic HPSA designation. In addition, although officials that work with health centers and rural health clinics reported that these facilities in general welcomed the automatic HPSA designation because it could allow them the benefit of recruiting a physician through the NHSC, few had HPSA scores associated with the automatic designation that were high enough to qualify for a physician through the NHSC Scholarship Program. Specifically, as of September 2005, less than 5 percent of the health centers and less than 1 percent of the rural health clinics with automatic facility HPSA designations had HPSA scores that were high enough to qualify for a physician through the NHSC Scholarship Program. However, all health centers and rural health clinics that received automatic designations as HPSAs, even those with lower HPSA scores, could apply in 2005 for a health care provider through another NHSC program, the NHSC Loan Repayment Program.

We are recommending that HHS (1) publish a list of designated HPSAs in the *Federal Register* or otherwise remove, through *Federal Register* notification, the HPSA designations for those HPSAs that no longer meet the criteria or have not provided updated data demonstrating they still meet the designation criteria and (2) complete and publish HHS's proposal to revise the HPSA designation system and address the problems that have been identified in the current methodology for designating HPSAs.

In commenting on a draft of this report, HHS concurred with our recommendations. Specifically, the department agreed that more timely publication of a list of designated HPSAs in the *Federal Register* is necessary, noting that publication in the *Federal Register* ensures that those HPSAs that have been proposed for withdrawal have their designations removed. The department also agreed with our recommendation to complete and publish its proposal to revise its HPSA designation system, stating that its proposal would address the various shortcomings that we have identified in this and previous reports.

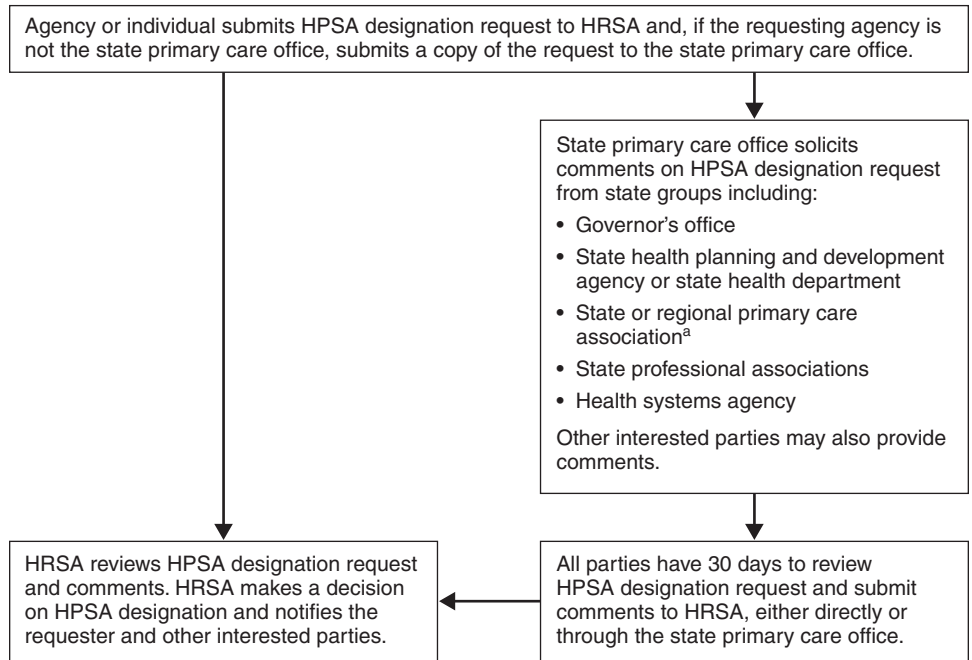
Background

Any agency or individual may request a HPSA designation for a geographic area, population group, or facility.¹¹ According to HRSA officials, the vast majority of HPSA designation requests are submitted by state primary care offices.¹² These requests are received and reviewed by the Shortage Designation Branch within HRSA. Individual and agency requesters, other than state primary care offices, are required to submit a copy of their request for HPSA designation to their state's primary care office. The state primary care office solicits comments about the request from state groups, including the state health department and state professional associations, and forwards the comments to HRSA. Other interested parties may also provide comments on the request and submit the comments directly to HRSA. HRSA's final designation decision is based on a review of the request and comments received from the state and other interested parties (see fig. 1).

¹¹HPSA designations may be requested for geographic areas, population groups, and facilities located in all states and the District of Columbia, as well as in American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, Puerto Rico, the Republic of the Marshall Islands, the Republic of Palau, and the U.S. Virgin Islands. The HPSA request and review process is the same for all locations.

¹²State primary care offices work toward addressing the needs of the medically underserved in their states and receive funding through HRSA grants and cooperative agreements. For more information, see HRSA, Bureau of Primary Health Care, "Directory of Primary Care Offices (PCO): December 2005," <http://bphc.hrsa.gov/OSNP/PCODirectory.htm> (downloaded June 19, 2006).

Figure 1: HPSA Designation Request and Review Process, 2005



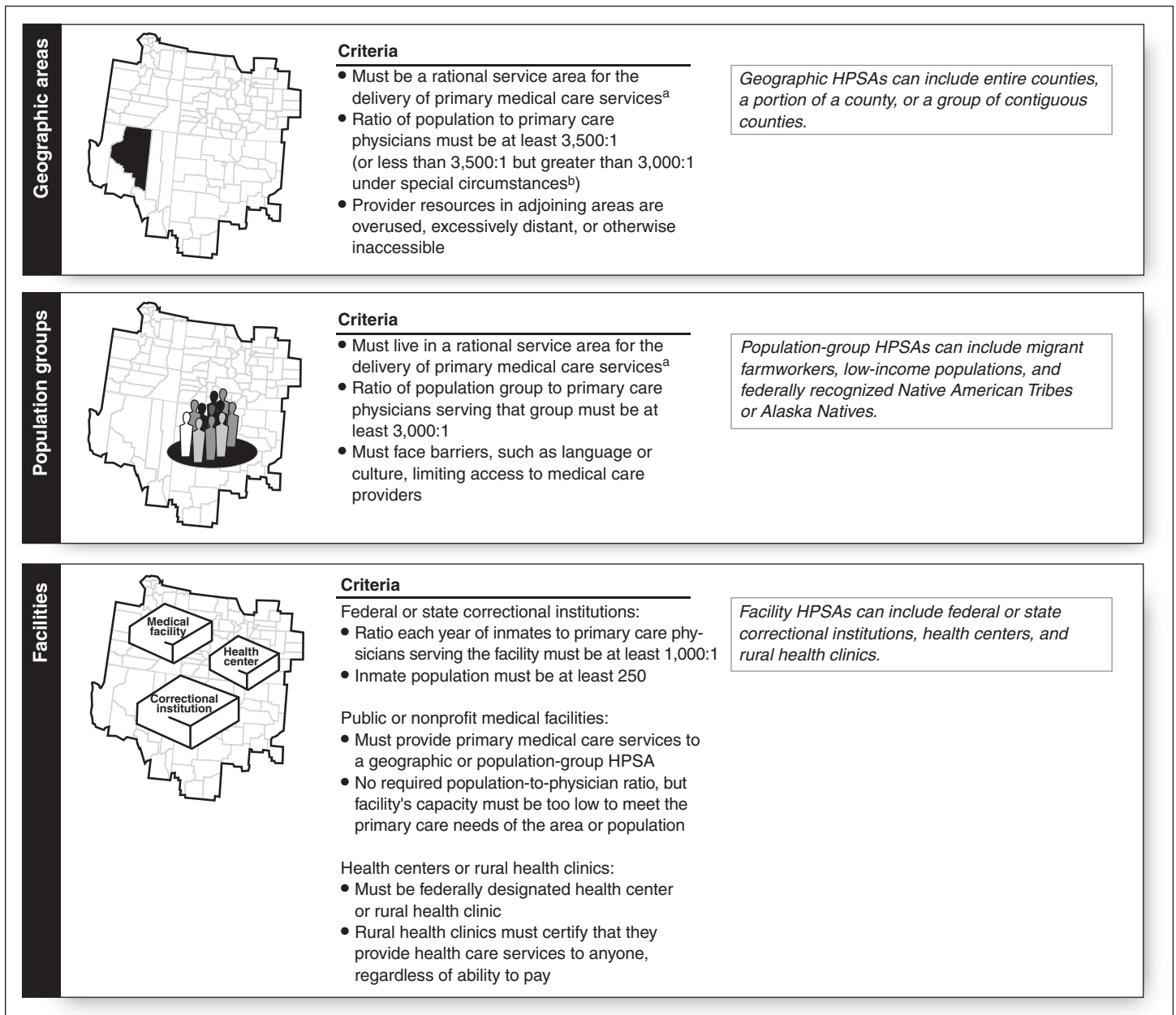
Source: GAO analysis of relevant statutes, regulations, and guidance.

^aPrimary care associations are private, nonprofit organizations representing states or regions that provide training and technical assistance to facilities, including health centers, to help ensure that these facilities deliver high-quality primary care services in underserved communities. For more information, see HRSA, Bureau of Primary Health Care, "Directory of Primary Care Associations (PCA): April 2005," <http://bphc.hrsa.gov/OSNP/PCADirectory.htm> (downloaded Apr. 3, 2006).

HRSA designates three types of HPSAs: geographic, population-group, and facility. Geographic HPSAs include entire counties, a portion of a county, or a group of contiguous counties. Population-group HPSAs include groups, such as migrant farmworkers, low-income urban populations, or federally recognized Native American Tribes or Alaska Natives, within a particular geographic area. Facility HPSAs include federal or state correctional institutions, health centers, and certain rural health clinics. To receive HPSA designation, the requesting agency or individual must provide HRSA with information demonstrating that the area, population group, or facility meets applicable criteria (see fig. 2).¹³

¹³See 42 C.F.R. pt. 5, apps. A–G (2005).

Figure 2: Types of HPSAs and Criteria Used to Designate Them, 2005



Source: GAO analysis of relevant statutes, regulations, and guidance.

^aHRSA defines a rational service area for the delivery of primary medical care services as (1) a county or group of contiguous counties whose population centers are within 30 minutes travel time of each other; (2) a portion of a county, or an area made up of portions of more than one county, whose population, because of topography, market or transportation patterns, distinctive population characteristics, or other factors has limited access to contiguous area resources, as measured generally by a travel time greater than 30 minutes to such resources; or (3) established neighborhoods and communities within metropolitan areas that display a strong self-identity (as indicated by a homogeneous socioeconomic or demographic structure or a tradition of interaction or interdependency), have limited interaction with contiguous areas, and that, in general, have a minimum population of 20,000. 42 C.F.R. pt. 5, app. A, I B.1, II A.1.(a) (2005).

^bSpecial circumstances exist in an area if it has unusually high needs for primary care services or an insufficient supply of primary care providers. Unusually high needs may be demonstrated if, for example, more than 20 percent of the population have incomes below the federal poverty level. Insufficient supply of providers may be demonstrated if, for example, the area has unusually long waits for appointments for routine medical services and at least two-thirds of the area's physicians do not accept new patients. 42 C.F.R. pt. 5, app. A, I B.4., 5 (2005).

Since 2002, two kinds of facilities—(1) health centers and (2) rural health clinics that certify that they treat everyone regardless of ability to pay—have been automatically designated as facility HPSAs without going through the standard request and review process.¹⁴ Health centers include consolidated health centers, health center look-alikes, and tribal health centers:¹⁵

- *Consolidated Health Centers*: These health centers—which include community health centers, migrant health centers, health centers for the homeless, and health centers for residents of public housing—receive grants and grant funding¹⁶ under section 330 of the Public Health Service Act. Consolidated health centers provide comprehensive community-based primary care services to individuals regardless of their ability to pay and are required to serve the medically underserved.¹⁷
- *Health center look-alikes*: These facilities have been determined to meet all of the requirements necessary to receive a grant under section 330 of the Public Health Service Act but do not receive such funding.

¹⁴42 U.S.C. §§ 254e(a)(1), 254g(a)(1), 1395x(aa)(2), (4).

¹⁵Health centers are reimbursed under CMS's Medicare and Medicaid programs using special payment mechanisms that serve as an incentive for becoming a health center. See also GAO, *Health Centers and Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System*, GAO-05-452 (Washington, D.C.: June 17, 2005).

¹⁶Some health centers receive grant funding from another entity that is the recipient of such a grant. To be considered a health center, they must also be eligible to receive a grant directly.

¹⁷A consolidated health center must serve an area or population designated by HHS as an MUA or MUP. See appendix II for information on the MUA and MUP designations.

-
- *Tribal health centers:* These facilities receive federal support to provide outpatient health services and are operated by tribes, tribal organizations, or urban Indian organizations under the Indian Self-Determination Act or the Indian Health Care Improvement Act.

Rural health clinics are located in rural areas and can operate either independently or as part of a larger organization, such as a hospital, skilled nursing facility, or home health agency.¹⁸ Unlike health centers, which are public or private nonprofit facilities, rural health clinics may function as for-profit entities. Rural health clinics must offer primarily outpatient primary medical care, but unlike health centers, they are not required to serve all individuals regardless of their ability to pay. Therefore, those rural health clinics that wish to receive automatic facility HPSA designation must certify to HRSA that they provide services to all individuals, regardless of their ability to pay, in order to receive the designation.

