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Michigan Department of Community Health

Michigan Primary Care Association

And

Michigan Center for Rural Health

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# Foreword

The Michigan Primary Care Association is pleased to publish the Primary Health Care Profile of Michigan in collaboration with the Michigan Department of Community Health and the Michigan Center for Rural Health.

The **Primary Health Care Profile of Michigan** is designed to provide communities, policymakers, and advocates with a demographic, economic, health status ‘snapshot’ of primary health care in Michigan’s counties. The **Profile** is one of several efforts to provide major stakeholders with information to help improve the delivery of health care in their communities. The **Profile** provides demographic, economic, health status, health resource, and health insurance status information at both state and county level. The **Profile** also includes descriptions of federal and state grant programs that support primary health care services.

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# Primary Health Care

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Primary Health Care is a term used to describe a basic level of health care services that include disease and prevention services. Primary health care services are typically comprehensive and provide continuity of care. Ideally, they are community oriented and coordinated: the primary health care provider serves as the point of access into the health care system. Primary health care services generally include: general/ family practitioners, internal medicine physicians, pediatricians, obstetrician/gynecologists, and midlevel providers (nurse practitioners, physician assistants, and certified midwives). Primary care services are provided in ambulatory care settings such as physicians' offices, hospital outpatient departments, community and migrant health centers, local public health department clinics, free clinics, and rural health clinics.

Over the past decade, health care costs in America have escalated while access to primary care services has decreased. The increase in costs can also be associated with a variety of factors. Often times, health insurance policies do not cover preventive visits or require significant co-pays that present a barrier to people using the health care system. Also, there has been a decrease in the number of primary care physicians, as more physicians enter into specialty fields. Consequently, patients are entering the health care system at costly secondary and tertiary stages of illness. According to a June 2005 physician workforce study commissioned by the Michigan State Medical Society and Public Policy Associates of Michigan, approximately one-third (33%) of all Michigan's physicians provide primary care services.

In addition, ninety percent of Michigan's physicians reside and/or practice in only 20 of the state's 83 counties according to that same source. Recruiting and retention of primary care providers is very difficult for a number of Michigan's rural and urban communities and often times it is the Medicaid and uninsured populations that feel these effects. There are numerous statewide efforts to address the physician shortage.

Primary care expands access to health care and is cost effective. Early intervention, prevention, patient management, and health maintenance are components of primary care delivery. Studies have demonstrated that their associated costs are much less than the costs of providing tertiary care which is usually more intrusive and complex.

Other components of primary care delivery, such as community involvement, strategic locations, and services that target the needs of the community, are critical to health care access. These critical elements help insure access to primary health care by the poor and other vulnerable populations—those who have fallen through the cracks of the current health care system. It is well known that low income populations and people of color experience worse health conditions across spectrums of illness, injuries and treatment outcomes. Eliminating racial and ethnic health disparities will require increased efforts to provide preventive care.

According to "Healthy Michigan 2010, and Characteristics of the Uninsured and Select Health Insurance Coverage in Michigan" reports published by the Michigan Department of Community Health, the following health disparities exist in Michigan:

- Minority Populations have higher diabetes prevalence rates than the overall population (Black 11.3/100; Hispanic 6.2; Native American 9.4; Overall 8.1/100).
- There are over 16,000 tobacco-related deaths in Michigan each year.
- The rate of HIV infection is 8.5 times higher in the black population than in the white population. Black males make up 58% of persons living with HIV/AIDS, but only 14% of Michigan's population.
- In 2006 the white infant mortality rate was 5.4 per 1,000 live births while the black rate was 14.8 per 1,000 live births, and the infant mortality rate for infants of other races was 10.6 per 1,000 live births.

The health care delivery system continues to evolve from reliance on the private practice physician to an expansion of the interdisciplinary team approach to primary health care delivery. This practice model involves physicians and midlevel providers working together to deliver primary care services to their communities.

