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American Dental Association Response to Health Resources and Services Administration Health Professional Shortage Area Scoring Criteria RFI

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On behalf of the American Dental Association (ADA) and our more than 163,000 member dentists, thank you for the opportunity to respond to the Health Resources and Services Administration's (HRSA) Request for Information (RFI) regarding Health Professional Shortage Area (HPSA) Scoring Criteria.

As you know, HPSAs are a critical issue as lawmakers and policymakers work to improve oral health services across America, especially in underserved and rural areas. In light of HRSA efforts on the HPSA Modernization Project, we especially are appreciative of the opportunity to offer constructive comments for consideration.

Together with its constituent state dental societies, the ADA has worked tirelessly to develop and nurture innovative and lasting programs and solutions for improving access to care and oral health outcomes.

OVERVIEW

The ADA applauds HRSA for soliciting stakeholder feedback on the methodology used to calculate Dental Health Professional Shortage Areas (HPSAs) and for considering future approaches to prioritize and measure resources as the healthcare marketplace modernizes and evolves.

Over time, the way people access goods and services changes and this variability is no different with health care. Technology has evolved affording us the ability to be precise – with greater accuracy and responsiveness. A one-size-fits-all approach to measuring need across rural communities is a disservice to patients. Real solutions are necessary to improve access to and utilization of healthcare services.

When shortage areas are incorrectly defined, human and capital resources are improperly disbursed, policy is improperly focused, and bad proposals move forward. Thus, those most in need are likely left behind in favor of others who may not need as great a degree of help.

The current model of defining where the greatest needs lie in respect to number and distribution of providers is sorely outdated and inflexible. With an updated, technology-driven approach, we can better allocate resources to enact responsive policy that meets the unique needs of each community.

To that end, the ADA is hoping to clarify the widespread misconception in the oral healthcare community that HPSAs are used solely to determine an adequate number of healthcare providers in a specific geographic area. This perception has led policymakers and stakeholders to focus on solutions that are misaligned with the unique needs of a particular area or county just because it's designated as a dental HPSA.

The ADA would also like to use this opportunity to offer suggestions on how to update and improve the methodology used to calculate HPSA scores and readjust weighting criteria used in those calculations.

We have already seen how efforts in applying RUCA (Rural Urban Commuting Areas) scores to many areas offers contemporary consideration of factors aside from the number of healthcare providers in a geographic location. These factors include the presence of elementary schools, number of medical providers, small business development, and location of pharmacies, car dealers as well as "low order" goods / services such as gas stations or grocery stores.

THE CURRENT DENTAL HPSA SCORING CRITERIA

The ADA would like HRSA to reiterate that the number and type of dental providers in the area is one of multiple factors that is considered for HPSA designation. According to HRSA's scoring criteria for dental HPSAs, the population-to-provider ratio represents only one of the four metrics used to evaluate whether a county's designation, and that ratio represents less than half of the aggregate score, accounting for only ten points out of 26 total points. In some scenarios, an area may be designated as a dental HPSA without any points from the population-to-provider ratio but having either full points or nearly full points in the other three metrics.

Additionally, the ADA would like to suggest to HRSA other ways in which the HPSA designations can be improved. For example, the use of community water fluoridation (CWF) as a scoring consideration for HPSA designation is significantly misleading. While CWF has been shown to be effective in prevention of tooth decay, it's presence or absence does not reflect on the number or type of dental providers within a community.

The dental department of a health center serving medically underserved patients within a HPSA may serve as an outreach site for a dental school or residency program. This influx of professionals providing care is not typically reflected in the HPSA designation.

Dentists who practice full time within a community health center as part of the National Health Service Corps loan repayment programs are usually not "counted" within the provider population. In fact, despite several dental professionals expanding access to care within a geographic region, the area would still be classified as a HPSA using the population to provider ratio factor, which is a double weighted consideration.

Using the Nearest Source of Care (NSC) may result in a county with enough providers still being designated as a dental HPSA. We believe that this criteria may result in the perception that states with expansive rural areas suffer from a dramatic shortage of providers. Even areas which are designated "FAR" (Frontier and Remote) have various designation levels which delineate the degree of low population size and time it takes to travel by car to the edges of Urban Areas.

THE ADA'S APPROACH TO MEASURING GEOGRAPHIC ACCESS TO DENTISTS

While the shortcomings to HRSA's methodology have been documented more broadly in the literature [1], there has not been anything better developed to replace it, at least when it comes to dental care. This led the Health Policy Institute (HPI) group at the American Dental Association to launch an innovative, data-driven, analysis of geographic access to dentists in every state. This 2-year effort involved creating a new, unique proprietary database of all locations in the United States.

This dataset includes locations of private dental practices, Federally Qualified Health Centers (FQHCs) with dental care services, and dental school clinics and the profile of dentists working in these facilities. The data are then merged with detailed population data, which allows for analyzing

the geographic proximity of dentists to the population using geo-mapping techniques. Through a partnership with the Centers for Medicare and Medicaid Services (CMS), HPI researchers are able to identify dental care locations where dentists participate in Medicaid or the Children's Health Insurance Program (CHIP). This allows for a separate analysis of geographic access among the publicly-insured population to dentists that participate in Medicaid or CHIP.

HPI's analysis is at the Census tract level, which is much more detailed than county level, and uses transportation network data to calculate travel times. The detailed methodology, including limitations, and results for every state are all available online [2]. A side-by-side comparison of HRSA HPSA estimates with HPI's estimates are also available in one state, as an illustrative example [3].

The main advantage of HPI's approach to measuring geographic access to dentists is that it takes account of where the population lives, including Medicaid-insured populations, relative to where dentists are located and incorporates travel time data. The analysis is done at the Census tract level, which is key, but the results can be aggregated to develop county-level metrics as well. In our view, HPI's analysis presents a more accurate picture of true geographic proximity of the population to dental care providers. The analysis could easily be replicated by HRSA with some modifications to the database HRSA already acquires each year from HPI.

HPI's analysis has already had important impacts for policy makers at the state level. The HPI team is currently working directly with several state Medicaid agencies to extend the methodology, incorporate additional tailored research, and develop actionable insights in the area of geographic access to dental care providers. The important take-away from these collaborations with policy makers is that the HPI methodology is very actionable in that it is being used to guide decisions on where to invest state resources to improve access to dental care.

Thank you again for the opportunity to submit comments to HRSA. The ADA looks forward to working with the agency to develop alternative methods of determining access to dentists, such as that developed by HPI.

[1] https://www.gao.gov/new.items/d0784.pdf
[2] https://www.ada.org/en/science-research/health-policy-institute/geographic-access-to-dental-care
[3] https://www.ncmedicaljournal.com/content/78/6/391.full