After receiving the HPSA designation, each geographic, population-group, and facility HPSA is scored on a scale of 0 to 25, with higher scores indicating greater relative need for primary care providers. The HPSA score is based on four elements, including elements used for HPSA designation: the ratio of population to primary care physicians (1 to 5 possible points, then doubled), poverty rate (0 to 5 possible points), infant mortality rate or low birth weight rate (0 to 5 possible points), and travel time or distance to the nearest available source of primary care (0 to 5 possible points). For a health center or rural health clinic automatically designated as a facility HPSA, if complete data are not available or HRSA cannot match the facility to appropriate data to calculate a HPSA score, the HPSA receives either a score of 0 or a partial score based on the sum of factors for which data are obtainable.¹⁹ According to HRSA's data on health centers and rural health clinics that received automatic designation as facility HPSAs, 10 percent of these facility HPSAs had a HPSA score of 0 as of September 2005.

¹⁸Rural health clinics are reimbursed under CMS's Medicare and Medicaid programs using special payment mechanisms that serve as an incentive for becoming a rural health clinic. To be reimbursed under Medicare and Medicaid, a rural health clinic must be located in a geographic or population-group HPSA in a rural area, a rural area designated by a state's governor (or chief executive officer) and certified by HHS as an area with a shortage of personal health services, or a rural area HRSA has designated as an MUA. See appendix II for additional information on the MUA designation.

¹⁹See appendix I for additional information on the scoring of HPSAs.

HRSA calculates the HPSA score using the information from the HPSA designation request. For health centers and rural health clinics that receive automatic facility HPSA designation, HRSA calculates the HPSA score using nationally available data and approximates the service area of a health center or rural health clinic by using data on the Primary Care Service Area in which the facility is located.²⁰ Any automatically designated facility HPSA located in a geographic or population-group HPSA may instead use the HPSA score for that geographic area or population group, which, according to HRSA officials, is likely to be much higher than the automatic facility HPSA score.²¹ According to HRSA officials, nationally available data used for automatic facility HPSA scores are often not as current or as precise as data collected for individual geographic and population-group HPSA designations.

HHS is required by law to review HPSA designations annually to determine if the designations remain appropriate in light of the applicable requirements.²² Each year, it must also publish a list of designated HPSAs in the *Federal Register*.²³ For HPSAs designated through the standard request and review process, HHS reviews the designations by giving a list of HPSAs that have been designated for 3 full years to each state and asking the relevant state groups—including the state’s governor’s office and state health department—to update the information. HPSA designations for which data are not provided or that no longer meet the designation criteria are proposed for withdrawal. A HPSA that is proposed for withdrawal remains designated as a HPSA until HHS publishes in the *Federal Register* either a notification that the HPSA designation has been withdrawn or an updated list of designated HPSAs that does not include

²⁰ A Primary Care Service Area is a zip code with one or more primary care providers or any contiguous zip codes whose Medicare populations seek the largest share of their primary care from those providers. For more information, see Center for Evaluative Clinical Sciences at Dartmouth, “The Primary Care Service Area Project,” <http://www.dartmouth.edu/~cecs/pcsa/pcsa.html#> (downloaded Jan. 31, 2006).

²¹ In addition, health centers that provide services at more than one delivery site receive a HPSA score for the entire entity, which is calculated by averaging the individual HPSA scores assigned to each site. If any individual site of a health center is in a geographic or population-group HPSA or has been designated as a facility HPSA through the standard request and review process, the site may use that HPSA’s score for purposes of applying for federal programs.

²² 42 U.S.C. § 254e(d)(1); 42 C.F.R. § 5.4(b) (2005).

²³ 42 U.S.C. § 254e(d)(2).

that HPSA.²⁴ Before a HPSA designation can be withdrawn, however, interested parties and groups must be allowed to provide data and information in support of the designation. A health center or rural health clinic receiving automatic facility HPSA designation must demonstrate every 6 years after receiving its automatic designation that it meets the definition of a HPSA.²⁵

HPSAs Are Located in Every State and Are Used by Multiple Federal Programs

More than 5,500 HPSAs were located throughout the country as of September 2005. We estimated that over half of these HPSAs were geographic or population-group HPSAs; the rest were facility HPSAs. Numerous federal programs have used these HPSA designations to allocate their programs' resources or provide benefits, which is an incentive for obtaining and retaining the HPSA designation.

Number and Location of HPSAs

Using HRSA data, we identified 5,594 designated HPSAs as of September 2005. We estimated that slightly more than half (3,032) of these HPSAs were designated for geographic areas or population groups. HRSA calculated that geographic and population-group HPSAs needed 6,941 additional full-time primary care physicians to achieve ratios of population to primary care physicians that would remove the HPSA designations (see table 1).

²⁴42 C.F.R. § 5.4(d) (2005).

²⁵42 U.S.C. § 254e(a)(1).

Table 1: Number of, Population in, and Physicians Needed in Geographic and Population-Group HPSAs, September 2005

HPSA type	Number of HPSAs	Population in HPSAs^a	Primary care physicians needed^b
Geographic area	1,646	34,821,125	3,549
Population group	1,386	24,912,956	3,392
Total	3,032	59,734,081	6,941

Source: HRSA.

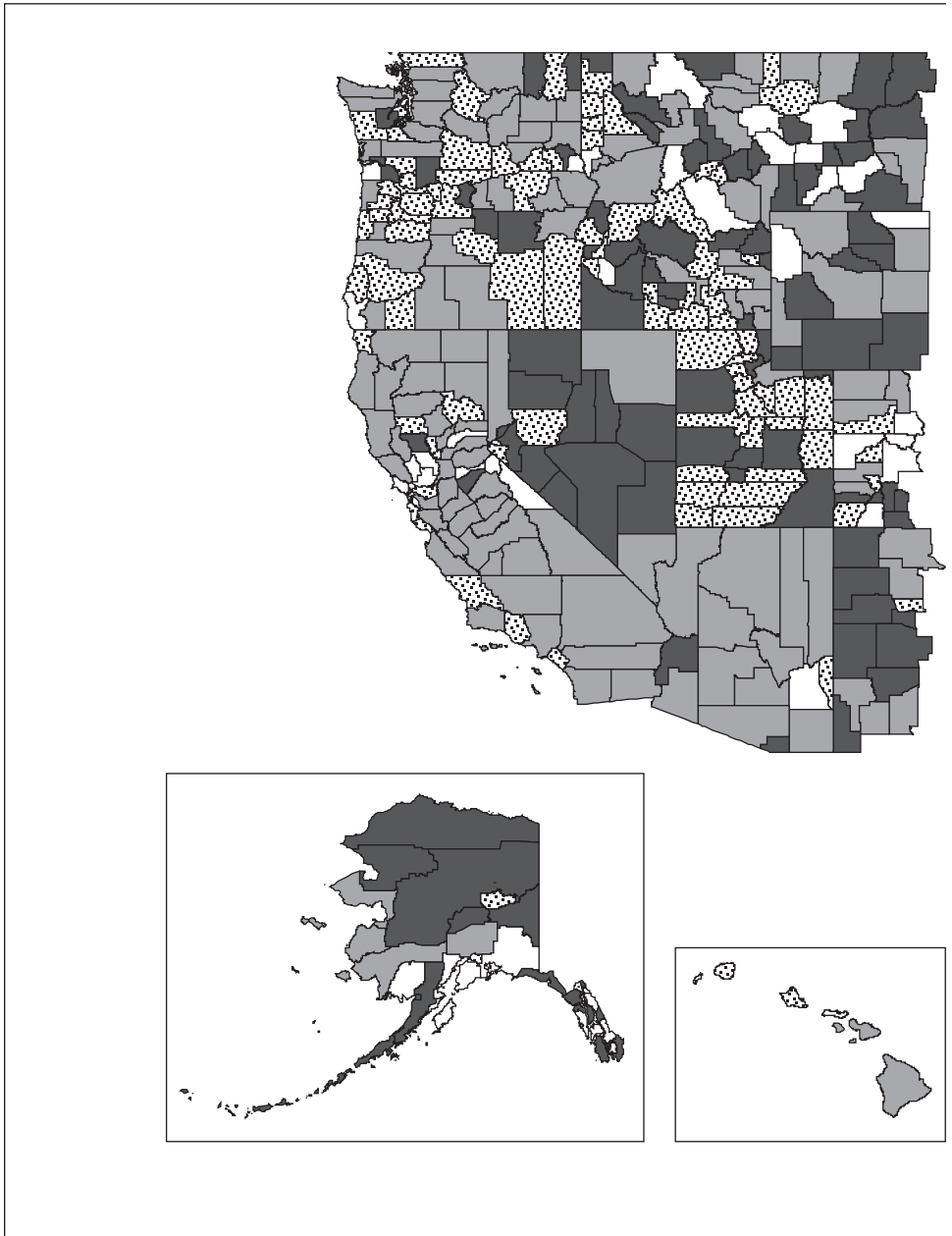
^aThese numbers represent the resident civilian population of the related HPSA. For example, for geographic HPSAs that consist of an entire county, this number reflects the resident civilian population of the entire county. For population-group HPSAs, this number reflects that groups' population within particular geographic areas.

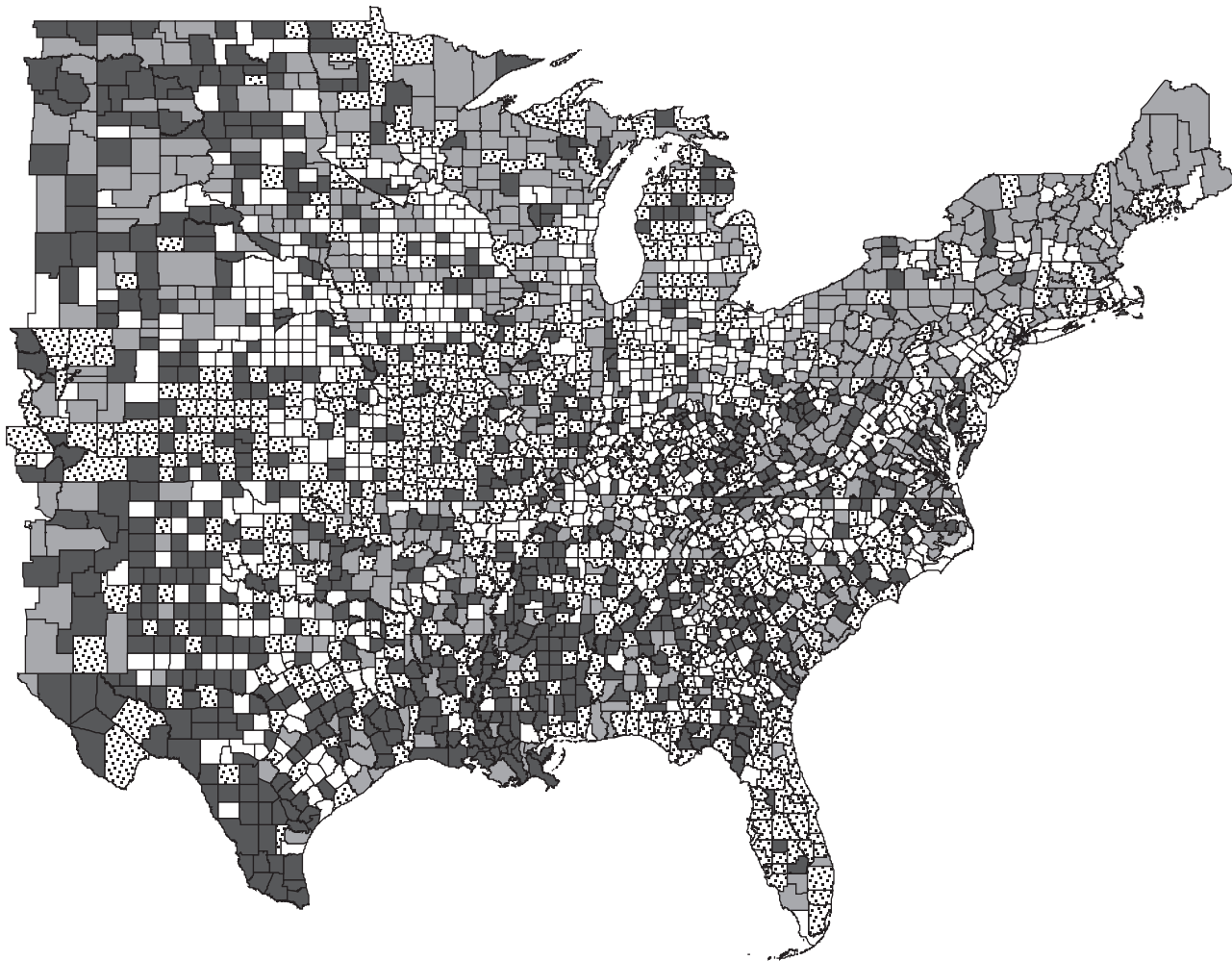
^bThe number of additional full-time-equivalent primary care physicians required to achieve population-to-primary care physician ratios of 3,500:1 (less than 3,500:1 but greater than 3,000:1 under special circumstances), which are needed to remove the HPSA designations.

Of the 1,646 geographic HPSAs, slightly more than half (831) consisted of an entire county, and the remainder (815) consisted of other service areas within counties, such as specific census tracts. As illustrated in figure 3, geographic and population-group HPSAs designated as of January 2006 were located in 2,494 counties in all 50 states and the District of Columbia.²⁶

²⁶Geographic HPSAs were also located in American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, Puerto Rico, the Republic of the Marshall Islands, and the Republic of Palau. Population-group HPSAs were also located in Puerto Rico and the U.S. Virgin Islands.