State and federal initiatives have encouraged the development of systems to improve the delivery of primary care services. Publicly funded programs provide additional access points to deliver primary health care services to people in Michigan who otherwise would lack access to care. Types of publicly funded programs include:

- Community and Migrant Health Centers (C/MHC)
- Health Care for the Homeless (HCH)
- Outpatient Early Intervention Services with respect to HIV
- Rural Health Clinics (RHC)
- Indian Health Services (IHS)
- School Based School Linked Health Centers (SBSL)
- Critical Access Hospitals (CAH)
- Michigan Essential Health Provider Program
- National Health Services Corps
- J-1 Visa Waiver Programs
- Michigan State Loan Repayment Programs (SLRP)

## Federal Grant Programs

The Federal Government provides funding for several types of programs. The term 'health center' refers to five programs that receive federal funding under Section 330 of the Public Health Service Act to provide comprehensive care to medically underserved populations.

### Community and Migrant Health Centers

Community Health Centers (CHC) have provided comprehensive primary health care services to medically underserved population for over 40 years. Community Health Centers were first

developed in 1965 in response to community need for improved health services for inner city populations. As part of the federal government's War on Poverty, funding was made available to communities to establish primary health care centers to provide comprehensive health services, regardless of the ability to pay. Although there have been many changes to the CHC program over the years, including its expansion into rural areas, its foundation remains the same: community responsive, comprehensive primary care.

Under a similar program initiated in 1962, Migrant Health Centers were established to provide comprehensive primary health care services to migrant and seasonal agricultural workers and their families, including former migratory agricultural workers and their families whose primary employment is no longer in agriculture due to age or disability. Similar to the CHC program, Migrant Health Centers provide comprehensive health services to their target population, regardless of ability to pay.

Health Centers are developed and operated by the member communities in which they are located. As the needs of the community vary, so does the range of services provided by each health center. Health Centers are required to have a governing board composed of community leaders and residents, a majority of whom use the health care services they help to govern. Community empowerment has been a key factor in the success of C/MHCs through ensuring that community responsive care is provided. Along with health center staff, the consumer board develops a health care plan, which identifies community needs and implements intervention strategies.

Community and Migrant Health Centers have professionally trained staffs. Health center clinicians include primary care, behavioral and dental health providers as well as midlevel providers, social workers, nurses, and medical assistants. The health care team works together to provide ongoing care management to individuals and families throughout all stages of life—pediatric through geriatric.

Community and Migrant Health Centers are required to provide a core of primary health services. These preventive health services include: perinatal, well child, and family planning services' preventive dental services; emergency medical, radiological, and diagnostic laboratory services. Community and Migrant Health Centers also provide services such as mental health, substance abuse, dental, health education/promotion, translation, and transportation, depending on the needs of the community. C/MHCs have established relationships with local health departments, public schools, churches, hospitals, and other community agencies to avoid duplication of health services. In addition to the core services provided by Community Health Centers, Migrant Health Centers must also provide, as appropriate for their center, infectious and parasitic disease screening and control services and accident prevention programs.

The consumer board and staff of C/MHCs work together to identify resources to finance health center activities. Revenue is generated from government and foundation grants, third party insurers, Medicaid, Medicare, fee for service, and other local and state resources. Federal grant dollars are awarded to C/MHCs under sections 330(e) and (g) of the U.S. Public Service Act.

The Omnibus Budget Reconciliation Act of 1989 amended the Social Security Act to allow the establishment of Federally Qualified Health Centers (FQHC). FQHCs receive increased reimbursement as specified by the Centers for Medicare and Medicaid Services formerly known as the Health Care Financing Administration for services provided to Medicaid and Medicare beneficiaries. All C/MHCs have FQHC status.

Federally Qualified Health Centers (FQHCs) constitute an important component of the nation's health care safety net. FQHC is an umbrella term for a number of community-based safety net programs because they meet rigorous government standards and refers to how they are reimbursed by Medicaid. A few benefits an organization receives if designated as an FQHC is:

- the ability to be awarded federal grants that support the costs of uncompensated care,
- enhanced revenue due to the Prospective Payment System reimbursement for services to Medicaid and Medicare patients, and
- access to medical practice coverage under the Federal Tort Claims Act (FTCA) which aims to improve access to primary care services.

