HRSA'S LONG-RANGE PLAN TO IMPROVE ACCESS TO PRIMARY HEALTH CARE FOR UNDERSERVED POPULATIONS

Problem

In many areas of the country, significant numbers of people still lack access to **preventive and primary care services** because of a combination of financial, geographic or cultural barriers. Access to services in these areas will not be achieved by financing reforms alone. Rather, interventions which **build primary care capacity** are needed to assure the presence of:

- Providers
- Facilities
- Organized systems of care which:
  - Provide case management and, where possible co-location of services;
  - respond to local health care problems and needs of special populations; and
  - provide outreach and other support services which will increase utilization and effectiveness of preventive and primary care by vulnerable populations.

Identifying Underserved Areas

In identifying the number of areas in the United States with access problems, an estimate was made of the number of counties with their need for preventive and primary care services partially as opposed to fully met.

Of the 3,199 counties in the U. S. (including territories):

- 1,108 are not designated as a Health Manpower Shortage Area (HMSA), or Medically Underserved Area (MUA), or Medically Underserved Population (MUP). They are presumed to be adequately served through permanent provider capacity.
- 2,091 counties have been identified as having primary care access problems because of containing areas designated either as an MUA/MUP or HMSA. Of these counties:
  - 365 are now **adequately** served due to Federal intervention. Specifically, these counties have a C/MHC or freestanding community-based NHSC site.

- Additionally, the intervention results in a primary care physician to population ratio that meets the HMSA threshold.

- In 419 counties, primary care needs have been partially, although not fully, met due to a Federal intervention. These counties also have C/MHC or NHSC sites, but the HMSA threshold requirements have not been met; there is a remaining need for at least one primary care physician in each of these counties.

- In 1,307 counties there is no federally supported provider of last resort for the underserved.

- Approximately 800 local health departments (LHDs) provide preventive and primary care services or perinatal services and well baby care. However, we do not know which counties these LHDs are located in, or the extent to which there is overlap with Federal interventions.

The color-coded map shows the breakout of counties described above. LHDs will be included on this map when permission to reveal their location is received from those responding to a NACHO survey already completed. We are also undertaking a new survey to define the scope of services and population served in these LHDs.

HRSA's Role in Primary Care

HRSA's role is not to provide, but rather to help to **assure** the availability of preventive and primary care services to vulnerable populations in underserved areas in close collaboration with State and local governments, non-profit organizations, and academic institutions. Directly and indirectly, HRSA serves its target populations in the following ways:

- o Developing the capacity for coordinated, community-based systems of primary care for vulnerable persons in locations of unmet need. An example is the Community/Migrant Health Center Program.

- o Providing grants for the delivery of health services which are not being financed through other means. An example is the Maternal and Child Health Block Grant.

- o Supporting health professions education and training and the placement of primary care personnel targeted to underserved areas. An example is the National Health Service Corps.

HRSA's Long-Range Goals

In projecting its long-range goals, HRSA proposes -- in collaboration with State and local government and with voluntary and academic organizations -- to assure the availability of primary care services to underserved areas.

For those programs which are directly funded, HRSA's BHCDA programs will have established by FY 1996 additional preventive and primary care capability in 750 of those 1,726 counties which are now only partially supported or not supported by Federal funds. This will assure that there is a provider of last resort for the target populations in those areas. The revitalized National Health Service Corps will have begun to generate providers in this expanded care system which includes C/MHCs, LHDs and free-standing delivery sites.

The Agency, through its cooperative agreements with State health departments, will help plan for capacity building in these 750 and, hopefully, additional underserved counties, which may have their needs met through State or local support. This will be prompted by MCH shifting more of its focus to one of provider of last resort and, therefore, playing a greater role in HRSA's strategy to improve access to preventive and primary care. For example, currently about 8% of C/MHC revenues are from State Maternal and Child Health funds, but it is not known how other MCH funds augment primary care capacity.

Of the 750 counties receiving BHCDA support, approximately 500 will be rural and 250 urban. Further specifics (allocation of resources to unserved vs. partially served counties; whether the intervention is a NHSC provider, a C/MHC or both) will depend on the number of unserved persons in the county, additional need factors (infant mortality or poverty) and, most important, the State plan.