Figure 3: U.S. Counties with Geographic and Population-Group HPSAs, January 2006





- Did not have a geographic or population-group HPSA
- Had a population-group HPSA
- Had a partial-county geographic HPSA
- Was a whole-county geographic HPSA

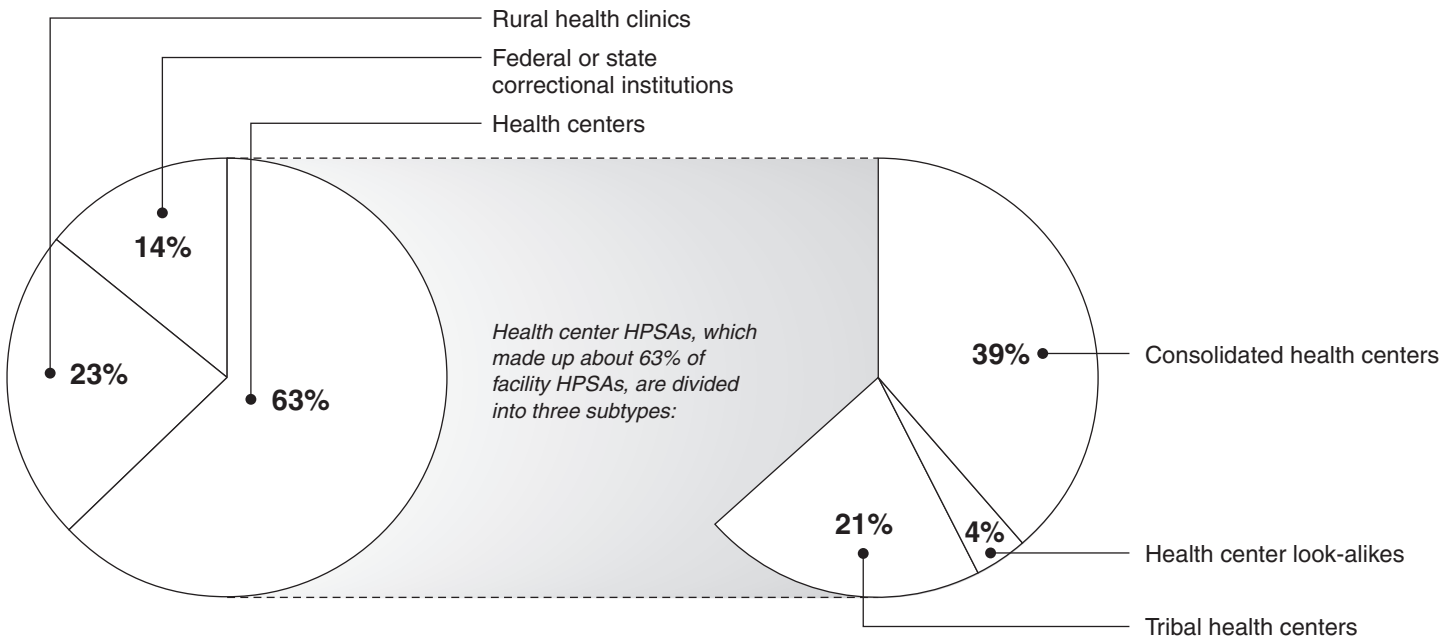
Sources: GAO analysis of HRSA and U.S. Census Bureau data and MapInfo (map).

Note: Counties that contained both geographic and population-group HPSAs are shown as geographic HPSAs. We identified 218 counties that included both geographic and population-group HPSAs as of January 2006.

We estimated that slightly less than half (2,562) of all HPSAs designated as of September 2005 were facility HPSAs. Of these, about 63 percent (1,625) were health centers,²⁷ about 23 percent (590) were rural health clinics, and about 14 percent (347) were federal or state correctional institutions (see fig. 4). Excluded from this count of facility HPSAs were 136 public or nonprofit medical facilities that HRSA's data indicated had requested and received a facility HPSA designation, but that HRSA officials said could be duplicates of health centers that HRSA's data showed as having automatically received a facility HPSA designation. Also excluded were 21 health centers that HRSA's data identified as health centers for Alaska Natives that received automatic facility HPSA designations, but that HRSA and IHS officials said could be duplicates of health centers HRSA's data identified as tribal health centers.

²⁷Of the 1,625 health centers that were automatically designated as facility HPSAs as of September 2005, we estimated 989 were grantees under HHS's consolidated health center program. (Consolidated health center program grantees may provide services at more than one delivery site, and although data were not available on the number of these delivery sites, a HRSA official estimated that consolidated health center program grantees operated more than 3,700 service delivery sites in 2005.) In addition, we estimated 99 health center look-alikes and 537 tribal health centers were automatically designated as facility HPSAs as of September 2005.

Figure 4: Types of Facility HPSAs, September 2005



Source: GAO analysis of HRSA data.

Note: Percentages of health center subtypes do not add to 63 percent because of rounding.

As of September 2005, health centers with facility HPSA designations were located in all 50 states and the District of Columbia.²⁸ Rural health clinics with facility HPSA designations were located in 41 states, and federal or state correctional institutions with facility HPSA designations were located in 46 states.²⁹

²⁸Health centers with facility HPSA designations were also located in American Samoa, Guam, Puerto Rico, the Republic of the Marshall Islands, the Republic of Palau, and the U.S. Virgin Islands.

²⁹As of September 2005, rural health clinics with facility HPSA designations were located in all states except the following: Alaska, Arizona, Connecticut, Delaware, Hawaii, Massachusetts, Maryland, New Jersey, and Rhode Island, as well as the District of Columbia. Federal or state correctional institutions with facility HPSA designations were located in all states except Alaska, Delaware, North Dakota, and New Mexico, as well as the District of Columbia. A federal or state correctional institution with a facility HPSA designation was also located in Puerto Rico.

Federal Programs Using HPSA Designations

Although the HPSA designation system was originally used to designate areas for placement of providers through NHSC programs, the HPSA designation, and in some cases the HPSA score, have since been used by more than 30 federal programs to allocate resources or provide benefits. In fiscal year 2005, NHSC—which received \$131 million in funding from HRSA appropriations—administered four programs that used the HPSA designation—three of which also used the HPSA score:³⁰

- *NHSC Scholarship Program*: NHSC awards scholarships to health professions students who agree to practice for at least 2 years in a HPSA after completing training as a primary care physician, nurse practitioner, nurse-midwife, physician assistant, or other eligible provider.³¹ Scholarship recipients are limited to practicing at NHSC-approved practice sites in HPSAs with high need, as determined by the HPSA designation score.³² For the period July 1, 2005, through June 30, 2006, scholarship recipients completing training who were primary care physicians were required to practice in HPSAs with scores of 14 or higher, while those completing training as nurse practitioners, physician assistants, and nurse-midwives were required to practice in HPSAs with scores of at least 13, 13, and 8, respectively.³³ At the end of fiscal year 2005, about 670 NHSC scholarship recipients, including primary care physicians, nurse practitioners, nurse-

³⁰A fifth NHSC program—the Community Scholarship Program—did not award any new scholarships in fiscal year 2005, and therefore we excluded this program from our analysis.

³¹42 U.S.C. § 2541(f)(1)(B)(v). Scholarship recipients receive payment of tuition and other educational expenses, such as fees and books, as well as a stipend for up to 4 years of education. For each year of support received, the recipient is required to serve 1 year in an NHSC-approved practice site in a high-need HPSA, with a minimum service commitment of 2 years.

³²NHSC providers must practice in NHSC-approved practice sites that agree to use a sliding fee schedule or other method to reduce fees to ensure that no financial barriers to care exist.

³³70 Fed. Reg. 51356–7 (Aug. 30, 2005). The minimum HPSA score for the practice sites eligible for NHSC scholarship recipients in a given year depends on both the practice sites applying for scholarship recipients in that discipline and the number of scholarship recipients graduating in each discipline that year.

midwives, and physician assistants, were practicing in HPSAs to complete their NHSC service obligations.³⁴

- *NHSC Loan Repayment Program:* NHSC repays educational loans of fully trained health professionals who agree to practice for at least 2 years in a HPSA.³⁵ In addition to the practice sites approved for scholarship recipients, loan repayment recipients—including primary care physicians, nurse practitioners, physician assistants, nurse-midwives, and other providers—may practice at NHSC-approved sites in other HPSAs, including those with lower HPSA scores. Loan repayment awards are made to providers who practice in higher-scoring HPSAs first, and then to providers who practice in lower-scoring HPSAs in descending order as long as program funds are available. Sufficient funds were available for fiscal years 2003 through 2005 to make awards to all providers with eligible and complete loan repayment applications, regardless of the practice location’s HPSA score. At the end of fiscal year 2005, about 1,700 NHSC loan repayment recipients were practicing in HPSAs to complete their NHSC service obligations.
- *NHSC State Loan Repayment Program:* NHSC provides grants to states to operate state loan repayment programs.³⁶ Eligibility requirements and benefits, such as the maximum amount of loan repayment each year, may vary from state to state, but state loan repayment recipients must agree to provide primary health services in a HPSA. At the end of fiscal year 2005, about 680 NHSC state loan repayment recipients were practicing in HPSAs under this program.

³⁴In this report, the numbers of NHSC providers represent those primary care providers practicing in HPSAs to fulfill their service obligation at the end of fiscal year 2005; they do not include about 550 NHSC dental providers and about 920 NHSC mental health providers practicing in HPSAs designated for dental or mental health. The numbers also exclude 13 NHSC loan repayment recipients who were chiropractors or pharmacists practicing in HPSAs to fulfill their NHSC service obligation under a demonstration project authorized by the Public Health Service Act. See 42 U.S.C. § 254t.

³⁵42 U.S.C. § 254l-1(f), (g). For the 2-year minimum service commitment, NHSC will pay up to \$50,000, based on the loan repayment recipient’s qualifying educational loans, with the potential to participate in the program for additional years, one year at a time, with NHSC paying up to \$35,000 per year. See HRSA, Bureau of Health Professions, National Health Service Corps, “Loan Repayment Program,” http://nhsc.bhpr.hrsa.gov/join_us/lrp.asp (downloaded May 13, 2006).

³⁶42 U.S.C. § 254q-1. States must provide matching funds to be eligible for a grant.

-
- *NHSC Ready Responder Program*: Providers—including primary care physicians, nurse practitioners, physician assistants, and nurses—can receive salaries, benefits, and moving expenses to serve as commissioned officers in the U.S. Public Health Service who are assigned by NHSC to practice for 3 years in the neediest HPSAs.³⁷ In determining practice locations for Ready Responders, NHSC gives preference to NHSC-approved sites in HPSAs with high scores. HRSA’s 2004 notice to recruit providers to participate in this program stated that NHSC Ready Responders would be part of a mobile team of health professionals who, in addition to the services they provide to patients at their assigned sites, might be called upon to respond to regional or national emergencies. At the end of fiscal year 2005, 56 NHSC Ready Responders were practicing in HPSAs.

In addition to the 4 NHSC programs, more than 26 other federal programs have used the HPSA designation to allocate resources or provide benefits.³⁸ For example:

- CMS’s Medicare Incentive Payment program pays physicians a 10 percent bonus for services provided to Medicare beneficiaries in a geographic HPSA.³⁹ According to CMS’s Office of Financial Management, the Medicare program paid about \$148 million in these bonus payments in fiscal year 2005.
- CMS’s Rural Health Clinic program employs special payment rules for the reimbursement of services provided by rural health clinics under Medicare and Medicaid, which is an incentive for becoming a rural health clinic. For example, rural health clinics are reimbursed under a modified cost-based method of payment under Medicare. For reimbursement purposes, a rural health clinic must be located in a geographic or population-group HPSA in a rural area, a rural area designated by a state’s governor (or chief executive officer) and certified by HHS as an area with a shortage of

³⁷69 Fed. Reg.70459 (Dec. 6, 2004). Applicants for the Ready Responders must file a U.S. Public Health Service Commissioned Corps application and meet the requirements for such commissioning. Initial assignments will last up to 3 years, after which providers choosing to stay in the U.S. Public Health Service move on to new assignments.

³⁸See appendix IV for a list of programs using the HPSA designation and HRSA’s other designations of underservice (MUA and MUP) to allocate resources or provide benefits in fiscal year 2005.

³⁹42 U.S.C. § 1395l(m).

personal health services, or a rural area HRSA has designated as a medically underserved area (MUA).⁴⁰

- Federal agencies—including HHS, the Appalachian Regional Commission,⁴¹ and the Delta Regional Authority⁴²—as well as state health departments, operate programs, called J-1 visa waiver programs, to attract foreign physicians who have just completed their graduate medical education in the United States to practice in underserved areas. In exchange for a commitment to practice for at least 3 years at a facility located in, or treating residents of, a HPSA, an MUA, or a medically underserved population (MUP), foreign physicians can receive the benefit of a waiver of a 2-year foreign residence requirement.⁴³ Of the federal agencies administering J-1 visa waiver programs in 2005, HHS required foreign physicians receiving J-1 visa waivers through its J-1 visa waiver

⁴⁰See appendix II for additional information on the MUA designation.

⁴¹The Appalachian Regional Commission is a federal-state economic development partnership between the federal government and 13 states. The commission initiates economic and community development programs and serves as an advocate for the people in the Appalachian Region, including all of West Virginia and parts of 12 other states: Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, and Virginia.

⁴²The Delta Regional Authority is a federal-state partnership between the federal government and eight states. The authority was created to remedy severe and chronic economic distress by stimulating economic development and fostering partnerships that will have a positive impact on the economy of the region. The authority covers 240 counties and parishes in Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee.

