America's Voice for Community Health Care

NATIONAL ASSOCIATION OF
Community Health Centers

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The NACHC Mission

The National Association of Community Health Centers (NACHC) represents Community, Migrant, and Homeless Health Centers, as well as Public Housing Primary Care Programs and other community-based health centers.

Founded in 1971, NACHC is a nonprofit organization providing advocacy, education, training and technical assistance to health centers in support of their mission to provide quality health care to underserved populations.
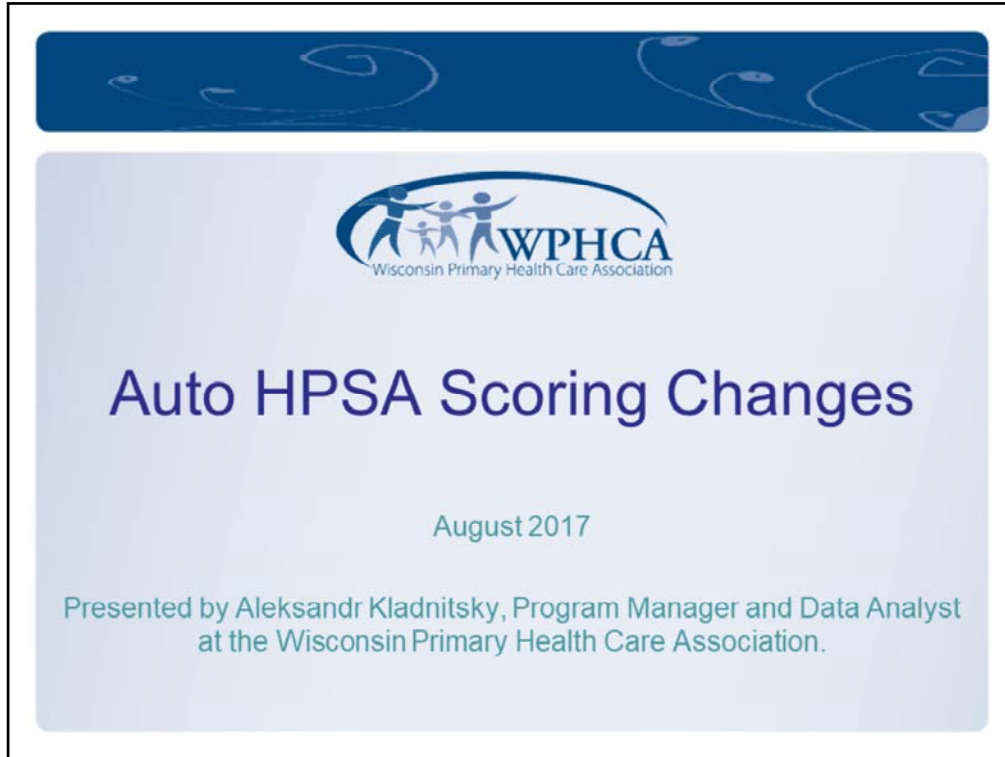
Good afternoon and thank you for joining me for this discussion about the proposed changes to how automatic Health Professional Shortage Areas are scored.

Why are HPSAs important?

- ➢ Key to provider recruitment via

  - ▪ National Loan Repayment

  - ▪ State Loan Repayment

    - ▪ Nationally Health Centers have almost 5,000 providers that are receiving some kind of NHSC funding.

      - ▪ Including Physicians, Nurse Practitioners, Physician Assistants, Certified Nurse Midwifes, Licensed Professional Counselors, Health Service Psychologists, Licensed Clinical Social Workers, Dentists, and Dental Hygienists