HRSA Action Plan for Achieving Its Long-Range Goals

The achievement of these long-range goals relies on the following set of five capacity-building actions being undertaken in Fiscal Year 1992:

Targeting Increases to Direct Services Program Support

This first action step will continue the current level of support to assure the availability of needed services and, in addition, provide new dollars to expand capacity in both direct delivery and training.

Delivery System Support

- The funding request for FY'92 for C/MHCs is $597 million, allowing an increase in the number of C/MHC users by 125,000. This will be accomplished by establishing centers in 5 counties previously unserved and increasing capacity in approximately 20 counties that are now partially served,

- Expand and enhance the C/MHC Comprehensive Perinatal Care Program to improve outreach, prenatal services, and to support first trimester enrollment of 55 percent of women served and post partum visits of 60 percent of those women served.

- Maintain existing C/MHC capacity by: (1) improving the physical plants of centers; and (2) making physician salaries comparable to the local competitive marketplace.

- The Maternal and Child Health program includes $25 million to initiate demonstrations of One-Stop Shopping to improve the delivery of health care services for pregnant women and infants.

- The Infant Mortality Prevention Initiative is proposed for an increase of $4 million to a level of $36 million which would provide case management services to 75,000 additional mother and infant pairs.

- Under the Maternal and Child Health program, community-based infant mortality initiative demonstrations would be conducted in 20 sites, with a target population of 200,000. The focus would be to build on existing public health systems and to expand their capacity to reach high-risk women and infants. ($10 million increase)

Training and Recruitment of Health Care Providers

- Assure the adequacy of primary care personnel in all underserved areas by establishing first-dollar preference in funding to programs with formal educational linkages with health facilities serving the underserved.

- The budget request for scholarship and loan repayment activities in FY 1992 is for $92 million. This will support 394 scholarships and a total of 1,138 loan repayment recipients. The loan repayment program helps maintain existing capacity and stems the loss of approximately 900 physicians per year, while scholarships will add to capacity in the future.

- Provide service-linked educational networks such as Area Health Educational Centers with new approaches to meeting the health care needs of underserved populations. Priority in funding of the $20 million will be given to applications with formal linkages with primary care providers, such as community/migrant health centers.

- Maintain the Secretary's Minority Health Professions Initiatives proposed in FY 1991 President's Budget.

- Establish a Special Minority/Disadvantaged Health Professions Student Loan (HPSL) Initiative to help students in need as a result of the phase-out of the HEAL program.

Developing and Coordinating Needs Assessment Activities

Critical to the development of the Agency's capacity-building program is the creation of a solid data and information base upon which to effectively target resources and assess program outcomes. The following immediate steps will set that facet of the plan in operation:

- Improve needs assessment and reporting of information under the Maternal and Child Health program by initiating funding at a level of $7.9 million. Approximately 10 States would participate in this demonstration effort designed to track more specifically progress in meeting infant mortality targets.

- Maintain the $6 million in funding for cooperative agreements covering all 50 States and require specific plans for building primary care capacity. In FY 1992, a minimum of 20 county plans in 10 States will be produced.

- Expand selected cooperative agreements to use epidemiological data bases for small area analysis to evaluate primary care interventions in high risk populations, with 5 such expansions by the end of FY 1991, and 5 more by the end of FY 1992.

- Assess and refine existing designation systems for determining underservice on either population or geographic basis.

Improving Medicaid Reimbursement

Increasing the level of reimbursement of federally-qualified health centers will result in more money for services to underserved populations thereby permitting more of the available dollars to be directed at capacity-building activities.

Therefore, in FY 1992 special technical assistance efforts will be undertaken to enhance the fiscal capacity of nonfederally supported primary care providers to meet the Federally Qualified Health Center (FQHC) designation requirement.

Improving Community Based Coordination

The Agency can accomplish its goals at the local level only through the cooperation and integration of a strong community-based effort. Therefore, two specific actions are planned:

- Assure capacity through services coordination at the local level by establishing funding preferences for new service/capacity grants to those programs which demonstrate effective linkages for community based coordination of primary care service delivery.

- Require funding applicants to provide a "public health impact statement" which addresses (1) how the grantees' proposed activities reinforce other ongoing community health efforts, and (2) impact of the program on the available community of health care services to the disadvantaged and those at risk.