⁴³Foreign physicians may enter the United States for graduate medical education as participants under an exchange visitor program administered by the Department of State. These physicians enter the United States with J-1 visas and are required to return to their home country or country of last legal residence for at least 2 years when they complete their graduate medical education. They may, however, obtain a waiver of this requirement from the Department of Homeland Security's U.S. Citizenship and Immigration Services (USCIS) at the request of a state or federal agency, if the physician has agreed to practice in or work at a facility that treats residents of a geographic area or areas designated by the Secretary of Health and Human Services as having a shortage of health care professionals, such as a HPSA, for 3 years. 8 U.S.C. § 1184(i)(1)(D). In May 2006, we testified that, in fiscal year 2005, states and federal agencies requested more than 1,000 waivers for physicians—including those practicing primary care specialties and those practicing nonprimary care specialties—to work in facilities that are located in, or treat residents of, HPSAs or other underserved areas. More than 90 percent of these were states' waiver requests; less than 10 percent were federal agencies' requests. See GAO, *Foreign Physicians: Preliminary Findings on the Use of J-1 Visa Waivers to Practice in Underserved Areas*, [GAO-06-773T](#) (Washington, D.C.: May 18, 2006).

program to practice in certain health centers, rural health clinics, or other facilities in HPSAs with a HPSA score of 14 or higher.⁴⁴

- More than 15 federal programs that funded health professions education and training grants in fiscal year 2005 used the HPSA designation to provide funding preferences to grant applicants.⁴⁵ Authorized under title VII of the Public Health Service Act—with more than \$160 million in funding from HRSA's fiscal year 2005 appropriations—these programs provided funding preferences to grant applicants, such as health professions schools that placed a high or increasing number of graduates in settings serving medically underserved communities, including HPSAs. For purposes of the funding preference, the Public Health Service Act defines medically underserved communities to include areas or populations that are eligible for HPSA designation, or that meet other criteria, such as being eligible to be served by a community or migrant health center.⁴⁶

The use of the HPSA designation by more than 30 federal programs to allocate resources or provide benefits is an incentive for obtaining and retaining a HPSA designation, even if the HPSA does not want or need additional primary care providers. Agencies or individuals requesting initial designations or continuations of the HPSA designations for geographic areas, population groups, or facilities may instead want the designation for other purposes, for example, to be eligible for benefits such as the 10 percent bonus payment for physician services under CMS's Medicare Incentive Payment program. In 1998, COGME reported that one possible reason that the number of HPSAs had not declined was that “as the penalty for designation loss has increased, organizations have become

⁴⁴Effective April 3, 2006, HHS revised its J-1 visa waiver policy. Rather than require foreign physicians to practice in HPSAs with a score of 14 or higher, the revised policy requires foreign physicians seeking a waiver to practice in HPSAs with a score of 7 or higher in order for HHS to request a J-1 visa waiver through its program. See HHS, “Applications for Waiver of the Two-year Foreign Residence Requirement (Clinical Care) of the Exchange Visitor Program,” <http://www.globalhealth.gov/newguidelines1.shtml> (downloaded Mar. 17, 2006).

⁴⁵See 42 U.S.C. §§ 295d(c), 295j. Funding preferences are factors that place a grant application ahead of others without a preference on a list of applicants recommended for funding by a review committee.

⁴⁶42 U.S.C. § 295p(6)(A), (B).

more adept at making the case for retaining or attaining this coveted status.”⁴⁷

Research Points to Shortcomings with Designation Methodology

Of the reports published since 1995 that addressed the criteria or methodology used to designate HPSAs, we identified one that supported one key element of the criteria and six that pointed to shortcomings in the designation methodology. These six reports were consistent with what we reported in 1995. HHS officials have acknowledged these shortcomings and the department has been working on a proposal for revising the HPSA designation system since 1998, which, as of September 2006, had not been finalized. Another problem we identified in 1995 that persists in 2006 is HRSA’s lack of timely removal of HPSA designations that no longer meet the designation criteria.

Of the seven reports we identified as research on the HPSA criteria or methodology, one of the peer-reviewed reports addressed the relationship between one key element of the HPSA designation criteria and primary care physician supply. This report found a positive association between primary care physician supply and an area’s income—one of the elements of the HPSA criteria used to demonstrate unusually high needs for primary care services. Specifically, the researchers found that areas with higher incomes had a greater number of primary care physicians than areas with lower incomes.⁴⁸

Other published reports have, however, pointed to shortcomings in the methodology HRSA uses to designate HPSAs—specifically that the system has not effectively identified areas with primary care shortages or helped

⁴⁷Council on Graduate Medical Education, Department of Health and Human Services, Health Resources and Services Administration, *Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner-City Areas* (Rockville, Md.: February 1998).

⁴⁸Kevin Grumbach et al., “Physician Supply and Access to Care in Urban Communities,” *Health Affairs*, vol. 16, no. 1 (1997). For this report, researchers analyzed data from a 1993 survey of a sample of California residents from 41 urban communities based on guidelines for defining primary care service areas developed by state agencies. Researchers examined the relationship between income of the respondents and the number of physicians per 100,000 population in those areas, using data from the 1994 American Medical Association Physician Masterfile for physicians in medical specialties of general or family practice, general internal medicine, pediatrics, and obstetrics and gynecology.

target federal resources to benefit those who are underserved.⁴⁹ For example, reports—including one we issued in 1995—have noted that HRSA’s designation methodology does not accurately identify those providers available to furnish primary health care services.⁵⁰ As a result, the HPSA methodology can overstate the need for additional primary care providers, limiting the usefulness of the HPSA designation system as a screen to identify which communities should be eligible for additional program benefits. Since 1995, we and others have reported problems with HRSA’s exclusion of several categories of primary care providers when calculating the available primary care providers. For example, in our 1995 report, we estimated that the reported need for additional providers in 1994 would have been reduced by up to 50 percent if certain categories of primary care physicians and nonphysician providers—which were excluded by HRSA—had been included in the HPSA calculations.⁵¹ In total, we estimated that 2,539 primary care physicians already providing services in shortage areas (including NHSC physicians and foreign physicians with J-1 visa waivers) and other categories of providers who deliver primary care services in HPSAs (including physician assistants and nurse-midwives) were excluded by HRSA in 1994.

Reports have also concluded that some of the geographic areas that HRSA evaluates for designation—that is, those based on county boundaries—may not always provide a realistic reflection of an area’s health care needs. For these HPSA designation requests, measuring the availability of primary care physicians only in the county where individuals live may underestimate certain residents’ access to medical care.⁵² For example, two reports we identified discussed the likelihood of people crossing

⁴⁹See, for example, Council on Graduate Medical Education, Department of Health and Human Services, Health Resources and Services Administration, *Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner-City Areas*, and Donald H. Taylor Jr. and Thomas C. Ricketts, “Examining Alternative Measures of Medical Underservice for Rural Areas: Executive Summary” (Working Paper No. 39, North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, August 1995).

⁵⁰See [GAO/HEHS-95-200](#).

⁵¹This estimate was derived by subtracting the total number of primary care providers practicing in HPSAs from the total number reported as needed by the HPSA system. See [GAO/HEHS-95-200](#).

⁵²Not all HPSAs rely on county-level data. For example, in September 2005, although 831 geographic HPSAs were entire counties, 815 geographic HPSAs were portions of counties, such as census tracts.

county lines to obtain health care services when these services were not available in their community.⁵³ In one report, researchers evaluated the relationship between health status and medical care resources and found that individuals aged 64 years or younger living in nonmetropolitan areas reported better health when there was greater physician supply in the county where they lived and adjoining counties. According to these researchers, the results suggested that younger individuals in nonmetropolitan areas were willing and able to cross county lines to obtain health care.⁵⁴

Researchers have also noted that the HPSA designation methodology favors those states or areas that have experience in completing and submitting a HPSA designation request.⁵⁵ One team of researchers reported that officials in certain states and localities were effective in identifying areas that would qualify for a HPSA designation and in providing timely and appropriate data for the request, whereas other areas were unable to navigate the process as effectively. The researchers observed that certain areas were more likely to have HPSA designations than others— independent of the actual local situation.⁵⁶

Recognizing the shortcomings in the HPSA designation system identified by available research and our prior work, HHS has been working on a proposal for a revised designation system since 1998. According to HRSA officials, the proposal incorporates factors to account for all primary care providers in an area—including foreign physicians with J-1 visa waivers, NHSC physicians, and nurse practitioners and physician assistants—and includes the creation of a master database to house national data relevant

⁵³See John Robst and Glenn G. Graham, “The Relationship between the Supply of Primary Care Physicians and Measures of Health,” *Eastern Economic Journal*, vol. 30, no. 3 (2004), and Richard A. Wright et al., “Finding the Medically Underserved: A Need to Revise the Federal Definition,” *Journal of Health Care for the Poor and Underserved*, vol. 7, no. 4 (1996).

⁵⁴Robst and Graham, “The Relationship between the Supply of Primary Care Physicians and Measures of Health.”

⁵⁵See, for example, Council on Graduate Medical Education, Department of Health and Human Services, Health Resources and Services Administration, *Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner-City Areas*, and Taylor and Ricketts, “Examining Alternative Measures of Medical Underservice for Rural Areas: Executive Summary.”

⁵⁶Taylor and Ricketts, “Examining Alternative Measures of Medical Underservice for Rural Areas: Executive Summary.”

to HPSA criteria. As of September 2006, this proposal was in the department's clearance process.

Another problem we identified in 1995, that remains a problem in 2006, is that HRSA does not review designated HPSAs and subsequently remove the designation of those areas, population groups, or facilities that no longer meet the HPSA criteria in a timely manner. While we did not audit HRSA's process for periodically reviewing HPSAs, in August 2005, the HHS Office of Inspector General reported that as of 2003, HRSA had not conducted timely reviews of HPSA designations.⁵⁷ In the agency's comments that were included in the August 2005 report, HRSA acknowledged this problem, stating that the agency was unable to complete the review of designated HPSAs for continued eligibility in less than 3 years because of resource limitations. As of September 2006, we found that although HHS is required to publish a list of designated HPSAs in the *Federal Register* by July 1 of each year—thereby removing the designation of any HPSAs that were proposed for withdrawal that are not published—the department has not done so since February 2002.⁵⁸ HRSA officials told us in June 2006 that the department has not published a list of HPSAs in the *Federal Register* for more than 4 years because of difficulties with computer programming, but the agency hoped to resolve those issues and to forward an updated list for publication by fall 2006.⁵⁹ Meanwhile, those HPSAs that were proposed for withdrawal because they no longer

⁵⁷Office of Inspector General, Department of Health and Human Services, *Status of the Rural Health Clinic Program*, OEI-05-03-00170 (Chicago: August 2005). The Inspector General's review was limited to those HPSAs where rural health clinics were located. HRSA stated in its response to this report that the actual submission of updates of HPSA data by interested parties and groups, and the review and action for existing HPSA designations by HRSA, took place after the fourth or possibly fifth year after a HPSA designation was received. HRSA also stated that its ability to review depended on the number of requests HRSA received for individual HPSA updates and the complexity of those requests.

⁵⁸67 Fed. Reg. 7740–88 (Feb. 20, 2002).

⁵⁹According to HRSA officials, the impact of not publishing a list of designated HPSAs in the *Federal Register* may have been lessened because (1) HRSA has a publicly available Web-based application that can be used to search a regularly updated, real-time database of HPSA designations, including those proposed for withdrawal, and (2) NHSC, for which the HPSA designations were originally developed and the major reason for the designations, does not place providers in HPSAs that are proposed for withdrawal, so the absence of the *Federal Register* publication has not affected the practice locations for NHSC programs. HHS officials also noted that, for other programs that use the HPSA designation, the decision to use or not use HPSAs proposed for withdrawal is generally made by the individual programs.

meet the HPSA criteria have retained their HPSA designation.⁶⁰ As a result, federal programs that use the HPSA designation, such as the Medicare Incentive Payment program or HRSA's health professions education and training programs, may have been allocating resources or providing benefits to areas, population groups, or facilities that no longer meet the HPSA criteria.

Many Health Centers and Rural Health Clinics Did Not Benefit from Automatic HPSA Designation

Many health centers and rural health clinics did not benefit from automatic designation as facility HPSAs because they were located in geographic or population-group HPSAs. Most health centers also received a HPSA score associated with the automatic designation that was too low to qualify them for programs that required a minimum HPSA score in 2005, although they qualified for programs that did not have such a requirement. Of the relatively few rural health clinics that chose to certify that they would treat anyone regardless of ability to pay and, as a result, received the automatic designation as facility HPSAs, most also received scores too low to qualify for benefits from certain programs that required a higher HPSA score.

Relatively Few Health Centers Had HPSA Scores High Enough to Obtain Providers through Certain Federal Programs

For health centers that were located in a geographic or population-group HPSA, automatic designation as a facility HPSA provided no benefit unless the HPSA score associated with automatic designation was higher than the score for the geographic or population-group HPSA in which they were located. According to the National Association of Community Health Centers, health centers had advocated for automatic HPSA designation because it would allow those not located in geographic or population-group HPSAs to be eligible for providers from NHSC. Although limitations in HRSA's data prevented us from measuring the precise impact of the automatic HPSA designation on health centers, HRSA officials estimated that about half of the health centers that received automatic designation as a facility HPSA in 2002 were located in a geographic or population-group HPSA and therefore did not receive this benefit.

