July 18, 2025

Thomas J. Engels
HRSA Administrator
5600 Fishers Lane
Rockville, Maryland 20857

RE: Agency Information Collection Activities: Proposed Collection: Public Comment Request; Information Collection Request Title: Shortage Designation Management System, OMB No. 0906-0029-Extension

Submitted via: paperwork@hrsa.gov.

Dear Administrator Engels:

The Iowa Primary Care Association (Iowa PCA) appreciates the opportunity to provide input on the Shortage Designation Management System. The Iowa PCA supports our fourteen community health centers (CHCs or Federally Qualified Health Centers (FQHCs)) members. Collectively, our members provide healthcare to over 253,000 Iowans annually through more than 920,000 visits. Iowa's CHCs are a vital part of the healthcare received by Iowans in rural areas and other locations where access to care is scarce.

As you know, CHCs are an efficient, innovative, and resilient part of our nation's healthcare system. For nearly 60 years, CHCs have provided high-quality, comprehensive, affordable primary and preventive care. In addition to medical services, CHCs provide dental, behavioral health, pharmacy, vision, and other essential health services to America's communities in urban, rural, suburban, and frontier parts of the country.

An essential component of becoming a CHC is being located in a Medically Underserved Area (MUA) or serving a Medically Underserved Population (MUP), which then automatically designates these entities as Health Professional Service Area (HPSA). As designed, HPSAs, MUAs, and MUPs support communities with the most significant barriers to care, enabling policies and incentives to attract essential providers and resources that bridge access to care and workforce shortage gaps.

As highlighted in the Make America Healthy Again agenda, CHCs are well-positioned to be leaders in expanding access to primary care across the country and addressing chronic diseases. These designations are essential to the viability of CHCs, guiding our resource allocation, service expansion, and funding to ensure care for the communities that need it most. The Iowa PCA appreciates the opportunity to comment on the Information Collection Request regarding the Shortage Designation Management System, and we look forward to working with HRSA on this topic.

I. The Value of Community Health Centers

CHCs are uniquely positioned to address the nation's growing primary care gap while simultaneously delivering substantial cost savings to the healthcare system. According to NACHC's report, "Closing the Primary Care Gap,"[1]

[1] https://www.nachc.org/wp-content/uploads/2023/06/Closing-the-Primary-Care-Gap_Full-Report_2023_digital-final.pdf.

over 100 million Americans (one-third of the nation) lack access to a usual source of primary care due to a shortage of providers in their communities. These individuals are considered medically disenfranchised and include people of all income levels, locations, ages, races, ethnicities, and insurance status. Many of these individuals have insurance yet are still unable to access care in their community due to a shortage of providers. Without CHCs, 15 million more patients would be at risk of going without primary care.[2]

CHCs serve as a critical access point for comprehensive, affordable healthcare, particularly for underserved populations. CHC patients are four times more likely to have incomes at or below the Federal Poverty Level (FPL) and twice as likely to have income under 200% of FPL than the U.S. population. CHC patients are more than twice as likely to be uninsured as the U.S. population.[3] CHCs provide care to all patients, regardless of their ability to pay, and evaluate uninsured and underinsured patients on a sliding fee scale to help lower the cost they pay for services based on family size and income. In 2023 alone, CHCs also served 1.47 million homeless individuals, 6.55 million patients residing in public housing, 1.03 million agricultural workers and families, and 419,000 veterans.[4]

This preventive care model improves health outcomes and reduces costs. The Department for Health and Human Services (HHS) estimates that CHCs save $1,411 per adult and $741 per child enrolled in Medicaid, contributing to $11.4 billion in gross Medicaid savings.[5] These savings are achieved by reducing reliance on costly emergency departments and specialty care, lowering prescription drug spending, and better managing chronic diseases. [6] In fact, costs for health center patients with Medicaid coverage have been found to be lower than costs for non-health-center Medicaid patients by 8.4%[7] to 24%.[8] In short, CHCs are an efficient and effective investment of federal resources.

CHCs have also shown success in reducing chronic disease burden through early detection and ongoing management. In 2023, CHCs significantly increased screenings for breast cancer (52.5% Urban, 52% Rural), cervical cancer (57.2% Urban, 48.1% Rural), and colorectal cancer (40.2% Urban, 42.7% Rural),[9] demonstrating their commitment to early detection and prevention. From 2022 to 2023, as the overall patient population grew by 3%, CHCs also saw notable increases in patients diagnosed with and treated for chronic conditions, including asthma (6%), chronic lower respiratory diseases (5%), diabetes (6%), heart disease (8%), hypertension (5%), and obesity (11%). These efforts reflect a holistic, patient-centered approach that improves community health and mitigates long-term healthcare spending.

Despite operating on razor-thin margins, CHCs continue to demonstrate their value by delivering high-quality, cost-effective care to millions of Americans while contributing to local economies by creating jobs and generating income. One study found they support over 650,000 total jobs and create more than $118 billion in total economic impact.[10] CHCs' proven ability to address unmet care needs, reduce healthcare costs, and improve community health outcomes make them an integral part of the solution to our nation's primary care crisis.