Strengthening Capacity Through Cooperative Relationships

In addition to local initiatives, new and better organized coordination efforts should take place at the State and national levels as well. Specifically --

- Expand joint activities with other Federal agencies including the Alcohol, Drug Abuse and Mental Health Administration; the Centers for Disease Control and the Health Care Financing Administration to address such priority problems as infant mortality, low birth weight, substance abuse and AIDS/HIV.

- Expand HRSA support to national public interest associations for such projects as --

  - Facilitating linkages between C/MHCs and local health departments

  - Improving the delivery of health care in rural areas

  - Strengthening the infrastructure of public health

  - Improving health care for minorities

HRSA Outyear Plan

The planned outyear projections which reflect the above direct service support and capacity-building actions are as follows:

Five Year Budget Direct Funding Requirements

The Agency estimates its C/MHC and NHSC funding requirements through FY 1996 and the accompanying impact on capacity in underserved areas, as follows:

	FY90	FY 91	FY 92	FY 93	FY 94	FY 95	FY96
Funding ($ in millions)							
BHCDA support	$530	$546	$627	$779	$858	$929	$996
Non-grant revenue	641	689	735	765	800	850	900
Total	1,171	1,235	1,362	1,544	1,658	1,779	1,896
Capacity of C/MHCs and NHSC Sites							
Counties Served	784	784					
Counties with Added Capacity (Cumulative)			25	200	400	575	750
Millions of Users	6.4	6.4	6.5	7.2	8.0	8.7	9.4

In expanding capacity, some additional counties where there is currently no Federal intervention would be targeted. In addition, some counties which are now partially served would receive new Federal resources. The ratio will depend on more detailed analysis and priorities expressed in State plans. BHCDA support includes funds for C/MHCs and perinatal services as well as funds for NHSC field support attributable to community

based programs.

Increases in non-grant revenue attributable to eligibility expansions under OBRA (primarily FY 1990) and higher reimbursement rates through the Federally Qualified Health Center legislation (primarily FY 91 and 92) are built into the FY 92 projection. These non-grant increases will be spent largely to improve the range of services so that every center offers health promotion/disease prevention geared to PHS goals for the year 2000. After FY 1992, increased capacity is driven by increases in grants. The non-grant revenues increase to the extent that more people are served and some of these additional users are eligible for public or private insurance under current law.

Should non-grant revenues increase due to comprehensive financing reforms, the projected amounts of grant funds would need to be reexamined. Much of the growth could be accomplished through increases in reimbursement. However, even if all persons had health insurance, roughly 25 percent of C/MHC costs would still require Federal grant assistance. This provides seed money for building capacity, facility and start-up costs, and funding for the outreach, health promotion, disease prevention and case management services that are needed to make access to care a reality in underserved areas but which are not appropriate for a general health insurance program.

NHSC Recruitment

HRSA would request a significant budget increase for NHSC recruitment over the next 5 years. The loan repayment will support future capacity expansions. The scholarships will eventually result in significantly higher numbers of providers available for placement in underserved areas but their impact on capacity will not be felt until 1996 or 1997. The five year budget request for the NHSC recruitment program is:

	FY90	FY91	FY 92	FY 93	FY 94	FY 95	FY 96
Costs for scholarship & loan repayment (millions)	$9	$64	$92	$128	$159	$174	$176
# scholarships	60	464	394	464	464	464	464
# of loan repayment recipients	74	921	1,138	1,717	2,654	2,841	2,667
Field Strength	1,700	2,450	2,500	3,000	3,400	3,800	4,200

Building Service Capacity with State and Local Public Health Organizations

Through the changes leveraged by such requirements as the proposed "public health impact statement," it is expected that other public sources of funding will provide annual increases in the number of people served by county. This will involve a combination of expanded State and local health department programs, increased access to public and non-profit providers through incremental changes in Medicaid, limited expansions in employer-based coverage, and, in part, by a variety of other Federal programs which provide access to a partial range of primary care services, including, in particular, the MCH block grant.