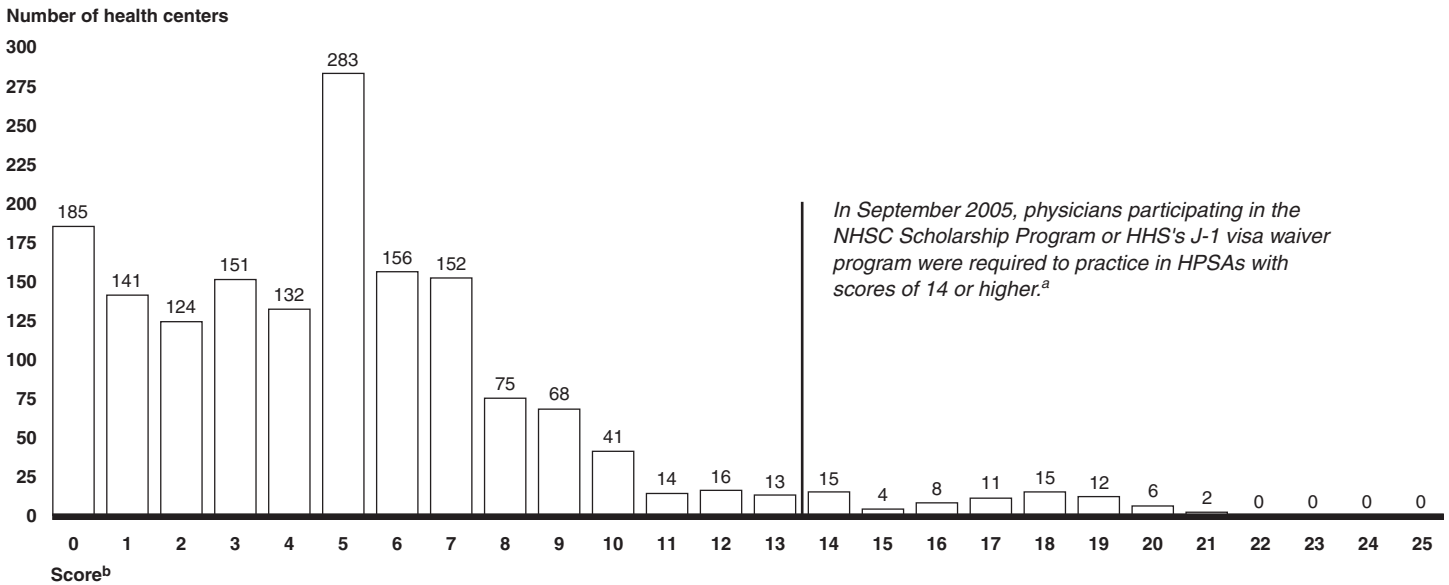
As of September 2005, 73 (less than 5 percent) of the 1,625 health centers that had received automatic designation as facility HPSAs had an

⁶⁰Of the 2,746 geographic and population-group HPSAs designated as of January 2006, about 12 percent were proposed for withdrawal because they no longer met the criteria or had not provided HRSA with updated data in support of their designations.

associated HPSA score high enough to qualify for a physician through the NHSC Scholarship Program or HHS's J-1 visa waiver program.⁶¹ These health centers received a HPSA score of 14 or higher—the HPSA score required by these programs for physician placement (see fig. 5). Eighty-six (about 5 percent) of the 1,625 health centers with automatic facility HPSA designation received a HPSA score of 13 or higher—the HPSA score required by the NHSC Scholarship Program to qualify for placement of a nurse practitioner or physician assistant.

⁶¹One tribal health center had not received a HPSA score from HRSA as of September 2005. Although health centers receiving automatic designation could also use the score of a geographic or population-group HPSA if the facility was located in one, HRSA officials we spoke with did not have data on how many health centers that were eligible for this provision chose to use it when applying for federal programs.

Figure 5: Distribution of HPSA Scores among Health Centers Automatically Designated as Facility HPSAs, September 2005



Source: GAO analysis of HRSA data.

Notes: This figure includes scores for 1,624 of the 1,625 health centers that, as of September 2005, received a HPSA score as part of automatic designation as a facility HPSA. One tribal health center had not received a HPSA score from HRSA as of September 2005. Health centers that automatically received facility HPSA designation include those that received grants under the consolidated health center program, health center look-alikes, and tribal health centers.

^aFor assignment of NHSC providers through the NHSC Scholarship Program for the period July 1, 2005, through June 30, 2006, a HPSA score of 14 or higher was required to be eligible for a physician; a score of 13 or higher was required for a nurse practitioner or physician assistant; and a score of 8 or higher was required for a nurse-midwife. HHS's J-1 visa waiver program required a HPSA score of 14 or higher for all of 2005.

^bThe maximum HPSA score a health center can receive is 25.

In contrast, automatic facility HPSA designation made health centers eligible, regardless of HPSA score, to apply in 2005 for a physician or other health care provider through the NHSC Loan Repayment Program.⁶² According to an official with the National Association of Community Health Centers, health center officials were pleased with this benefit but also viewed it with caution because NHSC loan repayment awards are

⁶²In addition to the NHSC Loan Repayment Program, health centers with automatic facility HPSA designations were eligible to apply for other programs that did not require a HPSA score, such as J-1 visa waiver programs administered by the Appalachian Regional Commission, the Delta Regional Authority, and many state health departments.

made first to providers who agree to practice in higher-scoring HPSAs and then to providers who agree to practice in lower-scoring HPSAs, in decreasing order of HPSA score. Although NHSC had sufficient funding for all qualifying loan repayment applicants from 2003 through 2005, health center officials were concerned that in future years, NHSC funding may be insufficient to sustain this benefit for health centers with relatively low HPSA scores.

Few Rural Health Clinics Have Received Automatic HPSA Designation as Facility HPSAs

As of September 2005, 590 (16 percent) of the 3,637 rural health clinics in the United States had received automatic designation as facility HPSAs. To receive automatic designation, rural health clinics, unlike health centers, must certify that they provide health care services regardless of an individual's ability to pay. To qualify for automatic HPSA designation, some rural health clinics—including those that are for-profit entities—would have to restructure their billing practices, and according to officials at the National Association of Rural Health Clinics and HRSA's Office of Rural Health Policy, it may not be in their interest to do so.

As with health centers, the main benefit cited by officials at the Office of Rural Health Policy of automatic HPSA designation for rural health clinics is to be eligible for NHSC physicians or other primary care providers. Rural health clinics that were located in geographic or population-group HPSAs would not benefit from automatic designation unless the associated HPSA score was higher than the score for the geographic or population-group HPSAs in which they were located. Data were not available to determine how many of the 590 rural health clinics with automatic facility HPSA designations were located in geographic or population-group HPSAs before the 2002 provision was implemented. An official at the National Association of Rural Health Clinics reported, however, that a recent study estimated that over 70 percent of all rural health clinics—including those that did not receive the automatic facility HPSA designation—were located in geographic HPSAs before 2002 and

were therefore already eligible for federal programs requiring HPSA designation.⁶³

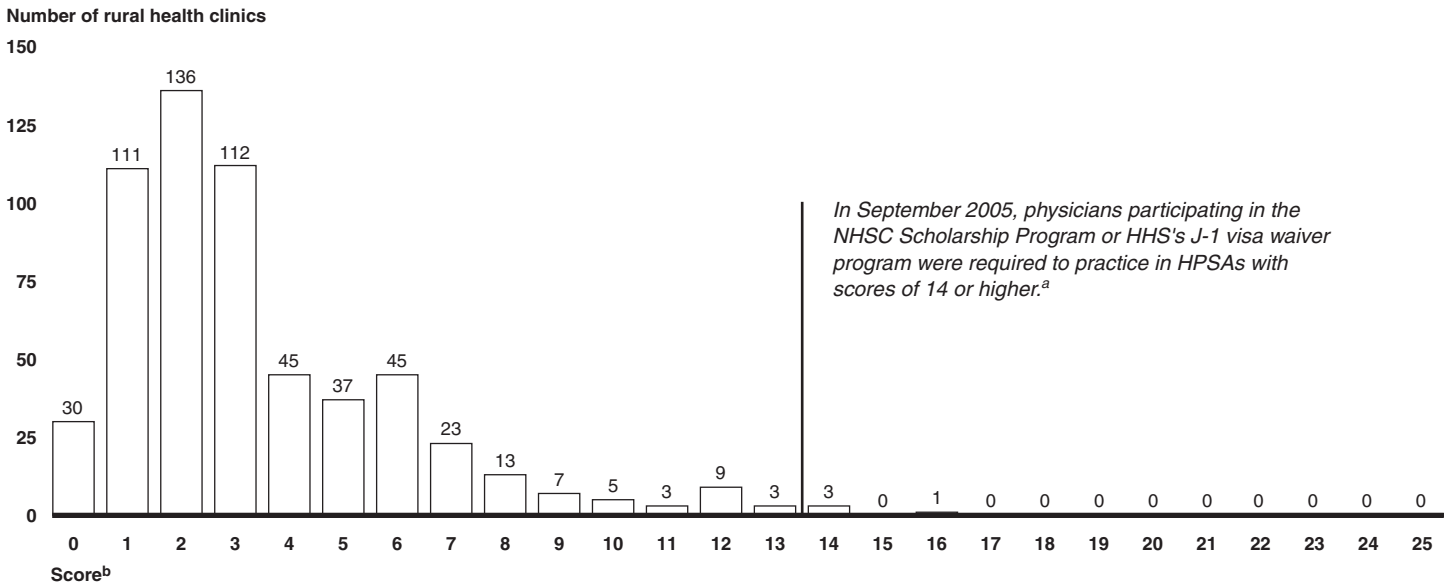
As of September 2005, less than 1 percent of the 590 rural health clinics that had received automatic designation as facility HPSAs had associated HPSA scores of 14 or higher needed to qualify for a physician through the NHSC Scholarship Program or HHS's J-1 visa waiver program (see fig. 6).⁶⁴ About 1 percent received a HPSA score of 13 or higher—the HPSA score required by the NHSC Scholarship Program to qualify for a nurse practitioner or physician assistant. Like health centers with lower HPSA scores, rural health clinics automatically designated as facility HPSAs but scoring lower than 14 could recruit a physician or other provider through the NHSC Loan Repayment Program.⁶⁵

⁶³See John A. Gale and Andrew F. Coburn, *The Characteristics and Roles of Rural Health Clinics in the United States: A Chartbook*, (Portland, Me.: Maine Rural Health Research Center, Institute for Health Policy, Edmund S. Muskie School of Public Service, University of Southern Maine, 2003). In addition, our analysis of data prepared for HRSA's Office of Rural Health Policy using 2003 and 2004 CMS data on rural health clinics and 2005 HRSA data on HPSAs indicated that nearly half of all rural health clinics—including those that did not receive automatic designation—were located in geographic or population-group HPSAs.

⁶⁴As of September 2005, 7 of the 590 rural health clinics that received automatic HPSA designation had not received a HPSA score from HRSA. Although rural health clinics receiving automatic designation could also use the score of a geographic or population-group HPSA if the facility was located in one, HRSA officials we spoke with did not have data on how many rural health clinics that were eligible for this provision chose to use it when applying for federal programs.

⁶⁵In addition to the NHSC Loan Repayment Program, rural health clinics with automatic facility HPSA designations were eligible to apply for other programs that did not require a HPSA score, such as J-1 visa waiver programs administered by the Appalachian Regional Commission, the Delta Regional Authority, and many state health departments.

Figure 6: Distribution of HPSA Scores among Rural Health Clinics Automatically Designated as Facility HPSAs, September 2005



Source: GAO analysis of HRSA data.

Notes: This figure includes scores for 583 of the 590 rural health clinics that, as of September 2005, received a HPSA score as part of automatic designation as a facility HPSA. Seven rural health clinics that received the automatic HPSA designation had not received a HPSA score from HRSA as of September 2005.

^aFor assignment of NHSC providers through the NHSC Scholarship Program for the period July 1, 2005, through June 30, 2006, a HPSA score of 14 or higher was required to be eligible for a physician; a score of 13 or higher was required for a nurse practitioner or physician assistant; and a score of 8 or higher was required for a nurse-midwife. HHS's J-1 visa waiver program required a HPSA score of 14 or higher for all of 2005.

^bThe maximum HPSA score a rural health clinic can receive is 25.

Conclusions

Many federal programs continue to rely on HPSA designations to allocate federal resources or provide benefits, even though shortcomings we and others have reported since 1995 have not been addressed. In particular, the omission of important categories of primary care providers—such as foreign physicians with J-1 visa waivers and nonphysician primary care providers—from calculations for HPSA designation can overstate the need for additional primary care providers. Although HHS has recognized the need for improvements and has been working since 1998 on a proposal to revise the HPSA designation system, it remains to be seen when HHS will make such improvements and what changes will be made. In addition, HRSA has not regularly removed the HPSA designation of those areas,

population groups, or facilities that no longer meet the designation criteria.

Available information suggests that the provision to automatically designate health centers and certain rural health clinics as facility HPSAs has benefited a relatively small number of these facilities. The precise impact of the provision could not be measured, however, because of limitations with available HHS data. For example, the available data did not include sufficient geographic information to determine which of these facilities were located in geographic or population-group HPSAs before receiving automatic designation as facility HPSAs.

Recommendations for Executive Action

We recommend that the Secretary of Health and Human Services take the following two actions: (1) publish a list of designated HPSAs in the *Federal Register* or otherwise remove, through *Federal Register* notification, the HPSA designations for those HPSAs that no longer meet the criteria or have not provided updated data in support of their designations and (2) complete and publish HHS's proposal to revise the HPSA designation system and address the shortcomings that have been identified in the current methodology for designating HPSAs.

Agency Comments

We received comments on a draft of this report from HHS (see app. V). The department generally agreed with our findings and concurred with both recommendations. Specifically, the department agreed that a more timely publication of the *Federal Register* listing of designated HPSAs is necessary to ensure that only those areas meeting the regulations remain designated, and stated that HRSA should publish lists of HPSAs or HPSA withdrawals to ensure that designations that have already been proposed for withdrawal are actually withdrawn. The department also noted that it is proposing a change in the process for withdrawing HPSA designations, but it did not provide any details on this proposal. HHS also agreed with our recommendation that the department complete and publish its proposal to revise the HPSA designation system. HHS stated that this proposal would address shortcomings that we identified in this and previous reports and would also affect the regulations governing MUA and MUP designations.