Like FQHCs, FQHC-Look Alikes (FQHCLAs) provide care to a federally designated Medically Underserved Area (MUA) or a Medically Underserved Population (MUP). FQHCLAs meet FQHC regulations, and receive other FQHC benefits, but do not receive Section 330 funding.

The following types of delivery sites are considered FQHCs:

- Community/Migrant Health Centers
- Health Care for the Homeless
- Ryan White Title III clinics (outpatient HIV early intervention services for low-income, medically underserved people in existing primary health care services)
- Indian Health Service clinics
- School Based School Linked Health Centers
- Public Housing Health Centers (to date, there are none in Michigan)

Today, Community and Migrant Health Centers (C/MHC) serve medically underserved populations ranging from inner city urban areas to rural frontiers. Currently there are 30 FQHCs and 3 FQHC "look alike" with 160 delivery sites serving over 500,000 patients in the state of Michigan. These patients include low income, uninsured, underinsured, elderly, minority, migrant and seasonal farmworkers, homeless and HIV-positive/AIDS populations.

## Health Care for the Homeless

The Health Care for the Homeless (HCH) program was initiated in 1987 as part of the Stewart B. McKinney Homeless Assistance Act and was modeled after a demonstration project jointly funded by the Robert Wood Johnson Foundation and the Pew Charitable Trust. The HCH program provides federal grants to nonprofit organizations to provide primary health care and substance abuse services to homeless individuals and families. Like the Community Health Center program, HCH programs provide a multidisciplinary approach to the delivery of care by

combining systems of primary health care, substance abuse and mental health services, patient management, and education with aggressive outreach.

Although originally envisioned as a provider to homeless single men, HCH programs are seeing families, children, pregnant women and teenagers, and persons living with HIV/AIDS. Many of the individuals served by a HCH program, in addition to lacking access to health care, have no resources such as Medicaid, Medicare, Aid to Families with Dependent Children, or Social Security Income benefits available to them. These high-risk population subgroups within an already at-risk population with limited resources put an additional burden on the Health Care for the Homeless program.

The seven HCH programs in Michigan serve individuals either through direct provision or through established linkages with other community agencies such as Community Health Centers, local health departments, community mental health and homeless shelters. Recognizing the special needs of the homeless community, HCH programs provide comprehensive, coordinated care and outreach in locations accessible to homeless individuals. Funding for HCH programs is authorized under Section 330(h) of the U.S. Public Health Service Act.

## Ryan White Title III Clinics- Outpatient Early Intervention Services with Respect to HIV Disease

This program was enacted in 1990 and amended in 1996 in honor of Ryan White, a teenager who publicly advocated for an end to AIDS-related discrimination. This program provides funding for high quality early intervention services, on an outpatient bases, to individuals with HIV infection. The grants increase the present capacity and capability of eligible ambulatory health service providers to offer a continuum of HIV prevention activities and care for individuals who are at risk for HIV infection or who are HIV infected.

These grants support the direct costs of providing such services as HIV testing, risk reduction counseling, education and counseling on living with HIV disease, appropriate medical evaluation, clinical care, and referrals. Grant funds may be used to pay the costs of providing optional services such as outreach, case management, and eligibility assistance, but only to the extent that these services are necessary to support the specified early intervention services. To be eligible to receive funding under this program, the applicant must be a qualified Medicaid participating provider. Eligible applicants may include the following organizations:

- Migrant Health Centers (Section 330(g));
- Community Health Centers receiving (Section 330(e)),
- Health Care for the Homeless (Section (h));
- family planning grantees receiving support under Section 1001 of the same act;
- Comprehensive Hemophilia Diagnostic and Treatment Centers;

- Federally Qualified Health Centers supported under Section 1905(1)(2)(B) of the Social Security Act;
- A public or nonprofit private entity that currently provides comprehensive primary health care services to populations at risk for HIV disease.

The authority for this program is the U.S. Public Health Service Act as amended by Public Law 101-381, the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. The Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), Department of Health and Human Services administers this grant program.

