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September 17, 2020

Dr. Luis Padilla
Associate Administrator for Health Workforce
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane,
Rockville, MD 20857

Subject: Health Professional Shortage Area Scoring Criteria RFI

Dear Dr. Padilla,

Bi-State Primary Care Association (Bi-State) appreciates the opportunity to provide information in response to the Health Professional Shortage Area (HPSA) Scoring Criteria RFI. Bi-State recognizes and appreciates that HPSA scoring is a component of the Bureau of Health Workforce's overall strategy to strengthen the health workforce and connect skilled health care providers to communities in need. We share the Bureau of Health Workforce's priorities of: access, supply, distribution, and quality. We also look forward to continued work with the Bureau on expanding health care training programs in New Hampshire and Vermont.

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization promoting access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in Vermont and New Hampshire. Bi-State's combined Vermont and New Hampshire membership includes 21 Federally Qualified Health Centers, one Look-Alike, one Rural Health Clinic, Planned Parenthood of Northern New England, Vermont Coalition of Clinics for the Uninsured, North Country Health Consortium, Community Health Access Network, and the Area Health Education Centers in both Vermont and New Hampshire.

We thank you for this opportunity and note that the value of a HPSA is in the federal program opportunities the designation affords, particularly access to the National Health Service Corps Loan Repayment Program. Access to this program is a factor both of scoring and of program funding. While our comments today focus only on scoring, Bi-State strongly supports the National Health Service Corp's Loan Repayment Program and would like to see sufficient funding so that this program could meet the needs of all health care facilities and providers who would like to participate.

Bi-State offers the following feedback regarding current HPSA scoring criteria:

(1) Scoring criteria currently common to all HPSA disciplines:
Bi-State has concerns about the use of data on "travel time or distance to nearest source of accessible care outside the HPSA" particularly for states that have established comprehensive statewide plans that already factor in care-seeking patterns. Vermont has had a comprehensive statewide plan for almost two decades. This plan was developed through a multiyear process and with the involvement of many stakeholders. Every town in the state was analyzed for care-

seeking patterns and assigned to a "rational service area" where the preponderance of residents gravitates for their primary care. All primary care designation requests (i.e., HPSAs, MUAs, MUPs, and EMUPs) submitted by Vermont must adhere to the geographic boundaries of these rationale service areas (dental and mental health have different, larger rational service areas, reflecting the different care seeking behavior they elicit). Given the thought and effort put into Vermont's comprehensive methodology, additionally providing data on travel time or distance to the nearest source of accessible care outside of the HPSA is redundant and unnecessary. **Bi-State recommends that states that have comprehensive statewide plans should be permitted to leave this question blank or insert the maximum possible value in this data field.**

(2) Scoring criteria specific to Primary Care HPSAs:
Bi-State appreciates the suggestion to use the Standardized Mortality Ratio (SMR) in lieu of the Infant Mortality Rate (IMR) or Low Birth Weight (LBW) data points. Vermont and New Hampshire are small states with low overall annual birth numbers; geographic areas within our states have even lower figures. The IMR and LBW data points, even when averaged over several years, can fluctuate because of small sample size. **Bi-State supports a transition from IMR or LBW to SMR.**
Alternatively, Bi-State has reviewed National Association of Community Health Centers' recommendation to collaborate with the Bureau of Primary Health Care to review various measures of population health that are predictive of unmet need and to consider replacing the IMR/LBW measure with whichever of these is determined to be most predictive. **Bi-State would also support NACHC's recommended approach.**

(3) Scoring criteria specific to Dental Health HPSAs:
Bi-State believes that the scoring criteria for Dental Health HPSAs is sound and the additional point that is awarded for geographic and facility DHPSAs in the worst quartile for the presence of fluoridated water is the best proxy for need that we can envision using available data. **Bi-State recommends no changes.**

(4) Scoring criteria specific to Mental Health HPSAs:
Bi-State believes that the scoring criteria for Mental Health HPSAs is sound and the additional point that is awarded for geographic and facility MHPSAs in the worst quartile for Substance Use Disorder Prevalence and Alcohol Use Disorder Prevalence, is the best proxy for need that we can envision using use available data. Given the nation's substance use disorder crisis, it may make sense to add an additional bonus point for these worst quartiles. **Bi-State recommends no changes and asks the BHW to consider adding a bonus point for substance use.**

Bi-State would also like to share feedback regarding criteria not currently used in HPSA scoring, other factors, or alternative approaches:

(1) Bi-State is intrigued with the idea of incorporating rurality into the scoring. Given that the northern part of New Hampshire and all of Vermont are considered rural, we continually experience challenges in recruitment to these areas compared to urban areas. Currently, the same population to provider ratios and scoring rules apply to all areas of the country, regardless of whether they are urban, suburban, rural, or frontier. However, it is not reasonable to expect that a rural or frontier provider can serve the same number of patients as a provider in an urban area for several reasons, including the extended travel times involved for patients to get to the provider, and for providers to do rounds on their patients at hospitals, skilled nursing facilities, etc.; the fact that rural/ frontier providers are often required to provide their patients with a wider range of services than their urban counterparts; the fact that rural populations are

generally older than their urban counterparts, and therefore in need of more medical care per capita. Patients in rural areas often have some of the greatest barriers to accessing care, and health care facilities in rural areas often struggle the hardest with recruiting rural providers. Bi-State has reviewed the National Association of Community Health Center's recommendation to replace the current 0-5 point scoring system with a 0-10 point system and then adjusting this to include bonus points that are assigned based on the degree of rurality/frontier. Bi-State supports NACHC's recommended methodology. Even a system as simple awarding a bonus point for all areas with a RUCA score of 4+ would provide some reflection of rurality. **Bi-State supports the incorporation of rurality into HPSA scoring.**

Bi-State thanks the Bureau of Health Workforce for the care with which it implemented the auto-HPSA updates last year. We greatly appreciate the opportunity to respond to this RFI. Please contact Kate Simmons, Director, Operations with any questions (ksimmons@bistatepca.org).

Sincerely,

Tess Stack Kuenning, CNS, MS, RN

President and Chief Executive Officer