HHS also commented on our finding that many health centers and rural health clinics did not benefit from automatic designation as facility HPSAs. Specifically, HHS stated that our draft report provided a somewhat misleading assessment of the impact of the automatic designation process

and the department provided additional information on NHSC placements in automatically designated HPSAs in 2005. Our draft report stated that few health centers had HPSA scores associated with automatic designation that were high enough to qualify for a physician through the NHSC Scholarship Program, but that all health centers that received automatic designation as HPSAs, even those with lower HPSA scores, could apply in 2005 for a health care provider through the NHSC Loan Repayment Program. The data the department provided on NHSC placements in automatically designated health centers were actually consistent with the statement in our draft report. HHS's data, which HHS officials said included both primary care and nonprimary care providers, showed that of 216 NHSC providers placed in health centers, relatively few (less than 5 percent) were placed through the NHSC Scholarship Program and the NHSC Ready Responder Program (less than 1 percent), whereas the vast majority (more than 95 percent) were placed through the NHSC Loan Repayment Program. According to HRSA officials, data for primary care provider placements (which were not included in the department's comments), showed a similar distribution between the three NHSC programs for 155 primary care NHSC placements in health centers in 2005. In its comments, HHS also provided information on the process for scoring automatically designated HPSAs and on NHSC and J-1 visa waiver programs. In response, we added information on J-1 visa waiver programs administered by federal agencies other than HHS and by state health departments.

Finally, HHS suggested that we clarify that our scope was limited to primary care HPSAs. We made revisions to the report to highlight that our review only examined primary care HPSA designations.

The department also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of HRSA, the Administrator of CMS, and to appropriate congressional committees. We will also provide copies to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (312) 220-7600 or aronovitzl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made contributions to this report are listed in appendix VI.



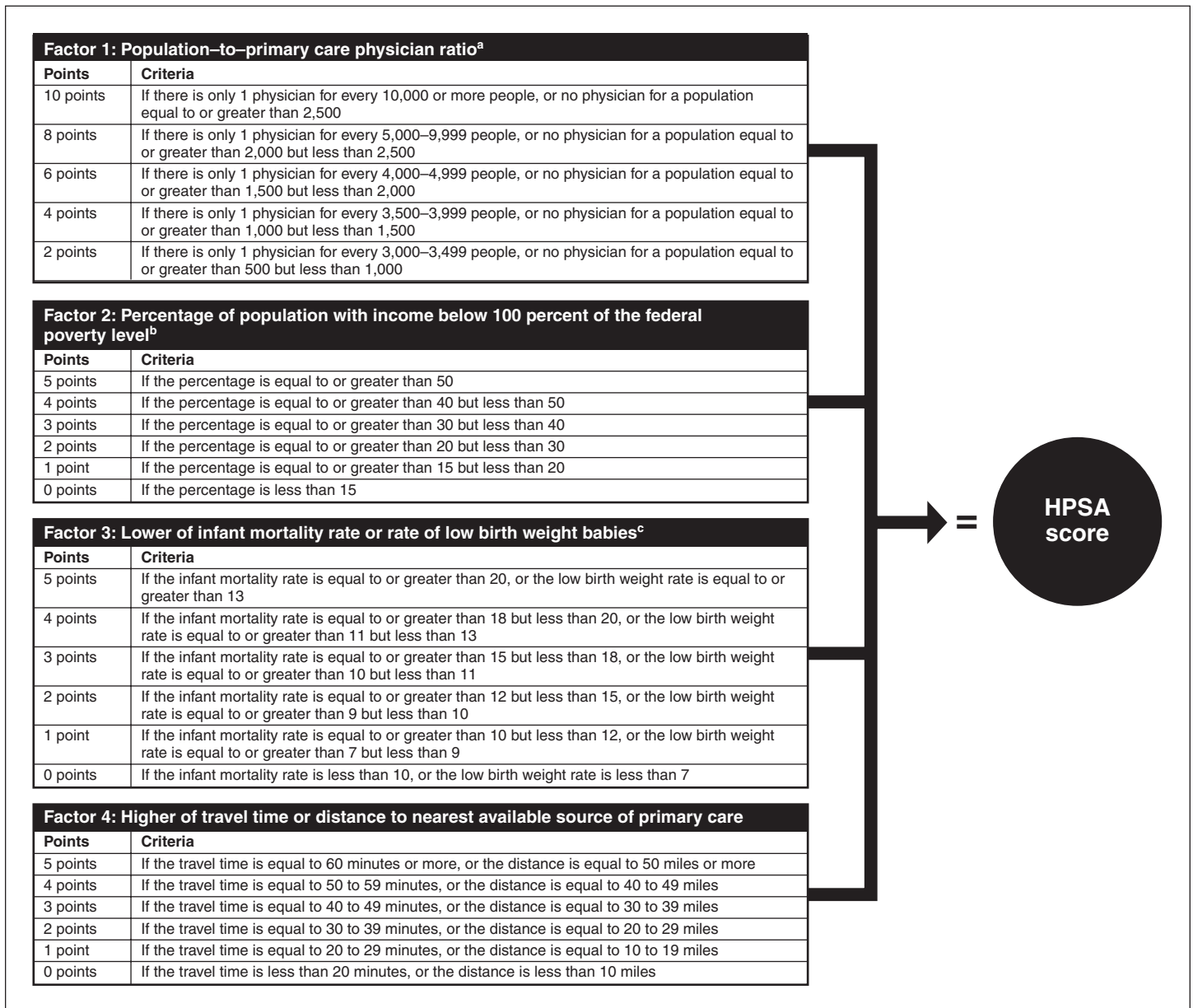
Leslie G. Aronovitz
Director, Health Care

Appendix I: Scoring of Health Professional Shortage Areas

Each designated health professional shortage area (HPSA) receives a score that the Department of Health and Human Services's (HHS) Health Resources and Services Administration (HRSA) uses to rank its shortage of primary care providers, or need, relative to other HPSAs. The HPSA score is used by some federal programs, such as the National Health Service Corps (NHSC) Scholarship Program, which requires participants to practice in locations with higher HPSA scores. The scores, ranging from 0 to 25, are based on four factors, for which each HPSA is given a certain number of points (see fig. 7). To calculate a HPSA score, points for the population-to-primary care physician ratio, ranging from 1 to 5 points, are doubled and then summed with the points for each of the other three factors. For health centers and rural health clinics receiving automatic designation as facility HPSAs, if complete data are not available, or if HRSA cannot match the facility to appropriate data to calculate a HPSA score, the HPSA receives either a score of 0 or a partial score based on the sum of factors for which data are obtainable.

Appendix I: Scoring of Health Professional Shortage Areas

Figure 7: Scoring of HPSAs, 2005



Source: HRSA.

Appendix I: Scoring of Health Professional Shortage Areas

^aFor HPSA designation and scoring, HRSA counts nonfederal physicians who practice principally in one of the primary care specialties of general or family practice, general internal medicine, pediatrics, or obstetrics and gynecology. HRSA does not count federal physicians; physicians with NHSC or J-1 visa waiver obligations; or physicians engaged solely in administration, research, or teaching. See HRSA, Bureau of Health Professions, "Health Professional Shortage Area Guidelines for Primary Medical Care/Dental Designation," <http://bhpr.hrsa.gov/shortage/hpsaguidepc.htm> (downloaded Nov. 14, 2005).

^bHHS's poverty guidelines for 2005 set the poverty level for a family of four at an annual income of \$19,350 in the 48 contiguous states and the District of Columbia (\$24,190 in Alaska and \$22,260 in Hawaii). Poverty guidelines are not defined for American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, Puerto Rico, the Republic of the Marshall Islands, the Republic of Palau, and the U.S. Virgin Islands; offices administering federal programs may decide whether to use the guidelines for the 48 contiguous states and the District of Columbia for those jurisdictions or some other procedure. 70 Fed. Reg. 8373-75 (Feb. 18, 2005).

^cInfant mortality rate is defined as the number of infant deaths per 1,000 live births. Low birth weight rate is defined as the percentage of live births below 2,500 grams (5 pounds, 8 ounces).

Appendix II: Medically Underserved Area or Population Designations and Medically Underserved Community Definition

Medically underserved areas (MUA) and medically underserved populations (MUP) generally are areas, or populations within areas, that are designated by HHS's HRSA as having a shortage of health care services. The MUA and MUP designations were developed about the same time as the HPSA designation system but independently from it. Authorized by the Health Maintenance Organization Act of 1973, MUA and MUP designations have been used for identifying areas eligible to participate in the consolidated health center program. That is, in order to receive health center grant funding as a community health center, migrant health center, or a center serving residents of public housing or the homeless, the health center must be located in or serve the residents of an MUA or MUP.

MUAs are designated for the entire population of a particular geographic area. MUP designations are limited to particular groups of underserved people within an area. Individual facilities are not eligible for MUA or MUP designations as they are under the HPSA designation system. As of September 2005, HRSA had designated 3,443 geographic areas as MUAs and 488 population groups as MUPs.

HRSA designates MUAs and MUPs on the basis of four factors of health service need, the first three of which are also used for HPSA designation or scoring:

- ratio of population to number of primary care physicians,
- infant mortality rate,
- percentage of the population with incomes below the federal poverty level, and
- percentage of population aged 65 or over.

To determine if an area meets the criteria to be designated as an MUA or if a population within an area meets the criteria to be designated as an MUP, each factor is assigned a weighted value, and these values are summed to

obtain a combined score.¹ This score is used to determine if an area or population can be designated as an MUA or MUP. Areas and populations in the country are ranked using this score to determine their order of need of health services. Areas and populations with scores at or below 62 (the median score that was calculated for all U.S. counties in 1975 for the four criteria) are designated MUAs or MUPs. Those populations within areas with scores above 62 may still be designated as MUPs if they demonstrate that unusual local conditions impede access to or the availability of personal health services. Such requests must be documented and recommended by the state chief executive officer and the responsible local officials.

One of the ways in which MUAs and MUPs differ from HPSAs is that MUA and MUP designations are not required to be regularly updated. According to a HRSA official, some areas with MUA or MUP designations have not been reviewed since the 1980s. In 1998, HHS published a proposal in the *Federal Register* to revise the MUA and MUP designations and combine them with the HPSA designation system.² The department received over 800 comments on the proposal; subsequently, HHS withdrew the proposal and began working on another one, which, as of September 2006, was in the department's clearance process.

Another term—medically underserved community—is used to identify underserved areas for purposes of funding preferences for health professions education and training programs authorized under title VII of the Public Health Service Act.³ A medically underserved community is defined as an urban or rural area or population that

- is eligible for HPSA designation;

¹Criteria for designation of MUAs and MUPs are based on the index of medical underservice, published in the *Federal Register* on October 15, 1976, and on the provisions of Pub. L. No. 99-280, enacted in 1986. Areas or populations are scored on a scale of 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved. Each service area or population group within an area found to have a score of 62 or less qualifies for designation as an MUA or MUP. See HRSA, Bureau of Health Professions, "Guidelines for Medically Underserved Area and Population Designation," <http://bhpr.hrsa.gov/shortage/muaguide.htm> (downloaded on June 23, 2006).

²63 Fed. Reg. 46538–55 (Sept. 1, 1998).

³Funding preferences are factors that place a grant application ahead of others without a preference on a list of applicants recommended for funding by a review committee.

**Appendix II: Medically Underserved Area or
Population Designations and Medically
Underserved Community Definition**

- is eligible to be served by a community health center, migrant health center, or a grantee serving residents of public housing or the homeless;
- has a shortage of personal health services, as determined under criteria issued by the Secretary of Health and Human Services under section 1861(aa)(2) of the Social Security Act (relating to rural health clinics); or
- is designated by a state governor (in consultation with the medical community) as a shortage area or medically underserved community.⁴

In fiscal year 2005, 15 programs authorized under title VII, with funding of more than \$160 million, provided funding preferences for any qualified applicant, such as a health professions school, that had a high rate for placing graduates in practice settings having the principal focus of serving residents of medically underserved communities or that achieved a significant increase in the rate of placing graduates in such settings during the previous 2-year period.⁵

In addition, two nursing traineeship programs authorized under title VIII of the Public Health Service Act used the medically underserved community definition in providing a funding preference to grant applicants. Title VIII provides a funding preference that includes nursing workforce grant applicants with projects that will substantially benefit rural or underserved populations.⁶ For purposes of this statutory funding preference for two title VIII programs—the Advanced Education Nursing Traineeship Program and Nurse Anesthetist Traineeship Program—HHS used established clinical sites identified under the definition of medically underserved community as proxies for rural and underserved populations.

⁴42 U.S.C. § 295p(6). In fiscal year 2005 guidance to grant applicants, HRSA stated that medically underserved communities include health centers (including those for migrant workers, the homeless, and residents of public housing); rural health clinics; National Health Service Corps (NHSC) sites; Indian Health Service (IHS) sites; HPSAs; state or local health departments; and sites in a shortage area designated by a state governor.

⁵42 U.S.C. § 295j. An additional grant program authorized under title VII of the Public Health Service Act provides a funding preference for applicants that have not less than 25 percent of their graduates in full-time practice settings in medically underserved communities, that recruit and admit students from medically underserved communities, that have established relationships with public and nonprofit providers of health care in the community involved, and that emphasize employment with public and nonprofit entities in their training of students. 42 U.S.C. § 295d(c).

⁶42 U.S.C. § 296d. The preference also applies to applicants that will help meet public health nursing needs in state or local health departments.

**Appendix II: Medically Underserved Area or
Population Designations and Medically
Underserved Community Definition**

In fiscal year 2005, these two programs authorized under title VIII had about \$17 million in funding.

Appendix III: Scope and Methodology

To conduct our work, we examined relevant laws, regulations, and HHS documents related to the HPSA criteria and designation methodology that were in effect in 2005 for primary care HPSAs, and reviewed our prior work on the HPSA designation system.