IMPROVING ACCESS TO PRIMARY CARE FOR UNDERSERVED POPULATIONS

Long Range Plan

- The Problem: Lack of primary care capacity
- HRSA's Role: Assuring availability of preventive and primary care services
- Long Term Goals: Build adequate capacity in collaboration with others
- FY 1992 Action Plan: Resources and results
- Outyear Plan: Increase services in 750 underserved or partially served counties by 1996

THE PROBLEM

- Lack of access to preventive and primary care services
- Will not be addressed by financing reforms alone
- Primary care capacity is needed to assure:
  - Providers
  - Facilities
  - Organized systems of care

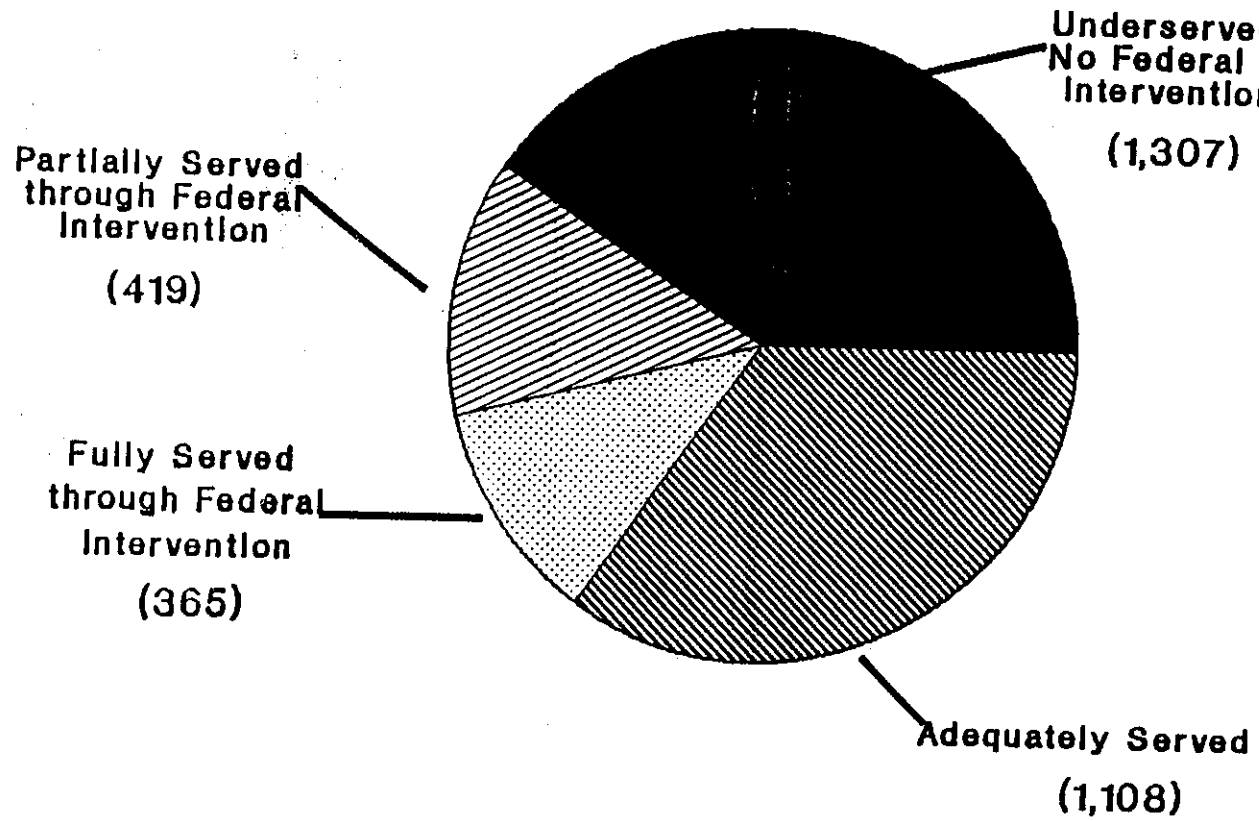
IDENTIFYING AREAS WITH ACCESS PROBLEMS

Of the Nation's 3,199 counties:

- o 1,108 adequately served (not designated HMSA or MUA/MUP)
- o 2,091 designated whole or part HMSA or MUA/MUP
  - 365 counties adequately served due to Federal intervention
  - 419 counties partially served due to Federal intervention
  - 1,307 counties with no federally supported provider of last resort
  - 800 LHDs provide preventive and primary care

THE PROBLEM

Of 3,199 U.S. counties, 2,091 have access problems



HRSA's ROLE

Assure, not provide, the availability of preventive and primary care services in underserved areas:

- Capacity development
- Grants for services not covered by insurance
- Training and placement of personnel

HRSA'S LONG TERM GOALS

- Build adequate capacity:
  - Add C/MHC or NHSC resources in 750 counties
  - CA plans for using Federal, State, and local resources
- Increase MCH focus on underserved areas

