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NATIONAL RURAL HEALTH ASSOCIATION

March 18, 2021

Rob Fairweather
Acting Director, Office of Management and Budget
Executive Office of the President
725 17th Street, NW
Washington, D.C. 20503

RE: Recommendations from the Metropolitan and Micropolitan Statistical Area Standards Review Committee to the Office of Management and Budget: Changes to the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas

Dear Acting Director Fairweather,

On behalf of the National Rural Health Association (NRHA), we appreciate the opportunity to provide formal comments on the recommendations from the Metropolitan and Micropolitan Statistical Area Standards Review Committee to the Office of Management and Budget (OMB). NRHA understands that population-related definitions need to be re-evaluated and modernized overtime. However, we are deeply concerned that this change in the definition of Metropolitan and Micropolitan Statistical Areas (MSAs and MiSAs, respectively) will result in a large shift in definition in a short time without fully understanding its impact.

NRHA is a national nonprofit membership organization with more than 21,000 members. The association's mission is to improve the health of rural Americans and provide leadership on rural health issues through advocacy, communications, education, and research. NRHA membership consists of a diverse collection of individuals and organizations, all of whom share the common goal of protecting rural health.

Unintended Consequence for Rural America

The proposed change has the potential to significantly affect the way researchers, policy makers, and federal funding agencies address rural needs. By implementing the desired change OMB has put forward, increasing the minimum urban area population to qualify an area as an MSA from 50,000 to 100,000, 144 MSAs will be reclassified as MiSAs. Currently, there are 392 MSAs listed for the United States. Removing 144 will result in a 37 percent reduction in identified MSAs. Alternatively, it would bring the total of MiSAs from 547 to 691, an increase of more than 25 percent. This proposal recategorizes 251 counties and 18 million people as nonmetropolitan by labeling a large number of micropolitan urban counties as rural.

Of the 144 MSAs that will ultimately be converted to MiSAs under this proposal, many are large by comparison, and not something the average person would consider non-Metro. For example, under this change, Santa Fe, New Mexico, the fourth largest city in the state and state capital, would be

redesignated as a MiSA. Similarly, Cheyenne, Wyoming, and Rapid City, South Dakota, the largest and second-largest cities in their respective states, would be redesignated as a MiSA. The proposed change would also designate Silver City, New Mexico, Missoula, Montana, Sheridan, Wyoming, and Pierre, South Dakota, in the same manner as larger cities in their states.

NRHA is concerned that if OMB moves forward with reclassifying 40 percent of the United States' designated MSAs as MiSAs, there will be unintended consequences for both rural and urban communities. While rurality across government programs is not completely tied to MSA/MiSA designation, there are a significant number of programs that rely heavily on these designations, both directly and indirectly, in determining funding allocation, program eligibility, and reimbursement rates. Several Medicare programs of significance to rural providers rely directly on the MSA definition, including the Medicare Hospital Wage Index and Ambulance Fee Schedule, as well as Graduate Medical Education payment.

OMB's MSA and MiSA designation is utilized in factoring rurality across various programs. However, the change in designation, in the majority of cases, will not coincide with an appropriate adjustment in funding. Thus, allowing up to 144 new MiSAs to become eligible for various rural programs, which will cause their hospitals and other health care providers become classified as rural in many cases, could have significant impacts on resource allocation to rural areas. This decision will make funding for rural programs, which already tends to be stretched thin, to become even more scare among eligible entities.

This change will allow providers in areas previously designated as MSAs, urban providers, the opportunity to compete with rural providers for grants and other programs. This could result in MiSA's of 95,000 completing for the same resources as a town of 5,000. NRHA has deep concerns about this imbalance, as urban designated providers often have the means to hire professional grant writers to advocate for funding on behalf of their facilities. This will put traditional rural providers at a distinct disadvantage when competing with traditionally urban providers for the same funds.

Recommendations and Questions:

1) **NRHA believes a more gradual approach to addressing the MSA and MiSA designation would be favorable to rural health care providers and the communities they serve. NRHA does not see the evidence-base to change the population threshold for an MSA from 50,000 to 100,000, and frankly, we believe it is too large of a leap.**

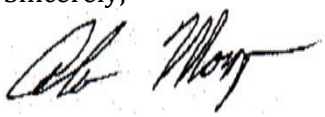
NRHA believes OMB would be better served to change the definition of an MiSA 75,000, or lower. In the example of Wyoming, under the current proposed designation, they would no longer have an MSA in the state. Wyoming would now be classified as 100 percent non-metro under OMB. The proposed change does not truly represent the differences between rural and urban communities. Further, the hospitals and healthcare providers in the impacted areas would not be advantaged having to share or compete with reclassified communities for resources. Gradually changing the definition from 50,000 to 75,000 will allow for less dramatic shifts in accompanying resources and policies.

2) **NRHA recommends OMB provide additional justification for the proposed policy change. While updating population, urban, and rural metrics is important, such a significant shift in policy could have unanticipated consequences. The benefit to rural or urban America created by shifting such a large number of MSAs to MiSAs is unclear.**

While the population of the U.S. has doubled since the metropolitan definition was established, the blunt approach of therefore doubling the threshold for determining metropolitan areas does not show the kind of nuance needed for complex policy development. NRHA recommends that OMB provide additional analysis on how the change in definitions may affect federal research and/or federal programs.

Thank you for the chance to offer comments on the recommendations OMB has received from the Metropolitan and Micropolitan Statistical Area Standards Review Committee for changes to those area standards. We look forward to continuing our work together to ensure our mutual goal of improving quality and access to care, especially in rural America. If you would like additional information, please contact Josh Jorgensen at jjorgensen@nrharural.org or 202-639-0550.

Sincerely,



Alan Morgan
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