To determine the number of HPSAs, we interviewed officials from HRSA, who reported that precise, accurate, historical data on the total number of HPSAs were not available. Therefore, we designed a methodology that HRSA officials confirmed was reasonable for estimating the number of HPSAs designated as of September 2005. We used the following HRSA data sources for our methodology:

- For geographic and population-group HPSAs, we obtained and analyzed summary statistics on HPSA designations as of September 2005 from the Shortage Designation Branch within HRSA's Bureau of Health Professions.
- For facility HPSAs that were federal or state correctional institutions and public or nonprofit medical facilities, we reviewed a more detailed HRSA database of HPSAs designated as of September 2005, downloaded from HRSA's Geospatial Data Warehouse.¹
- For facility HPSAs that were health centers and rural health clinics with automatic facility HPSA designations, we analyzed HRSA's data files of facilities with automatic HPSA designations as of September 2005.

We also analyzed HRSA data on the HPSA scores of health centers and rural health clinics that received automatic HPSA designation to determine which of these facilities qualified for federal programs that required a minimum HPSA score as of September 2005. In addition, we reviewed data as of January 2006 downloaded from HRSA's Geospatial Data Warehouse to identify the locations of geographic and population-group HPSAs and the HPSAs that were proposed to have their HPSA designations withdrawn

¹The HRSA Geospatial Data Warehouse provides a single point of access to HRSA programmatic information, related health resources, and demographic data for reporting on HRSA activities. The data warehouse provides access to information for reporting and mapping of HRSA data, including HPSAs. For more information, see HRSA, "HRSA Geospatial Data Warehouse," <http://datawarehouse.hrsa.gov> (downloaded Mar. 12, 2006). We downloaded data on HPSA designations as of September 2005 from the data warehouse on October 27, 2005. We limited our analysis of the HPSA database downloaded from the data warehouse to those data elements that we determined, following discussion with HRSA officials, were reliable for our purposes.

because they no longer met the criteria or did not provide updated data in support of their designations.²

We performed reliability checks on the HRSA data to identify potential duplicate entries or inconsistencies in the data—for example, inconsistencies between HRSA’s published summary statistics and our analysis summarizing the data from HRSA’s Geospatial Data Warehouse—and interviewed HRSA officials, Indian Health Service (IHS) officials, and officials from associations representing health centers and rural health clinics about the data. We accounted for limitations in the data by excluding from our analysis the lists of two categories of facility HPSAs—public or nonprofit medical facilities and Alaska Native health centers—that HRSA officials stated could have been duplicates of facilities in HRSA’s data of health centers that received automatic HPSA designation and that HRSA had not yet identified as duplicates and removed from its data.³ In total, we excluded 136 public or nonprofit medical facilities and 21 Alaska Native health centers. After taking these steps, we determined that the data were sufficiently reliable for our purposes.

To obtain information on HPSA designation and federal programs that use HPSA designations, we reviewed *Federal Register* notices, laws, regulations, and documents from HHS’s Centers for Medicare & Medicaid Services (CMS), HRSA, and IHS, including HRSA’s National Health Service Corps (NHSC) summaries of the NHSC programs’ field strength at the end of fiscal year 2005, and we reviewed our prior work on these programs.⁴

To identify available research on the criteria used to designate HPSAs since we last reported on the criteria in 1995, we conducted a literature search of articles, studies, and reports—which we call reports—issued from January 1, 1995, through November 1, 2005. We focused our review on the HPSA criteria that were in effect both in 2002 when the Health Care Safety Net Amendments were enacted and at the time of our review. We

²We downloaded data on HPSA designations as of January 2006 from HRSA’s Geospatial Data Warehouse on March 12, 2006.

³As of May 2006, the HRSA official responsible for designating HPSAs said that the agency was in the process of removing the duplicate entries of health centers for Alaska Natives so these facilities would be counted only once as a facility HPSA in HRSA’s databases. The HRSA official also reported that HRSA would remove duplicate public or nonprofit medical facilities when these HPSA designations were reviewed for continued eligibility.

⁴We reviewed information from these same sources to obtain information on federal programs that use other federal designations of medical underservice.

performed the literature search of peer-reviewed reports using the ProQuest search engine and keywords that were related to the following key elements of the HPSA designation criteria, including factors for determining areas with unusually high needs for primary medical care services:⁵

- ratio of population to primary care physicians,
- indicators of the population with incomes below the poverty level (poverty or income),
- infant mortality rate,
- distance to health care services, and
- birth rate.

We also identified reports published during that time frame related to the HPSA criteria or methodology from the bibliographies of relevant reports, recommendations from experts we interviewed, and our prior work. We did not independently assess the methods used in the reports we located.

Of the more than 340 reports located through the search, we identified 12 reports that we determined to be potentially relevant.⁶ After reviewing these 12 reports, we found 1 report in a peer-reviewed journal published from January 1, 1995, through November 1, 2005, that addressed the relationship between one of the key elements of the HPSA designation criteria (income) and primary care physician shortages or supply. We selected this report because it met the following criteria, in addition to the criteria outlined above:

⁵The factors used to calculate the HPSA score were also generally represented in our keywords.

⁶We identified reports as potentially relevant if they addressed the relationship between key elements of the HPSA designation criteria and primary care physician shortages or supply, including primary care disciplines, such as pediatrics. We determined the following types of reports not to be potentially relevant: those specific to other disciplines or professions, such as dental care, chiropractic care, specialty care, or nursing care; those related to recruitment and retention of physicians that focused on physician characteristics; those related to workforce projections; those using data from countries other than the United States or focusing on health care markets outside of the United States; and those with a narrow focus, such as on vaccine shortages.

- The report assessed the relationship between at least one key element of the HPSA designation criteria and primary care physician shortages or supply at the county, metropolitan statistical area, health service area, or other local level.⁷
- The report used a definition of primary care similar to the definition used for the HPSA designation (e.g., general or family practice, general internal medicine, pediatrics, and obstetrics and gynecology).

Of the 12 reports reviewed, 6 reports discussed aspects of the methodology used to designate HPSAs: 1 issued by the Council on Graduate Medical Education (COGME), 1 issued by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and 4 published in peer-reviewed journals.

To review the impact of the automatic designation on health centers and rural health clinics as facility HPSAs, we analyzed HRSA's data on automatic HPSA designations and their associated scores. We also analyzed data on rural health clinics prepared by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill for HRSA's Office of Rural Health Policy, which used 2003 and 2004 CMS data on rural health clinics and 2005 HRSA data on HPSAs. However, limitations in these data prevented us from determining exactly how many health centers and rural health clinics benefited when all health centers and certain rural health clinics received automatic designation as a result of the provision included in the Health Care Safety Net Amendments of 2002. For example, the available data did not include sufficient geographic information to determine which of these facilities were located in geographic or population-group HPSAs before receiving automatic designation as facility HPSAs. Because of the data limitations, we also interviewed HHS officials in HRSA's Office of Rural Health Policy and Bureau of Primary Health Care, as well as officials from the National Association of Community Health Centers and the National Association of Rural Health Clinics, to discuss the impact of the automatic designation.

We performed our work from August 2005 through September 2006 in accordance with generally accepted government auditing standards.

⁷We excluded reports that used state-level data because these data are not necessarily applicable to smaller geographic units such as counties, and HPSAs are often based on county boundaries or parts of counties.

Appendix IV: Federal Programs Using Health Professional Shortage Area and Other Designations of Underservice

Various federal programs have used the HPSA, MUA, MUP or other designations, such as medically underserved communities, to allocate resources, such as scholarships or grants, or to provide benefits, such as the waiver of requirements associated with a foreign physician's visa (see table 2).

Table 2: Programs and Administering Agencies That Used HPSA, MUA, MUP or Other Designations to Allocate Resources or Provide Benefits in Fiscal Year 2005

Program	Agency administering program or benefit	Resource allocated or benefit provided	Federal funding information ^a	Designation(s) used by program
Consolidated health center program	HRSA and CMS	Awards grants for operation of health centers and other activities; provides benefits associated with federally qualified health center status, including eligibility to participate in a drug discount program and to receive reimbursement from Medicare and Medicaid using special payment mechanisms, which serve as an incentive for becoming a health center.	\$1,734 million (funding from FY 2005 appropriations for HRSA) ^b	MUA MUP
Federally qualified health center look-alike program	HRSA and CMS	Provides benefits associated with federally qualified health center status, including eligibility to participate in a drug discount program and to receive reimbursement from Medicare and Medicaid using special payment mechanisms, which serve as an incentive for becoming a health center.	^b	MUA MUP
Indian Health Scholarship Program	IHS	Awards American Indian and Alaska Native students with scholarships for service in certain practices in HPSAs or other practice locations authorized by statute. ^c	\$9 million (funding from FY 2005 appropriations for IHS)	HPSA^c

**Appendix IV: Federal Programs Using Health
Professional Shortage Area and Other
Designations of Underservice**

Program	Agency administering program or benefit	Resource allocated or benefit provided	Federal funding information^a	Designation(s) used by program
J-1 visa waivers for physicians at the request of federal agencies (3 programs)	Department of Homeland Security's U.S. Citizenship and Immigration Services (USCIS), Department of State, Appalachian Regional Commission, Delta Regional Authority, HHS's Office of Global Health Affairs, and HRSA ^d	Waives requirement for certain foreign physicians to return to their home country or country of last legal residence for 2 years after graduate medical education at the request of an interested federal agency in exchange for at least 3 years of service in an area designated by the Secretary of Health and Human Services as having a shortage of health professionals.	Not applicable	HPSA^e MUA MUP
J-1 visa waivers for physicians at the request of state health departments (also known as the Conrad Program)	USCIS, Department of State, state health departments ^d	Waives requirement for certain foreign physicians to return to their home country or country of last legal residence for 2 years after graduate medical education in exchange for at least 3 years of service in an area designated by the Secretary of Health and Human Services as having a shortage of health professionals. Limited to 30 waivers per state per year. Up to five waivers may be for physicians to practice outside of shortage areas as long as they practice in a facility that serves patients residing in such areas.	Not applicable	HPSA^f : Practice in a HPSA or treating the residents of HPSAs MUA : Practice in an MUA or treating the residents of MUAs MUP : Practice in an MUP or treating the residents of MUPs
Medicare Incentive Payment program	CMS	Provides 10 percent bonus payment on Medicare payments for physician services in geographic HPSAs.	\$148 million (FY 2005 Medicare expenditures)	HPSA : Geographic HPSAs only
National Health Service Corps (4 programs) ^g	HRSA	Awards scholarships to or provides money to repay educational loans of students and health professionals in exchange for at least 2 years of service in a HPSA; supports commissioned officers of the U.S. Public Health Service to serve for 3 years in the neediest HPSAs.	\$131 million (funding from FY 2005 appropriations for HRSA)	HPSA

**Appendix IV: Federal Programs Using Health
Professional Shortage Area and Other
Designations of Underservice**

Program	Agency administering program or benefit	Resource allocated or benefit provided	Federal funding information^a	Designation(s) used by program
National Interest Waivers for Immigrant Physicians	USCIS	Waives the job offer requirement placed on certain immigrants, including physicians who agree to practice in a HPSA, an MUA, an MUP, or at Department of Veterans Affairs facilities. ^h	Not applicable	HPSA: Geographic HPSAs only MUA
Rural Health Clinic program	CMS	Provides special Medicare and Medicaid payment mechanisms for rural health clinics, which serve as an incentive for becoming a rural health clinic.	\$413 million (2004 Medicare expenditures); ⁱ \$333 million (FY 2004 Medicaid expenditures) ^j	HPSA: Rural geographic and population-group HPSAs only MUA: Rural MUAs only Other: Rural areas designated by a state's governor as shortage areas
Scholarships for Disadvantaged Students Program	HRSA	Awards grants to health professions schools to provide scholarships to full-time, financially needy students from disadvantaged backgrounds enrolled in eligible health professions or nursing programs. Funding priority is given to schools applying for the funding based on the proportion of graduating students going into primary care, the proportion of underrepresented minority students, and the proportion of graduates working in medically underserved communities. ^{j,k}	\$47 million (funding from FY 2005 appropriations for HRSA)	HPSA MUA MUP Other: Other medically underserved communities ^k

Appendix IV: Federal Programs Using Health Professional Shortage Area and Other Designations of Underservice

Program	Agency administering program or benefit	Resource allocated or benefit provided	Federal funding information^a	Designation(s) used by program
Title VII health professions education and training grant programs ^l (16 programs)	HRSA	Provides grants for health professions education and training programs. Funding preference is given to applicants that (1) place a high or increasing number of graduates or program completers in settings having the principal focus of serving medically underserved communities or (2) have 25 percent or more of their graduates in full-time practice settings in medically underserved communities and meet other statutory requirements. ^{k, m}	\$165 million (funding from FY 2005 appropriations for HRSA)	HPSA MUA MUP Other: Other medically underserved communities ^k
Title VIII nursing education programs ⁿ (2 programs)	HRSA	Provides grants to institutions to provide financial support through traineeships for registered nurses enrolled in advanced education nursing programs or in a master's degree nurse anesthesia program. In awarding grants, a funding preference is given to applicants whose projects will substantially benefit rural or underserved populations, using sites identified under the definition of medically underserved community as proxies, and gives special consideration for applicants with students who have committed to practicing in HPSAs after graduation. ^{k, o}	\$17 million (funding from FY 2005 appropriations for HRSA)	HPSA MUA MUP Other: Other medically underserved communities ^k

Source: GAO analysis of HHS and other federal and state agency information.

Note: In addition to the programs included in the table, other programs, including rural health grant programs administered by HRSA, have used the HPSA designation to some degree in allocating resources. For example, in fiscal year 2005, HRSA's announcement for rural health network development grants stated that a funding preference would be given to those qualified applicants where the service area was located in a designated HPSA, was a medically underserved community, or served medically underserved populations. HRSA does not maintain a list of all programs using the HPSA designation to allocate resources or provide benefits.