FY 1992 ACTION PLAN

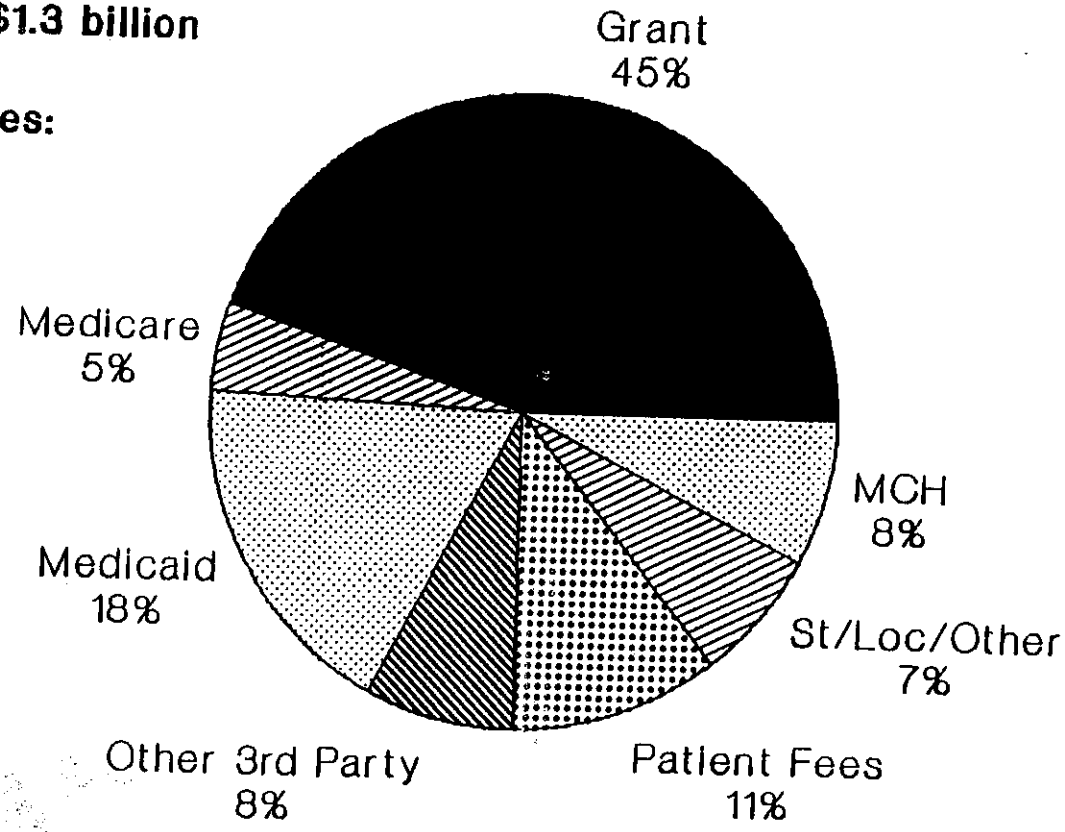
- Provide direct support
  - $597 million for C/MHCs (+25 counties)
  - $6 million for State Cooperative Agreements (20 county plans)
  - $92 million for 394 scholarships and 1,138 loans repaid
  - $10 million for MCH Infant Mortality Initiative
  - Minority Health Professions Initiatives
- Refine needs assessment
- Assist FQHC implementation
- Improve coordination at community level
- Expand linkages with agencies and interest groups

OUTYEAR PRIMARY CARE PLAN

- Capacity Building
  - Insurance under current law; growth driven by grant increases
  - Incorporates pre-1992 reimbursment increase due to OBRA and FQHC
  - If insurance increases, grants would still be needed for development and non-reimbursable services but share would drop
  - Incorporates MCH and other State and local funds allocated to C/MHCs
- NHSC Recruitment:
  - Loan repayment supports capacity building
  - Scholarships invest in future
- Collaboration with States

