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Associate Administrator
Luis Padilla, MD, FAAFP
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857 U.S.A.

Dear Dr. Padilla,

On behalf of the National Rural Health Association (NRHA), we appreciate the opportunity to provide formal comments on Section 332 of the Public Health Service Act, 42 U.S.C. § 254e, which authorizes the Health Resources and Services Administration's (HRSA) shortage designation activities. Under this authority, HRSA designates geographic areas, population groups within geographic areas, and certain facilities as Health Professional Shortage Areas (HPSA). Per statute and regulations, HRSA assesses three types of HPSAs by discipline: primary care, dental health, and mental health. After a HPSA is designated, it receives a score according to established criteria.

NRHA is a national nonprofit membership organization with more than 21,000 members, and 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.

Currently, three primary factors are used in scoring criteria for all disciplines: (1) population-to-provider ratio; (2) poverty rates; and (3) travel distance or time to the nearest accessible source of care. We strongly urge consideration and inclusion of the following measures as you look towards improving HPSA scoring.

A measure of rurality must be developed:

NRHA recommends HRSA add a factor to the HPSA-scoring process to reflect the rurality of a HPSA's location. This addition will ensure the unique access problems associated with rural locations are considered when identifying the relative need of a HPSA.

NRHA recommends this factor be added to all HPSA disciplines (primary care, mental health, and dental health HPSAs) and added to all HPSA designation types (geographic-, population-, and facility-based HPSAs). We believe this factor should reflect a variable range of rurality, and could include either, or a combination, of the following:

- Rural-Urban Commuting Area (RUCA) codes establish multiple levels of rural isolation from the nearest urban centers.
- Frontier and remote areas are characterized by a combination of low population size and high geographic remoteness, and Frontier and Remote area (FAR) codes define the remoteness and population size of these geographies. These codes can help identify places that are distant from necessary health care services. FAR codes are determined on a half-kilometer by half-kilometer grid and are easily aggregated at a granular level. FAR codes have four levels; level one FAR codes identify geographies where a relatively large number of people live far from cities providing "high order" goods and services, and level four FAR codes identify geographies where a much smaller population finds it hard to access "low order" goods and services.

Additionally, we recommend the Bureau of Health Workforce (BHW) establish a separate HPSA-scoring process for small rural and frontier HPSAs. NRHA members across the country have expressed frustration that the HPSA scoring process does not prioritize or accurately reflect the needs of areas with small populations. For example, in some circumstances, a remote community of 5,000 people and one full-time primary care provider is unable to qualify for the placement of National Health Service Corps (NHSC) providers. The presence of even one provider in a small population HPSA can result in a population-to-provider ratio which translates to a low score.

This issue has prevailed for several decades, and it is the basis of the Affordable Care Act's statutory mandate to create a separate Frontier HPSA. NRHA believes the addition of a rurality factor to the HPSA-scoring formula could partially address this issue, and we recommend that a separate scoring process be created for small rural and frontier HPSAs.

The HPSA auto scoring method assigns a single, average score to all clinic locations of a FQHC. In a large, multi-clinic organization, this could mean that a single score is assigned to multiple urban and rural locations. We recommend that a rurality factor be assigned to each individual clinic location. Although this scoring approach will be slightly more complex, it will more accurately reflect the relative need of individual locations.

We strongly recommend that BHW revise the HPSA-scoring process factors used in the measurement of population health status and health disparities:

Currently, the HPSA-scoring process includes extremely limited measures of a population's health status. We recommend that a national expert committee, such as a negotiated rulemaking committee, be convened to identify and select appropriate health status/health disparity factors to be used for HPSA-scoring all three HPSA disciplines. The aim is to identify measures that more

accurately reflect the unique health disparities of rural populations, which to be older and suffer from higher rates of chronic illness and disability.

Potential measures for Primary Medical Care HPSA-scoring could include:

- Life expectancy from birth.
- Years of Potential Life Lost (YPLL);
- Disability rates; and
- Mortality rates from all causes of death, including either age-adjusted rates or standardized mortality ratios

Potential measures for Mental Health HPSA-scoring could include:

- Mortality rates from diseases of despair;
- Measures of mental health status reported in the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Survey

A potential measure for Dental Health HPSA-scoring could include:

- Dental health measures from the Behavioral Risk Factor Surveillance System

In advance of such a national committee review, NRHA believes the following measures should be considered to reflect rural population health status/health disparities:

Measures and ratios regarding median age of populations:

In current HPSA-scoring process accounts for the unique needs of populations served. For example, primary care HPSA-scoring accounts for extra resources needed by infants by using low birthweight and infant mortality data. Ultimately, these measures are proxies for understanding the needs of a high utilization population and their related risk factors. However, the higher utilization of services by elderly populations and their related risk factors are not accounted for, and they should be.

On average, rural populations are older than their urban counterparts, and as a result, they have a greater need for access to health care. The Rural Health Research Recap on *Rural Communities: Age, Income, and Health Status* shows that rural counties have an older, sicker population compared to urban counties. The median age in Census defined rural areas is 51 years, six years older than in urban areas. Life expectancy is two years shorter in rural areas, which reflects the burden of poorer health. While the Mental Health HPSA criteria includes a factor to account for elderly populations (“ratios of the population under the age of 18 and over the age of 65 to the adult population ages 18 to 64”), the Primary Care HPSA scoring does not. Since 18.4% of the rural population is age 65 or older, compared to only 14.5% of the urban population, they have greater health care needs that are not being considered when scoring Primary Care HPSAs. The next HPSA designation guidelines should consider these older, rural populations to ensure they have better access to health care. The elderly ratio should carry more weight when identifying and scoring HPSAs. Data on percent of the population 65 or older is available by county from the [Census Bureau](#) and [U.S. Department of Agriculture](#).

Measurement weighting for Low birth weight infant mortality criteria should be decreased:

Less emphasis should be given to the low birth weight and infant mortality criterion when determining HPSAs; research has proven that these criteria have less to do with health care shortages than the other measures used to identify and score HPSA designations.

Low-income population measurement:

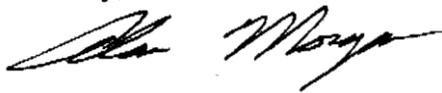
We recommend that BHW revise the HPSA-scoring process factor used in the measurement of low-income population. This factor should be changed to include the low-income population below 200% of the Federal Poverty Level. This change should be applied to the scoring of all HPSA disciplines and all HPSA types. We believe this will improve recognition of priority areas with significant financial barriers to access.

Income alone is not an accurate measure of financial barriers to accessing care; health care coverage should also be considered. For example, an individual that earns below the FPL with Medicaid coverage could have fewer barriers to care than an uninsured individual with the same income. We recommend that the Low-Income HPSA-scoring factor be changed to account for the uninsured population that earns below 200% of the FPL. This data is readily available at the county level from the Census Small Area Health Insurance Estimates (SAHIE) program.

Finally, it is important to note how complicated, arduous, and important the designation process is for ensuring fair and accurate designations. An extreme amount of research must go into changing the designations to make certain they are fair and reasonable. Data may not always be precise or complete, which can lead to areas not receiving HPSA designations that need them. Overall, the designation process is extremely challenging and needs to be carefully researched and reviewed before finalizing new HPSAs.

Again, thank you for the opportunity to provide these comments to HRSA on behalf of rural populations. Please do not hesitate to contact me for more information or materials to help you in this process.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan". The signature is fluid and cursive, with a long horizontal stroke at the end.

Alan Morgan
Chief Executive Officer