## Indian Health Services

The most prominent provider of health services to American Indians is the Indian Health Service (IHS). The IHS provides both direct care and contract care to members of federally recognized tribes on or near federal reservations. On the 2000 census, 60,675 people in Michigan described themselves as American Indian; however, 36,196 federally recognized Indians are registered at Indian clinics in Michigan but only 24,353 federally recognized Indian patients used health services at Indian clinics in the past three years. Therefore, 40% of Michigan residents who identified themselves as American Indian on the 2000 census accessed health care at an IHS clinic and 60% of people who identified themselves as American Indian are registered patients at IHS clinics across Michigan.

In Michigan thirteen tribal centers funded through P.L. 93-638, contract with the IHS to provide comprehensive health care to American Indians. At least 4 of the centers also provide care to non-Indian people within their geographic service area.

Funding for these activities is provided under the Indian Health Care Improvement and Education Act and the Indian Self-Determination Act (P.L. 93-638). The Field Health office provides management and technical assistance, consultation, and some direct preventive health care services to Michigan Tribal Communities. The preventive health care components include environmental health, health education, mental health/substance abuse, nursing and nutrition.

## School Based School Linked Health Centers

School Based School Linked Health Centers have been providing care for more than 15 years. The purpose of the School Based School Linked (SBSL) Health Center program is to increase access to comprehensive primary and preventive health care to underserved children, adolescents, and families.

The SBSL health centers and other Bureau of Primary Care (BPHC) -supported programs provide comprehensive primary and preventive health care services inside schools or on school grounds. School principals, school boards, parents, and providers determine the array of services provided on-site and no services are provided without fully informed parental consent. SBSL

health centers offer basic health services directly, through contracts, or through cooperative arrangements to provide the following services:

- primary health care;
- diagnostic laboratory and radiological services;
- preventive diagnostic laboratory and radiological services;
- preventive services including prenatal and perinatal;
- screening for cancer and other diseases;
- well child services;
- oral health services;
- mental health services;
- immunizations against vaccine-preventable diseases;
- screening for elevated blood lead levels, communicable diseases, and elevated cholesterol;
- eye, ear, and dental screenings;
- emergency medical services;
- pharmaceutical services as appropriate to a particular center;
- referral arrangements for services not available on-site.

Additionally, other services are provided that may be critical to improving the health status of a specific community or population group. Services beyond the required health center services are provided based on the needs and priorities of the community, the availability of other resources to meet those needs, and the resources of the health center.

SBSL health centers support education efforts by making sure that children are ready to learn. SBSL health centers are part of an integrated system of care and provide continuity of care to assure after hours and year round coverage. SBSL health centers are proven to increase access to comprehensive preventive and primary care services regardless of ability to pay.

## Rural Health Clinics

The Rural Health Clinics Services Act (PL 95-210) was passed by the federal government in 1977. The intent of this Act is to increase the availability and accessibility of primary and emergency health care to residents of rural areas that have a shortage of health care services and professionals. The Rural Health Clinic Services Act is the financing mechanism for increasing Medicare and Medicaid reimbursement to any type of public or private sector physician practice, clinic, hospital, nursing home, or home health agency that meets the certification criteria.

The law authorizes Medicare and Medicaid to reimburse qualified Rural Health Clinics (RHCs) for covered health care services furnished by nurse practitioners, physician assistants, and certified nurse midwives working with the supervision/collaboration of a physician. The RHC certification expands the Medicare reimbursable provider types beyond physicians to include

nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and/or clinical social workers.

A Rural Health Clinic may be either provider based (e.g., an integral part of a hospital, nursing home, or home health agency), or it can be an independent unit housed in a mobile or permanent structure. A clinic can be privately or publicly owned and operated either on a for-profit or not-for-profit basis.

## Critical Access Hospitals

The Balanced Budget Act of 1997 established the Medicare Rural Hospital Flexibility Program, which effectively replaced the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program and established the “critical access hospital” (CAH) designation. Any state may establish a rural hospital flexibility plan that provides for the creation of rural health networks, promotes regionalization of rural health services, and improves access to hospitals and other services for rural residents.

