

Date: September 18, 2020

To: Health Resources and Services Administration

From: The Association of Clinicians for the Underserved

Subject: Responses to Health Professional Shortage Area Scoring Criteria Request for Information (RFI)

Thank you for the opportunity to provide these responses to the RFI around HPSA Scoring. Given that the HPSA methodology dates back more than four decades, providing a means for a modernized scoring system that takes into account inequities in the provision of and access to care makes sense at this time.

In particular, we are concerned that the current HPSA scoring criteria, coupled with statutory methodology, do not allow for the most critical means of assessing the need of rural communities and for communities of color who have traditionally had a lack of access to care.

Recent revelations around systemic racism in our country call out the moral imperative we all share in not just addressing health disparities but putting in place policies and updating systems that will ensure true health equity going forward. Plainly, this must take into consideration all of the factors contributing to the health disparities, including geography, socio economics, education, and perhaps most pointedly, race and ethnicity.

Our proposals for revising scoring are as follows:

Response 1: Reduce the maximum score on the "Provider to Population Ratio" to 7 points, add additional points for a level of "Rurality" as its own category as stated here:

- Rurality would utilize Rural-Urban Commuting Areas Scoring (RUCA), and provide up to 3 points based on the facility's ¹[RUCA score](#) as noted here:

Other Large Rural	1 point
Small Rural Core or Other Small Rural	2 points
Isolated Rural	5 points

- ²[RUCA Codes](#) serve as a list of rural-urban commuting area (RUCA) code data sets. RUCA codes classify U.S. census tracts using measures of population density, urbanization, and daily commuting. The most recent RUCA codes are based on data from the 2010 decennial

¹ [HTTP://DEPTS.WASHINGTON.EDU/UWRUCA/MAP_7.PHP](http://depts.washington.edu/uwruca/map_7.php)

² [HTTPS://WWW.RURALHEALTHINFO.ORG/RESOURCES/769](https://www.ruralhealthinfo.org/resources/769)

census and the 2006-10 American Community Survey decennial census.³ We anticipate that RUCA Codes will be adjusted with the publication of the 2020 Census.

- Provider-to-Population Ratio Scoring would be adjusted as follows:
 - Under 3,500:1 0 points
 - 3,500:1 to 3,999:1 1 point
 - 4,000:1 to 5,999:1 2 points
 - 6,000:1 to 6,999:1 3 points
 - 8,000:1 to 7,999:1 4 points
 - 8,000:1 to 8,999:1 5 points
 - 9,000:1 to 9,999:1 6 points
 - 10,000:1 and above 7 points

Response 2: Remove “Infant Mortality” and replace it with a new measurement of chronic health condition prevalence of the target population in the Rational Service Area.

- Worst Quartile Diabetes 2 points
- Worst Quartile Obesity 2 points
- Worst Quartile Infant Mortality 1 point
- Total Possible:** **5 points**

Criterion	Max Points Awarded	Multiplier	Total Points Possible	New Proposed Scoring
Population – to – Provider Ratio	5	X2	5	7
New – Rurality	5	X1	5	3
% of Population below 100% Poverty	5	X1	5	5
Travel Time/Distance to the NSC	5	X1	5	5
<i>Infant Mortality</i>	5	X1	5	0
New – Prevalence of Chronic Health Conditions	5	X1	5	5

³ [HTTPS://WWW.ERS.USDA.GOV/DATA-PRODUCTS/RURAL-URBAN-COMMUTING-AREA-CODES/](https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/)

Justification to Response 1: The current scoring approach appears to disadvantage rural states and areas, where “all shortages are seen as equal” when they are not.

Currently, the highest weight is given to the population to provider ratio, and that is valid. However, we still have a system where each state determines how to measure that component. Despite HRSA’s goal of creating “greater transparency, accountability, and uniformity”, the methodology used to determine this critical element was delegated to each state’s Primary Care Office. While we assume that PCOs are doing their best to measure this to the extent of their capabilities, this subjective approach does not align with the goals of the Shortage Designation Modernization Project and results in disparate data gathering and inconsistent results state to state. We feel that this invalidates the intent of uniform scoring and equal standing for NHSC funds.