  - ▪ J1 Visa Waivers

Health Professional Shortage Areas or HPSAs for short are a key to provider recruitment at community health centers. They open the door to powerful recruitment tools including the ability to offer providers tens of thousands of dollars in loan repayment on top of their normal salary in return for working at the Health Center. The funding for this loan repayment comes from state and federal sources. Nationally Health Centers have almost 5,000 providers that are receiving some kind of loan repayment via the National Health Service Corps.
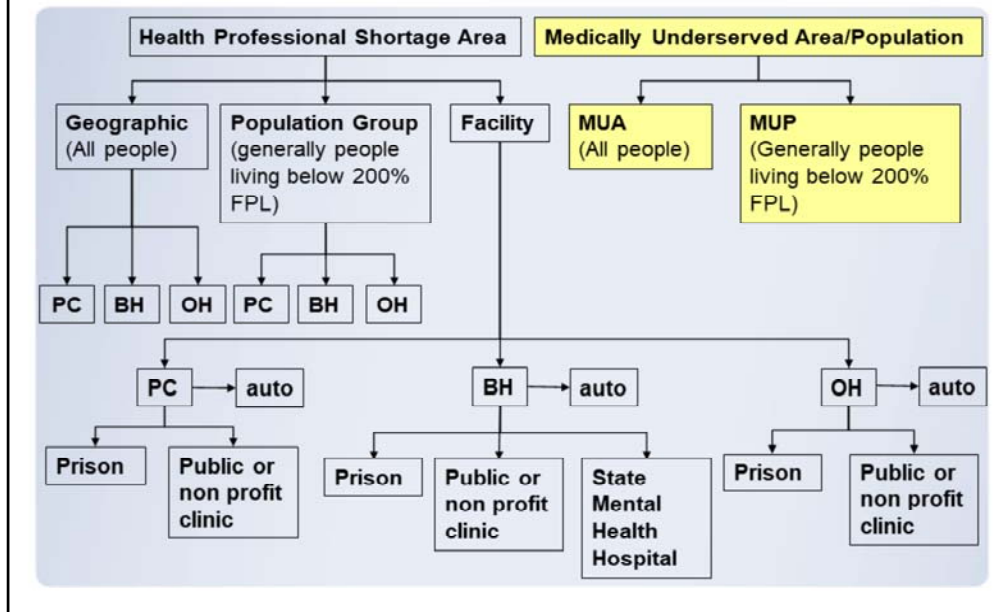
In addition, HPSAs allow Health Centers to offer medical students studying in the US the opportunity to stay and practice in the US via a waiver to the J1 Visa requirement that the student leave the US after completing medical school.
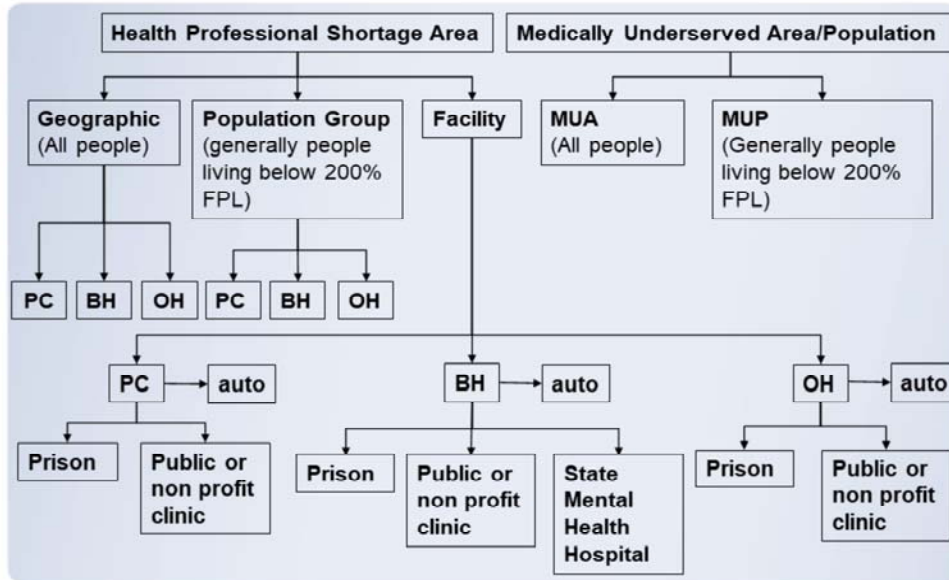
There are multiple types of designations that health centers can have. CLICK