Hospitals that ultimately qualify for CAH designation will be reimbursed at 101% of “reasonable cost” for inpatient and outpatient services (including lab) provided to Medicare patients.

According to the Michigan Center for Rural Health, a hospital must meet the following criteria in order to be designated as a CAH:

- Be located in a rural area;
- Provide 24-hour emergency care;
- Have 25 or fewer licensed acute care beds;
- Provide inpatient care for no more than 96 hours calculated on an annual average;
- May use any of its beds to furnish either inpatient acute care or swing bed services for CAHs with swing bed agreements; and,
- Be more than a 35-mile drive from another hospital (15 miles in mountain terrain or areas with only secondary roads).

# Provider Programs

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## State Loan Repayment Program

The State Loan Repayment Program (SLRP) is a program that helps primary care providers repay their professional educational loans, if they commit to working in a federally designated Health Professional Shortage Area (HPSA) for a minimum of two years. Currently, Michigan Department of Community Health (MDCH) operates the nation's largest federally funded SLRP.

Primary care physicians (family practitioners, internists, pediatricians, obstetricians, general practitioners), dentists, mental health practitioners, nurse practitioners, nurse midwives, and physician assistants are eligible to apply and participate in this program. Candidates must be licensed or certified to practice in Michigan, and be graduates of accredited training programs. Candidates must also be able to verify loans incurred for professional education, have a signed contract of firm commitment of employment with a health care agency in a Health Professions Shortage Area (HPSA), submit an application to (MDCH), and sign a two-year contract with the department agreeing to work full time in a HPSA for the contract period. All SLRP sites must submit a Site Application in order to become an approved SLRP site. All sites must meet the following criteria:

- Located in a Health Professional Shortage Area (HPSA)
- Must operate as a not-for-profit agency with an IRS code of 501(c) 3
- Must accept Medicaid and Medicare; and,
- Must participate with a Qualified Health Plan.

Physicians and dentists are eligible for repayment of up to \$25,000 per year. Nurse practitioners, nurse midwives, and physician assistants are eligible for repayment of up to \$15,000 per year. The first payment is made directly to the provider by MDCH six months after starting work at the selected site. Verification that the provider has been working is required and can be provided by the SLRP site administrator or other authorized staff.

The SLRP began operating in 1991 with a small amount (under \$200,000) of state and federal funding through the Cooperative Agreement. Nineteen medical providers were placed through the SLRP between 1991 and 1994. In fiscal year 1995, \$574,100 in federal funds was awarded to the SLRP program, which was matched with \$500,000 new state money through the Michigan Cigarette Tax Initiative and \$74,100 in state general funds. Beginning in FY 1998, SLRP requested and began receiving an additional \$150,000 in federal funds. This money is matched with local agency funds, and has been part of Michigan's "Local Match" program ever since.

In addition, starting FY 2005 SLRP selection of providers to fill vacancies will no longer rely solely on a lottery. Selections will first be based on the specific priority criteria described below.

Below are the types of facilities and medical providers that will be priority candidates among all applicants.

1. Dentists
2. Psychiatrists—Psychiatrists willing to work at State Psychiatric Hospitals, State Forensic Medicine Centers, Community Mental Health (CMH) agencies, and State Correctional Facilities will be priority considerations due to the current crisis these facilities are experiencing in the recruitment and retention of these mental health providers. Although psychiatrists are top priority for mental health placements, the following providers willing to work at one of the above facilities will also be considered: Clinic Social Workers, Psychiatric Nurse Specialists, Clinical or Counseling Psychologists, and Marriage & Family Therapists. All mental health provider placements will revive the federally-required matching funds from the CMH state General Funds that are normally made available to these state facilities for general expenses. Any of these state facilities identified above that are willing to expend their CMH General Funds for loan repayment will be eligible to have these funds equally matched with federal loan repayment funds for the recruitment and/or retention of mental health care providers.
3. Any medical or mental health provider wishing to extend his/her two-year contract for one more year
4. Any eligible primary care medical provider (Physician, DDS, PA, NP, CNM) willing to work at one of the following agencies:
  - a. Any local health department clinic
  - b. Any state-funded institution
  - c. Any Federally Qualified Health Center (FQHC)
  - d. Any Critical Access Hospital (CAH)

## **National Health Service Corps**

The National Health Service Corps (NHSC) was created in 1970 to assist communities in the recruitment of health professionals. The mission of the NHSC is to increase access to primary health care services and reduce health disparities for people in health professional shortage areas by assisting communities through site development and by the preparation, recruitment and retention of community-responsive, culturally competent primary care clinicians.