The Public Health Service Act outlines the criteria for HPSA designation, requiring the Secretary to consider the ratio of available health care providers to the population. The updated Shortage Designation Management System (SDMS) relies on provider data from the Centers for Medicare and Medicaid, with review and revision from state Primary Care Offices (PCOs). While we understand that HRSA works with state PCOs to encourage appropriate verification methodologies, reporting variation and delays may result in an outdated or inaccurate provider information. Given auto-HPSA scores depend most heavily on provider to population data, and uniform state reporting is not required, we feel that HRSA should give this factor an equal weight among all factors. We further recommend that HRSA use an approach for verifying provider capacity that is uniform among all states. And, we believe this criterion should be reduced in overall weight against all others, while still being the largest portion of the total scoring.

Rural provider practices, especially those serving the low income population, draw patients from a wide geographic area. Sometimes to get to 70% of their service area, the population may encompass areas where other providers work, but do not serve the volume of low income patients served by rural providers.

Additionally, having the population to provider ratio weighted at 40% of the scoring has a significant negative impact on rural facilities. The HPSA ratios used to calculate “sufficient access,” fail to account for rural realities and the burden placed on a single practitioner to deliver care to 3500 individuals 24/7, 365 days a year in a wide service area. In rural America, the traditional model used in population-to-provider ratios is fundamentally biased against rural and frontier health care providers because the population is low, however, the providers must cover a wider range of services and geographic area without any relief or reinforcement.

Other rural factors that must be considered are:

- ***Undercounted populations*** – ⁴Many times rural and frontier communities have populations that are often undercounted i.e., [Native Americans and seasonal farmworkers](#).
- ***Rural trauma*** - The current distance to care metric does not take into consideration the statistics regarding rural trauma or preventative care “No matter how you look at the statistics regarding rural trauma, whether it’s excess deaths, likelihood of dying, preventable mortality, it’s basically

⁴ [HTTPS://BECOUNTEDMI2020.COM/WP-CONTENT/UPLOADS/2020-CENSUS-FACES-CHALLENGES-IN-RURAL-AMERICA.PDF](https://becountedmi2020.com/wp-content/uploads/2020-Census-Faces-Challenges-in-Rural-America.pdf)



50% higher when compared to urban injury," [Dr. Richard Sidwell](#), a Des Moines, Iowa, trauma surgeon and chair of the American College of Surgeons Rural Trauma Subcommittee⁵

Adding points to those who qualify for the RUCA codes and equalizing the scoring on provider to population ratio will help balance those facilities who face rural barriers and a lack of medical expertise. Incentivizing well trained health professionals to serve these areas will also bring relief to health care facilities that area already facing many challenges operating in frontier communities. As HPSA scoring stands now, states like Idaho will see an even greater health crisis without the ability to maintain a competitive status for the National Health Service Corps, Nurse Corps, and loan repayment through the Rural Physician Incentive and the Rural Health Care Access Program.

Justification to Response 2: Remove "Infant Mortality" and create a new criterion that gives other health conditions such as obesity, and diabetes more weight, while allowing a smaller number of points for infant mortality to be considered.

We do know that ⁶[lower-income Americans experience higher rates of disease](#) such as heart disease, bronchitis, diabetes, liver disease, and arthritis, than Americans with higher incomes. HRSA's use of Poverty as a criterion makes sense. However, while poverty may increase the likelihood of the onset of mental illness, ⁷[intensify the experience](#), or prevent people from accessing proper treatment it makes sense to look at the prevalence of such poor health conditions as a factor requiring more access to care.

The disproportionate impact that lack of access to care can have on these chronic conditions emphasizes both the value and urgent need to update the scoring approach to take these wide spread chronic conditions into account to begin to address larger access issues.

⁵ [HTTPS://WWW.RURALHEALTHINFO.ORG/RURAL-MONITOR/UNINTENTIONAL-INJURIES/](https://www.ruralhealthinfo.org/rural-monitor/unintentional-injuries/)

⁶ [HTTPS://WWW.URBAN.ORG/SITES/DEFAULT/FILES/PUBLICATION/49116/2000178-HOW-ARE-INCOME-AND-WEALTH-LINKED-TO-HEALTH-AND-LONGEVITY.PDF](https://www.urban.org/sites/default/files/publication/49116/2000178-How-Are-Income-And-Wealth-Linked-To-Health-And-Longevity.pdf)

⁷ [HTTPS://WWW.SAMHSA.GOV/DATA/SITES/DEFAULT/FILES/REPORT_2720/SPOTLIGHT-2720.HTML](https://www.samhsa.gov/data/sites/default/files/report_2720/spotlight-2720.html)