^aFunding amounts from HRSA and IHS reflect fiscal year 2005 appropriations or budget authority as reported in the agencies' fiscal year 2006 budget justifications and provided by agency officials. Budget authority is the authority provided by federal law to enter into financial obligations that will result in future outlays involving federal government funds. Budget authority includes appropriations and also includes the authority to borrow, enter into contracts, or to obligate and expend offsetting receipts and collections. Funding amounts from CMS reflect expenditure amounts under the Medicare and Medicaid programs from data in reports provided by CMS officials.

**Appendix IV: Federal Programs Using Health
Professional Shortage Area and Other
Designations of Underservice**

^bAccording to CMS officials, although data on Medicare and Medicaid payments to federally qualified health centers are available, data on expenditures for specific types of health centers, such as consolidated health centers or federally qualified health center look-alikes, are not available. Data from reports provided by CMS officials show that in 2004, the most recent year for which complete data were available, Medicare payments to federally qualified health centers totaled about \$278 million; in fiscal year 2004, the most recent year for which data were available, Medicaid payments to federally qualified health centers totaled about \$778 million.

^cScholarship recipients must fulfill a service requirement by, for example, being engaged in full-time private practice in a HPSA addressing the health care needs of a substantial number of Indians. Other types of service opportunities are also available for scholarship recipients.

^dA federal agency or state (including the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands) can request J-1 visa waivers for physicians who entered the United States for graduate medical education under the Department of State's exchange visitor program. After being recommended by the Department of State, waivers are granted by USCIS. Three federal agencies—HHS, Appalachian Regional Commission, and Delta Regional Authority—requested waivers for physicians to practice in underserved areas in fiscal year 2005. Also in fiscal year 2005, all 50 states, the District of Columbia, and Guam requested J-1 visa waivers for physicians to practice in facilities located in or treating residents of underserved areas under a provision of the Immigration and Nationality Act, also known as the Conrad Program.

^eThe Appalachian Regional Commission's and HHS's J-1 visa waiver programs require waiver physicians to practice in HPSAs. The Delta Regional Authority's J-1 visa waiver program requires waiver physicians to practice in HPSAs, MUAs or MUPs.

^fIndividual state requirements may vary. For example, one state may require J-1 visa waiver physicians to practice in HPSAs, while other states may require them to practice in HPSAs, MUAs, or MUPs.

^gNational Health Service Corps programs include the Scholarship Program, federal Loan Repayment Program, State Loan Repayment Program, and Ready Responders.

^h8 U.S.C. § 1153(b)(2)(B)(ii), 8 C.F.R. § 204.12 (2006).

ⁱAccording to CMS officials, the most recent completed year for which data on rural health clinics were available was 2004 for Medicare payments and fiscal year 2004 for Medicaid payments.

^jFunding priorities are factors that provide a grant applicant with a fixed amount of additional rating points, which could place the applicant in a more favorable position to receive a grant award than the applicant would be without the additional rating points.

^kA medically underserved community is an urban or rural area or population that (1) is eligible for HPSA designation; (2) is eligible to be served by a community health center, migrant health center, or a grantee serving residents of public housing or the homeless; (3) has a shortage of personal health services, as determined under criteria issued by the Secretary of Health and Human Services relating to rural health clinics; or (4) is designated by a state governor (in consultation with the medical community) as a shortage area or medically underserved community.

^lIncludes 15 health professions education programs authorized under title VII of the Public Health Service Act that have a funding preference for applicants that place a high or increasing number of graduates or those completing the program in settings having the principal focus of serving medically underserved communities, including (1) programs for training in family medicine, general internal medicine, general pediatrics, physician assistants, general dentistry, or pediatric dentistry; (2) programs for area health education centers; (3) Health Education and Training Centers program; (4) Quentin N. Burdick Program for Rural Interdisciplinary Training; (5) programs for allied health projects and other disciplines; and (6) geriatric education programs. In addition to these 15 programs, 1 additional grant program authorized under title VII of the Public Health Service Act, Health Administration Traineeships and Special Projects, has a funding preference for applicants that have not less than 25 percent of their graduates in full-time practice settings in medically underserved communities, that recruit and admit students from medically underserved communities, that have established relationships with public and nonprofit providers of health care in the community involved, and that emphasize employment with public and nonprofit entities in their training of students.

**Appendix IV: Federal Programs Using Health
Professional Shortage Area and Other
Designations of Underservice**

^mA funding preference is also available to applicants implementing new programs if they meet at least four of seven statutory criteria.

ⁿIncludes the Advanced Education Nursing Traineeship Program and Nurse Anesthetist Traineeship Program.

^oThe funding preference also applies to applicants that will help meet public health nursing needs in state or local health departments. Special considerations are factors considered in making funding decisions that are not review criteria, preferences, or priorities, for example, ensuring that there is an equitable geographic distribution of grant recipients.

Appendix V: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

SEP 19 2006

Leslie G. Aronovitz
Director, Health Care
U.S. Government Accountability Office
Washington, DC 20548

Dear Ms. Aronovitz:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "*HEALTH PROFESSIONAL SHORTAGE AREAS: Problems Remain with Shortage Area Designation System*" (GAO-06-548), before its publication. These comments represent the tentative position of the Department of Health and Human Services and are subject to reevaluation when the final version of this report is received.

The Department provided several technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

A handwritten signature in cursive script that reads "Rebecca Howard".

for

Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation

**COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT
REPORT "HEALTH PROFESSIONAL SHORTAGE AREAS: PROBLEMS
REMAIN WITH SHORTAGE AREA DESIGNATION SYSTEM" GAO-06-548**

General Comments

The Department concurs with the two major recommendations, and is pleased to report progress on both items. The Department has developed a new methodology to address many of the issues raised in this report. There are, however, some areas in the report that should be modified to more accurately reflect the impact of the automatic designation process and has provided some additional data for consideration in these areas.

The Department agrees with the Government Accountability Office (GAO) that a more timely publication of the Federal Register listing is necessary to assure that only those areas that meet the regulations remain fully designated. Together, the Federal Register and HRSA on-line data bases, accessible by the general public, serve as notification of designated Health Professional Shortage Areas (HPSAs) to all interested parties. Additionally, the Department informs interested parties of new, continued, revised, or proposed for withdrawal designations by way of a formal letter which states the effective date of the action. However, the Department is proposing a change in the process of withdrawing Health Professional Shortage Areas (HPSAs).

The Department agrees with the GAO that the current methodologies for identifying areas and populations need to be revised to reflect the current health care environment. In addition to the primary care proposal referenced in this report, the Department is near completion of a revised methodology for designating dental shortage areas. The Department has also made significant progress in developing a revised methodology for mental and behavioral health. Finally, the Department is also near completion of the design of a totally new designation process for identifying areas and facilities experiencing a shortage of nurses. In the next 2 to 3 years, the Department hopes to have all of these new designation methodologies completed and implemented. The Department's goal is to designate shortage areas to facilitate access to primary health care services for the people without such services. The Department is always appreciative of suggestions to improve our designation process, as we strive for excellence in service.

Impact of Automatic HPSA Designation for Federally Qualified Health Centers and Selected Rural Health Clinics

It is the Department's opinion that the report as currently drafted gives a somewhat misleading assessment of the impact of the automatic designation process. Since an estimated 50 percent or more of the health centers were already in HPSAs, they would not be expected to be helped by this provision. A slight rewording of the document in places noted in the attachment would provide a more accurate assessment of the process.

**COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT
REPORT "HEALTH PROFESSIONAL SHORTAGE AREAS: PROBLEMS
REMAIN WITH SHORTAGE AREA DESIGNATION SYSTEM" GAO-06-548**

In the 2005 placement cycle of the National Health Service Corps (NHSC) there were, in fact, 216 placements made to health centers as a result of their automatic HPSA status. Of these, 6 were scholars, 209 were loan repayers, and 1 was a Ready Responder. At this point in the 2006 placement cycle, 108 placements have been completed or are pending at health centers with automatic HPSAs. In 2005, approximately 16 percent of new NHSC placements were made to sites with a HPSA score of "0." These are sites that clearly benefited from the new provision in the designation process. Also, most State Loan Repayment programs do not have scoring limits, so it is likely that some of these clinicians were placed in health centers that are now eligible based on their automatic status; 85 percent of the State Loan Repayment clinicians serve in health centers.

In addition, it should be acknowledged that the Health Resources and Services Administration (HRSA) took several steps to inform the health centers and interested parties about the automatic scoring process and how they could improve their scores if they wished. The scoring was performed per established regulations to determine the greatest shortage; in the absence of data being submitted, national data sources were used. Information was posted on the HPSA Web site in the first year after the scores were developed in 2003 to provide alternative data sources and options. The same information was shared with other interested parties, including the Primary Care Offices (PCOs), which are located in the State Health Departments. A number of sites took advantage of this information and submitted additional data that justified an increased score. In several cases, the backup data were shared with the PCOs to explain the source of the current scores and where alternative data could be applied.

Moreover, it should be recognized that the total number of HPSA sites which can qualify to receive NHSC Scholars in any particular year is limited by statute to no more than twice the number of scholars available. The HPSA scoring process is designed to allow comparison of relative need among sites, so that sites of greatest need will be included on each year's list. It is not surprising that HPSA sites in areas meeting the objective HPSA criteria typically score higher than other facilities automatically designated.

It is also important to recognize that having a higher score and obtaining a place on the scholarship list is no guarantee of getting a clinician through the NHSC or the Health and Human Services (HHS) J-1 Visa Waiver program. Every year there are health centers on the recruitment list that do not succeed in recruiting a clinician from the scholarship program. Increasing the number of sites with higher scores will increase the competition among health centers for an already scarce resource, so a singular focus on the scores perhaps provides a false sense of security for sites which feel that is the only obstacle to successful recruiting.

**COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT
REPORT "HEALTH PROFESSIONAL SHORTAGE AREAS: PROBLEMS
REMAIN WITH SHORTAGE AREA DESIGNATION SYSTEM" GAO-06-548**

Finally, in terms of the HHS J-1 Visa Waiver program, it is important to recognize that this program has decreased dramatically with the increase in the Conrad 3) programs at the State level. Therefore, the fact that there was initially a higher score required for eligibility for the Federal program had a very limited effect on the recruitment of J-1 Visa physicians, most of whom are now going through the State programs. In fact, in 2005 only 4 J-1 Visa Waivers were approved through the HHS program, while approximately 900 were placed through the State Conrad programs, most of which did not have a score limit.

GAO RECOMMENDATION

Publish a list of designated HPSAs in the Federal Register or otherwise remove, through Federal Register notification, the HPSA designations for those HPSAs that no longer meet the criteria or have not provided updated data in support of their designation.

HHS Response:

The Department also concurs with GAO's recommendation that HRSA should resume publishing lists of HPSA designations, or at least lists of HPSA withdrawals in the Federal Register, to ensure that designations which have already been proposed for withdrawal (by letter from the Bureau of Health Profession's Shortage Designation Branch) actually get withdrawn.

GAO RECOMMENDATION:

Complete and publish its proposal to revise the HPSA designation system and address the shortcomings that have been identified in the current methodology for designating HPSAs.

HHS Response:

The Department concurs with this recommendation that HRSA's already-developed proposal to revise the regulations governing primary care HPSA and Medically Underserved Area/Population (MUA/P) designations, in the works since a 1998 Notice of Proposed Rule Making was withdrawn, should be implemented as soon as possible. This would address the various shortcomings of the existing criteria and process that GAO has identified in this and previous reports.

HHS Overall Comment:

It should be clearly stated that this report covers only the primary care designation process, and does not include the dental or mental health processes. References to the scores and factors throughout the report would be slightly different if all three disciplines were included.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Leslie G. Aronovitz, (312) 220-7600 or aronovitzl@gao.gov

Acknowledgments

In addition to the person named above, Kim Yamane, Assistant Director; Ellen W. Chu; Jennifer DeYoung; and Julian Klazkin made key contributions to this report.

Related GAO Products

Foreign Physicians: Preliminary Findings on the Use of J-1 Visa Waivers to Practice in Underserved Areas. [GAO-06-773T](#). Washington, D.C.: May 18, 2006.

Health Professions Education Programs: Action Still Needed to Measure Impact. [GAO-06-55](#). Washington, D.C.: February 28, 2006.

Health Centers: Competition for Grants and Efforts to Measure Performance Have Increased. [GAO-05-645](#). Washington, D.C.: July 13, 2005.

Health Centers and Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System. [GAO-05-452](#). Washington, D.C.: June 17, 2005.

Health Workforce: Ensuring Adequate Supply and Distribution Remains Challenging. [GAO-01-1042T](#). Washington, D.C.: August 1, 2001.

Health Care Access: Programs for Underserved Populations Could Be Improved. [GAO/T-HEHS-00-81](#). Washington, D.C.: March 23, 2000.

Physician Shortage Areas: Medicare Incentive Payments Not an Effective Approach to Improve Access. [GAO/HEHS-99-36](#). Washington, D.C.: February 26, 1999.

Health Care Access: Opportunities to Target Programs and Improve Accountability. [GAO/T-HEHS-97-204](#). Washington, D.C.: September 11, 1997.

Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas. [GAO/T-HEHS-97-65](#). Washington, D.C.: February 13, 1997.

National Health Service Corps: Opportunities to Stretch Scarce Dollars and Improve Provider Placement. [GAO/HEHS-96-28](#). Washington, D.C.: November 24, 1995.

Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved. [GAO/HEHS-95-200](#). Washington, D.C.: September 8, 1995.

GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are \$2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

Public Affairs

Paul Anderson, Managing Director, AndersonP1@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548