The NHSC began its scholarship program in 1972, awarding tuition and stipends to students in health care professions training in return for commitments to serve in areas of need. The NHSC Scholarship Program offers payment of tuition, fees, books, supplies, and equipment for up to four years of education, plus a monthly stipend. United States citizens who are enrolled or accepted for enrollment in selected fully accredited training schools/programs including allopathic or osteopathic medical schools, family nurse practitioner and nurse-midwifery programs, bachelor's or master's physician assistant programs, or dental training programs are eligible to apply. Medical students are required to complete residency programs in family medicine, general pediatrics, general internal medicine, or obstetrics/gynecology. Upon completion of training, health professionals must choose a practice site in a HPSA and serve in

the practice one year for each year of support that was received, with a minimum of a two-year commitment.

In 1987, the NHSC launched a new program of loan repayment in return for service. The NHSC Loan Repayment Program is available to selected fully trained health professionals with qualified educational loans who serve at eligible sites. Qualifying health professionals must commit to provide primary health care services in a HPSA for a minimum of two years, be a US citizen, have an unrestricted license and/or certificate to practice in the state where they will practice, and meet other requirements. The maximum loan repayment amount during the initial contract is \$25,000 per year. Additional loan repayment beyond two years is possible.

## **State Conrad 30 J-1 Visa Waiver Program**

Through the State Conrad 30 Program, the State Of Michigan is allowed to act as an Interested Governmental Agency (IGA) and sponsor up to 30 J-1 Visa Waivers annually. This waives the two year return home requirement for International Medical Graduates (IMG) on the J-1 Visa studying in U.S. residency programs. In exchange for the waiver of the return home requirement, the IMG must agree to work in an underserved area for three years, and may be employed in private, public or not-for-profit clinics or hospitals.

The Michigan Department of Community Health will sponsor up to 30 waiver candidates per year. J-1 Visa Waiver candidates are prioritized based on the preference criteria described below.

**Criteria 1: Health Professional Shortage Areas:** The intent of the J-1 Visa Waiver Program is to place physicians into designated shortage areas. Michigan gives preference to placements in designated Health Professional Shortage Areas (HPSAs). If Michigan does not receive at least 30 requests for placements into HPSAs, we will consider placements into designated Medically Underserved Areas/Populations (MUA/P). Federal program guidelines allow for up to 5 waiver placements each year into areas that are not designated as either a HPSA or MUA/P. Michigan will consider placements outside of HPSAs or MUA/Ps if we do not receive at least 30 requests for placements into HPSAs or MUA/Ps. All placements outside of designated shortage areas must be made in facilities that can document that a portion of their annual patient caseload resides in a neighboring HPSA and/or MUA/P.

**Criteria 2: Primary Care and Specialists:** Preference is given to primary care physicians (IM, PEDS, FP, OB/GYN) and psychiatrists. If Michigan does not receive at least 30 requests for primary care physician or psychiatrist placement, consideration will be given to specialist physician placements. Among specialist physicians, there will be no restrictions regarding type of specialist allowed, with the exception of those specialties involved in care that is not medically essential (such as cosmetic surgery). Rural specialists will be given preference over urban specialists.

**Criteria 3: Priority Practice Sites:** Preference is given to physicians who will be employed at any of the following types of practice sites:

- Local Health Departments

- State funded Institutions
  - State-funded Primary Care Clinics
  - State Correctional Facilities
  - Community Mental Health (CMH) Agencies
  - Forensic Medicine Centers
  - State Psychiatric Hospitals
- Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes
- Critical Access Hospitals (CAH) and CAH Administered Clinics
- Certified Rural Health Clinics Designated as Facility HPSAs.

