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 California Primary Care Association (CPCA) represents over 2,300 community health center (CHC) sites that provide high-quality, comprehensive care to more than 7.7 million Californians annually. As you know, CHCs are the best, most innovative, and resilient part of our nation's health system. For nearly sixty years, health centers 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 most vulnerable, medically underserved communities in urban, rural, suburban, frontier, and island communities.

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 Areas (HPSAs). As designed, HPSAs, MUAs, and MUPs assist communities with the most significant barriers to care, enabling policies and incentives to attract essential providers and resources that bridge the gap.

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 health center mission, guiding our resource allocation, service expansion, and funding to ensure care for the communities that need it most. CPCA 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 National Association of Community Health Cetner's (NACHC's) report, "Closing the Primary Care Gap,"[1] 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 but are still unable to access care in their community due to a shortage of providers. Without health centers, 15 million more patients would be at risk of going without primary care.[2]

CHCs serve as a critical access point for comprehensive, affordable health care, 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. Health center patients are more than twice as likely to be uninsured as the U.S. population.[3] Health centers 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, health centers 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 not only improves health outcomes but also 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]

Health centers have also shown success in reducing chronic disease burden through early detection and ongoing management. In 2023, health centers 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%, health centers 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 not only improves community health but also mitigates long-term healthcare spending.

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

Despite operating on razor-thin margins, health centers 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] California's CHCs recruit locally and serve as economic engines, fostering job creation and stimulating economic growth. They create career opportunities across clinical, administrative, and support roles, often hiring from within the community to build a workforce that reflects and understands the populations they serve. In California, CHCs supported 134,249 jobs, generated $25.5 billion in economic output, and contributed $3.1 billion in tax revenue.[11] Health centers' 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.

II. Medically Underserved Areas (MUA) & Medically Underserved Populations (MUP) Designations

HRSA established these designations specifically to support the development of health maintenance organizations and CHCs in communities where care is limited.[12] Consequently, under Section 330 of the Public Health Service Act, health centers are explicitly defined as entities that serve medically underserved populations.[13] This makes MUA and MUP designations essential, not only in the establishment of health centers, but also foundational to the policy and operational framework of health centers. These designations can help CHCs strategically plan service area expansions and new site locations and assist staff in developing care to meet the needs of their patients.

Unfortunately, many of the communities health centers 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.[14] Individuals living in pharmacy deserts are often underserved groups who have historically faced barriers to care. 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. [15]

Food deserts present another critical challenge. In communities with limited access to affordable, healthy foods, residents have heightened risks of diet-related chronic diseases. Generally, limited access to nutritious food is more common in communities with higher rates of poverty, whether rural or urban, communities with greater shares of people of color, and rural American Indian or

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[10] https://www.nachc.org/wp-content/uploads/2025/01/PolicyPapers_NationalValueImpact_FINAL_Jan2025.pdf.

[11] California's Health Center Workforce State Profile

[12] https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.

[13] 42 USC § 254b (a)(1)

[14] 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.

[15] 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.

Alaska Native communities.[16] With food insecurity in the United States rising in recent years[17], health centers 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, health centers would be severely limited in their ability to address broader social risk factors of health. Pharmacy and food deserts would deepen, the chronic disease epidemic would rise, and patients already facing barriers to care would encounter even greater health disparities. MUAs and MUPs not only enable the existence of CHCs, but they also allow health centers to be responsive, adaptable, and effective in meeting their community's health needs.

In anticipation of any potential future updates to the methodology used for determining MUA/MUP designations, CPCA respectfully recommends that HRSA consider grandfathering existing MUA/MUP designations to preserve continuity and stability for affected communities and providers. This would prevent sudden disruptions in eligibility for federal programs that rely on these designations, such as the Health Center Program, and allow for a smoother transition if methodology changes are implemented. There is precedent for this approach with rural health centers (RHC). RHCs have, since the inception of the program, been allowed to remain RHCs despite the loss of the shortage area designation. This has prevented a "yo-yo" effect of clinics going on the RHC list and coming off it multiple times. The "yo-yo effect" occurs when a community is successful at bringing a health care provider into the community by virtue of a federal program based on a shortage designation, only to lose the ability to continue to participate in that program by virtue of its success. Absent this grandfather provision, an RHC physician could alter the physician-to-population ratio such that the area was no longer an HPSA, thus terminating eligibility for RHC designation. The clinic would likely close, once again pushing the community back into a shortage but re-establishing their eligibility for an RHC.

III. Health Professional Shortage Areas Designations

Health centers 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 health centers' ability to operate and deliver high-quality care in areas of high need. HPSA designations recognize that health centers 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 health centers would be unable to operate in their communities.

A HPSA designation also qualifies health centers 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.[18] This program is a critical workforce

[16] https://www.aecf.org/blog/food-deserts-in-america; Zhu AY. Impact of Neighborhood Sociodemographic Characteristics on Food Store Accessibility in the United States Based on the 2020 U.S. Census Data. Dela J Public Health. 2022 Aug 31;8(3):94-101. doi: 10.32481/djph.2022.08.016. PMID: 36177172; PMCID: PMC9495479.; https://www.reinvestment.com/wp-content/uploads/2024/01/RF-Limited-Supermarket-Access-Analysis-2024-1.pdf.
[17] https://www.cbpp.org/blog/food-insecurity-rises-for-the-second-year-in-a-row.
[18] https://data.hrsa.gov/topics/health-workforce/field-strength.

pipeline for CHCs and has more than doubled the health center workforce between 2010 to 2021.[19] Despite this growth, workforce shortages remain, particularly in rural and high-need areas. HPSA designations are essential to maintaining CHC 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, health centers 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.

Health centers have a long-standing record of delivering high-quality care to complex, underserved populations and rely on the support tied to HPSA, MUA, and MUP designations to sustain those services. 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 Anna Marshall, amarshall@cpca.org.

Sincerely,

Allie Budenz
Vice President of Health Center Optimization
California Primary Care Association

[19] https://nhsc.hrsa.gov/sites/default/files/nhsc/about-us/NHSC%20Field%20Strength%20Infographic%202022_remediated.pdf.