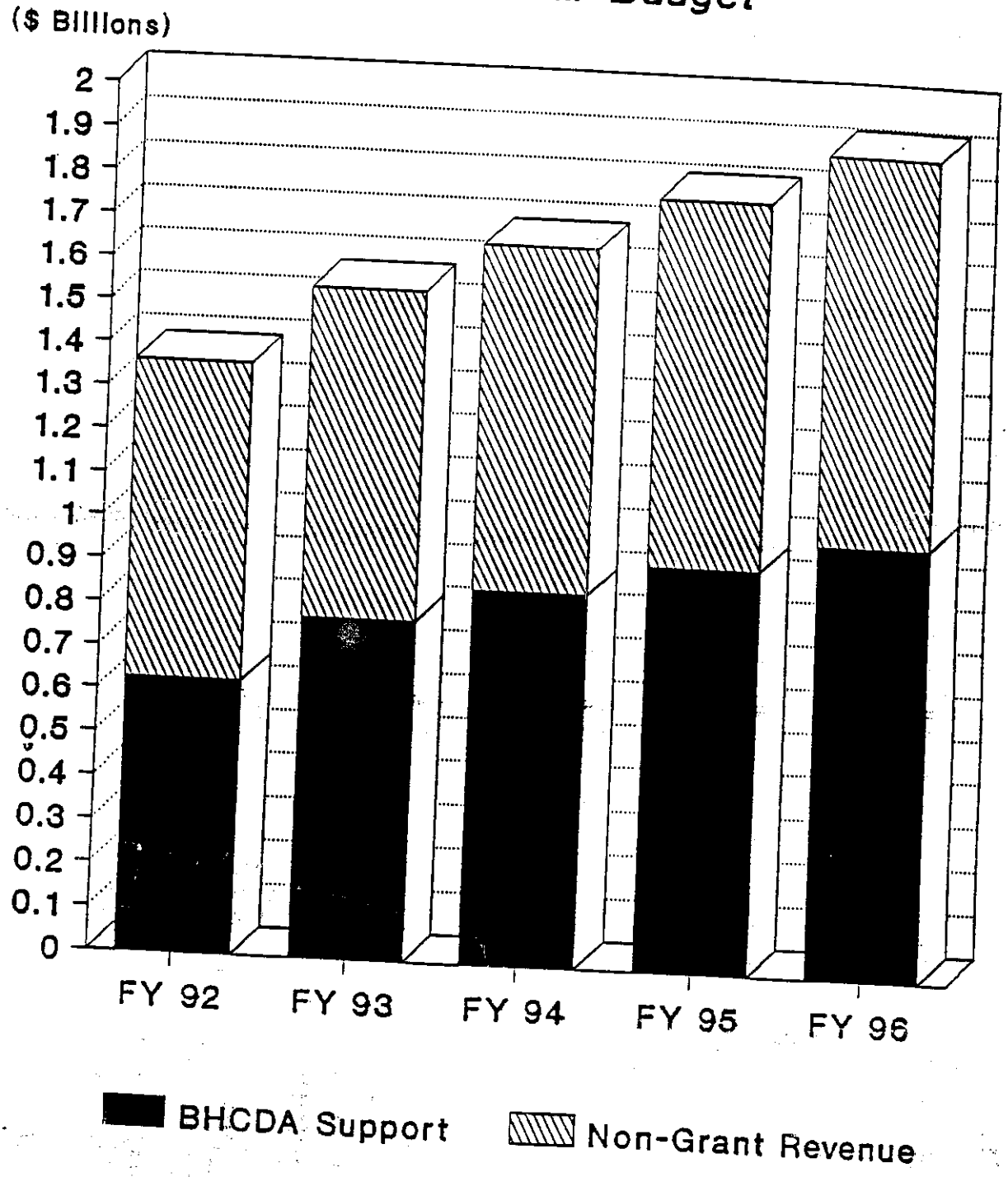
OUTYEAR PLAN
FY 1992 Funding for C/MHCs

- **Total $1.3 billion**
- **Sources:**



OUTYEAR PRIMARY CARE PLAN

Five Year Budget



OUTYEAR PRIMARY CARE PLAN
Growth in Capacity

	FY90	FY91	FY92	FY93	FY94	FY95	FY96
Counties Currently Served	784	784					
Counties w/ Added Capacity (Cumulative)*			25	200	400	575	750
Millions Served in C/MHCs and NHSC Sites	6.4	6.4	6.5	7.2	8.0	8.7	9.4

*Some partially served but high need; others not currently served.

OUTYEAR PRIMARY CARE PLAN
NHSC Recruitment

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Funding ($ millions)	9	64	92	128	159	174	176
Scholarships	60	464	394	464	464	464	464
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