**Criteria 4: Urban/Rural Mix:** Michigan will seek to select 16 urban and 14 rural waiver placements each year.

**Criteria 5: HPSA Score:** For candidates with equal preference, based on the criteria above, additional ranking will be based on the HPSA score (for those candidates working in a HPSA), with preference for higher scoring HPSAs. Candidates will also receive a randomly assigned lottery number at intake in the event that there is a “tie” between two applicants.

# Shortage Designations

Medically Underserved Areas and Populations (MUA/P) and Health Professional Shortage Areas (HPSA), are federal designations established under the U.S. Public Health Service Act (Sections 330 and 332) as amended. These designations are granted to geographic areas, population groups, and facilities which meet the federally-established criteria as needing additional primary health care services.

Federal designation as a MUA, MUP, or HPSA is based on a measure of the availability of health professional resources within a rational service area (a county or a group of demographically similar townships or census tracts usually defined in terms of a 30 minute travel time). Other factors considered in the designation process are the availability of primary health care resources in contiguous areas and the presence of high need indicators, such as high infant mortality rate or high poverty rate.

The Shortage Designation Branch within the Health Resources and Services Administration of the U.S. Department of Health and Human Services is responsible for the MUA/P and HPSA designation process.

## **Medically Underserved Area/Population**

Designation as a Medically Underserved Area/Population (MUA/P) is based upon a formula known as the Index of Medical Underservice (IMU). The IMU is a composite measure of infant mortality, percentage of the population age 65 years or older, percentage of population with incomes under 100 percent of poverty, and primary care physician to population ratio. When determining eligibility for an MUA designation, the primary care physician to population ratio is used to estimate access to primary care physicians for the entire population residing in the service area and is calculated by dividing the total primary care physicians' full time equivalencies by the total population. When determining eligibility for an MUP designation, the primary care physician to population ratio is calculated by dividing the estimate of the community's primary care physicians' time spent caring for the special population by the special population.

Each IMU variable is assigned a weighted value. If the sum of those weighted values (the IMU score) is under 62.0, the area qualifies for a MUA/P designation. Federal programs utilizing MUA/P designations are:

- Community and Migrant Health Centers;
- Federally Qualified Health Center 'look-alikes;'
- Health Care for the Homeless Clinics; and,
- Rural Health Clinics (MUP designation does not qualify a community for this program).

## Health Professional Shortage Area

A HPSA designation may be obtained for primary care, dental and mental health services. To obtain a primary medical care Geographic HPSA designation, the population to physician ratio must be at least 3,500:1 (or 3,000:1 for a high need area). A HPSA designation can also be obtained for a special population, such as individuals eligible to participate in the Medicaid program or persons with incomes under 200 percent of poverty guidelines. The population to physician ratio must be at least 3,000:1 for a population group HPSA. For Medicaid and low-income population group designations the percentage of persons below 200 percent of the federal poverty guidelines must be at least 30 percent. The infant mortality rate, low birth weight rate, and the percentage of population living below 100 percent poverty in the designated area are used to rank each HPSA for priority in National Health Service Corps provider assignment. The HPSA scoring system considers the population to FTE provider ratio, the travel time and/or distance to the nearest source of non-designated care, as well as the low birth weight rate, infant mortality rate, and poverty percent. A HPSA designation is reviewed every four years. State and Federal programs utilizing HPSA designations are:

- National Health Service Corps, including scholarship and loan repayment programs;
- J-1 Visa Waiver Program;
- Rural Health Clinics;
- Michigan State Loan Repayment Program;
- Incentive payments for physician services provided in geographic HPSAs (Medicare);
- Higher “customary charges” for new physicians;
- Physician assistant training;
- Residency training, traineeships, and fellowships in general, internal and family medicine, general pediatrics and general practice dentistry;
- Mental health clinical traineeships;
- Area Health Education Center Program; and,
- Federal Employees Health Benefits Program.