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[2] https://www.nachc.org/wp-content/uploads/2023/06/Closing-the-Primary-Care-Gap_Full-Report_2023_digital-final.pdf.
[3] 2023 Uniform Data System, Bureau of Primary Healthcare, HRSA, DHHS.
[4] 2023 Uniform Data System, Bureau of Primary Healthcare, HRSA, DHHS.
[5] https://bphc.hrsa.gov/sites/default/files/bphc/about/dec-05-2024-today-macrae.pdf.
[6] Nocon et al., (2016).
[7] Mundt, Charles, and Sha Yuan. 2014. "An Evaluation of the Cost Efficiency of Federally Qualified Health Centers (FQHCs) and FQHC 'Look-Alikes' Operating in Michigan." The Institute for Health Policy at Michigan State University. October
[8] Nocon et al., (2016).
[9] 2023 Uniform Data System, Bureau of Primary Healthcare, HRSA, DHHS.
[10] https://www.nachc.org/wp-content/uploads/2025/01/PolicyPapers_NationalValueImpact_FINAL_Jan2025.pdf.

II. Medically Underserved Areas & Medically Underserved Populations Designations

HRSA established these designations specifically to support the development of health maintenance organizations and CHCs in communities where care is limited.[11] Under Section 330 of the Public Health Service Act, CHCs are explicitly defined as entities that serve medically underserved populations.[12] This makes MUA and MUP designations essential in the establishment of CHCs and they are foundational to their policy and operational framework. These designations can help CHCs strategically plan service area expansions, new site locations, and assist staff in developing care plans to meet the needs of their patients.

Unfortunately, many of the communities CHCs serve experience a lack of access to essential services connected to healthcare due to living in areas designated as pharmacy and food deserts. Although pharmacies are often considered one of the most accessible care settings, an estimated 15.8 million (4.7%) Americans reside in a pharmacy desert, spanning both urban and rural settings in all 50 states.[13] Individuals living in pharmacy deserts often face significant barriers to accessing care and essential medications. One study found that pharmacy deserts exist at similar rates in both MUA and non-MUA urban areas, indicating that primary care access does not always correlate with access to pharmacy services. [14]

Food deserts present another critical challenge. In communities with limited access to affordable, healthy foods, residents have heightened risks of diet-related chronic diseases. With food insecurity in the United States rising in recent years[15], CHCs have stepped in to bridge the gap between food and health. Through innovative partnerships and culturally competent interventions, many CHCs now offer food prescription programs, community gardens, and connections to food assistance services.

Without the funding and support tied to MUA/MUP designations, CHCs would be severely limited in their ability to address broader risk factors of health. Pharmacy and food deserts would deepen, the rate of chronic diseases would rise, and patients already facing barriers to care would encounter even greater health challenges. MUAs and MUPs not only enable the existence of CHCs, but they also allow them to be responsive, adaptable, and effective in meeting their community's health needs.

III. Health Professional Shortage Areas Designations

CHCs are the foundation of the nation's health professional shortage areas. By statute, CHCs are designed as Automatic Facility HPSAs (Auto-HPSAs) due to the nature of their work and the medically underserved populations they serve. The designation is not merely administrative; rather, it is essential to CHCs' ability to operate and deliver high-quality care in areas of high need. HPSA designations recognize that CHCs are integral to maintaining access to primary and preventive care in the areas that need it most. These designations provide access to federal resources that enable CHCs to continue serving their patients, and without them, many would be unable to operate in their communities.

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[11] https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.
[12] 42 USC § 254b (a)(1)
[13] Wittenauer R, Shah PD, Bacci JL, Stergachis A. Locations and characteristics of pharmacy deserts in the United States: a geospatial study. Health Aff Sch. 2024 Mar 16;2(4):qxae035. doi: 10.1093/haschl/qxae035. PMID: 38756173; PMCID: PMC11034534.
[14] Guadamuz JS, Wilder JR, Mouslim MC, Zenk SN, Alexander GC, Qato DM. Fewer pharmacies in Black and Hispanic/Latino neighborhoods compared with white or diverse neighborhoods, 2007–15. Health Aff (Millwood). 2021;40(5):802–811. 10.1377/HLTHAFF.2020.01699.
[15] https://www.cbpp.org/blog/food-insecurity-rises-for-the-second-year-in-a-row.

A HPSA designation also qualifies CHCs to apply for and receive National Health Service Corp (NHSC) clinicians. In 2024, more than 9,000 NHSC clinicians served at CHCs, providing care to more than 21 million patients across the country.[16] This program is a critical workforce pipeline for CHCs and has more than doubled the CHC workforce between 2010 to 2021.[17] Despite this growth, workforce shortages remain, particularly in rural and high-need areas. HPSA designations are essential to maintaining CHCs' eligibility for NHSC staffing and addressing provider shortages in the areas they serve. Given persistent healthcare workforce shortages, market competition, provider burnout, and early retirement, CHCs heavily rely on the NHSC program to recruit and retain their workforce. Loss of their designation would compromise access to providers, reduce service availability, and ultimately harm the patients and communities that CHCs serve.

CHCs have a long-standing record of delivering high-quality care to complex populations and rely on the support tied to HPSA, MUA, and MUP designations to sustain those services. These designations are critical for CHCs and their ability to care for their local communities. Thank you for your consideration of these comments. We look forward to working with the Administration on this topic. If you have any questions, please feel free to contact Katie Owens, Senior Director of External Affairs, at kowens@iowapca.org.

Sincerely,

Aaron Todd
Chief Executive Officer
Iowa Primary Care Association

[16] https://data.hrsa.gov/topics/health-workforce/field-strength.
[17] https://nhsc.hrsa.gov/sites/default/files/nhsc/about-us/NHSC%20Field%20Strength%20Infographic%202022_remediated.pdf.