All Health Centers must be located in a Medically Underserved Area or Population. This is not the same as a Health Professional Shortage Area and does not provide the recruitment benefits I spoke about earlier. The benefit of a Medically Underserved Area or Population is the opportunity to start a Federally Qualified Health Center and the benefits that come with this status. CLICK
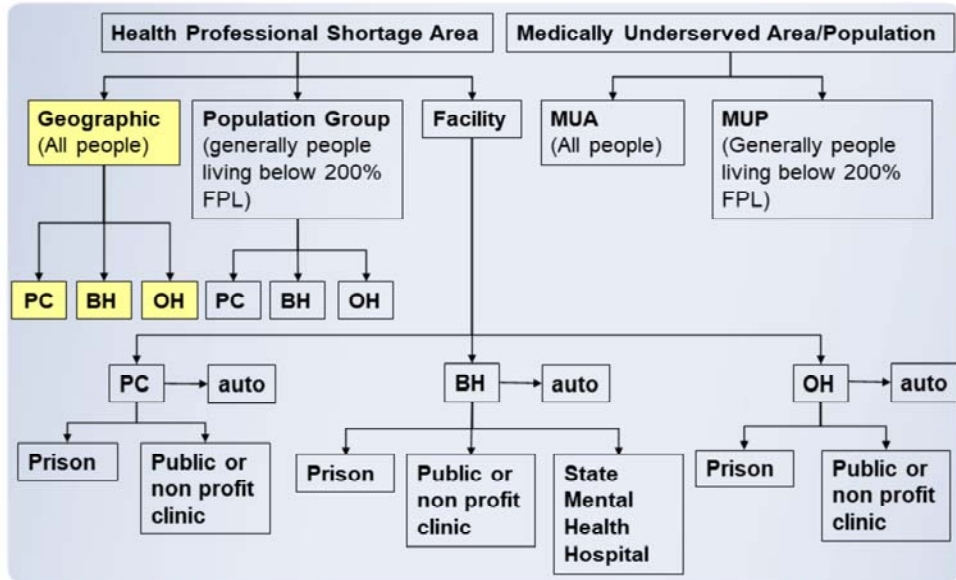
Health Centers can be located in either a Geographic HPSA. Which means all the people living in the area have a shortage of providers. CLICK
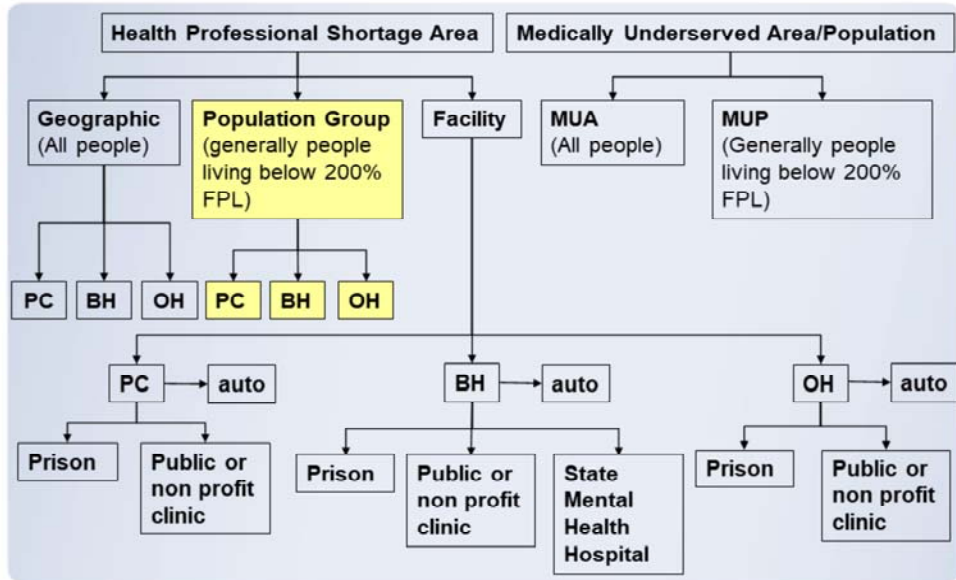
OR a Population Group HPSA. Which usually means that the population below 200% of the federal poverty level has a shortage of physicians. CLICK
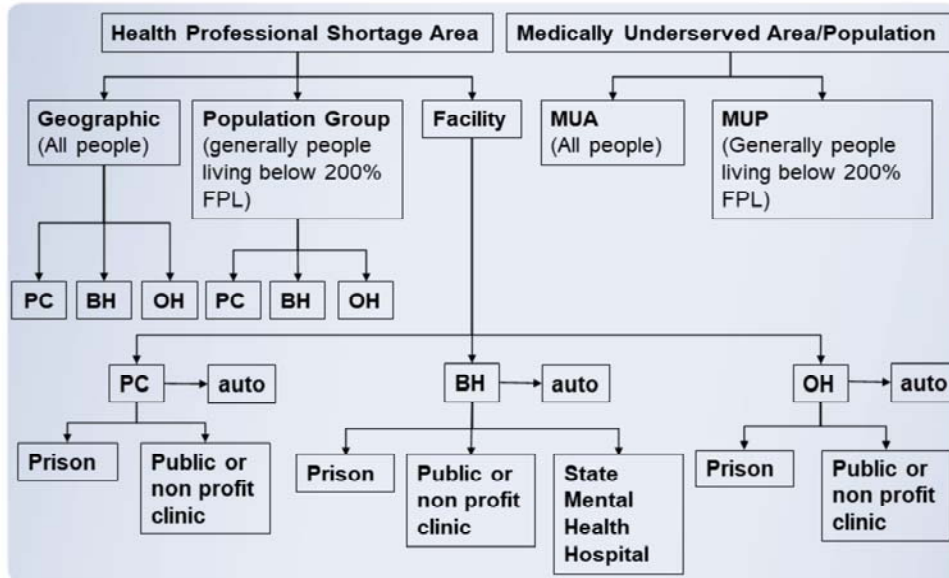
Some Health Centers are not located in Geographic or a Population Group HPSA.
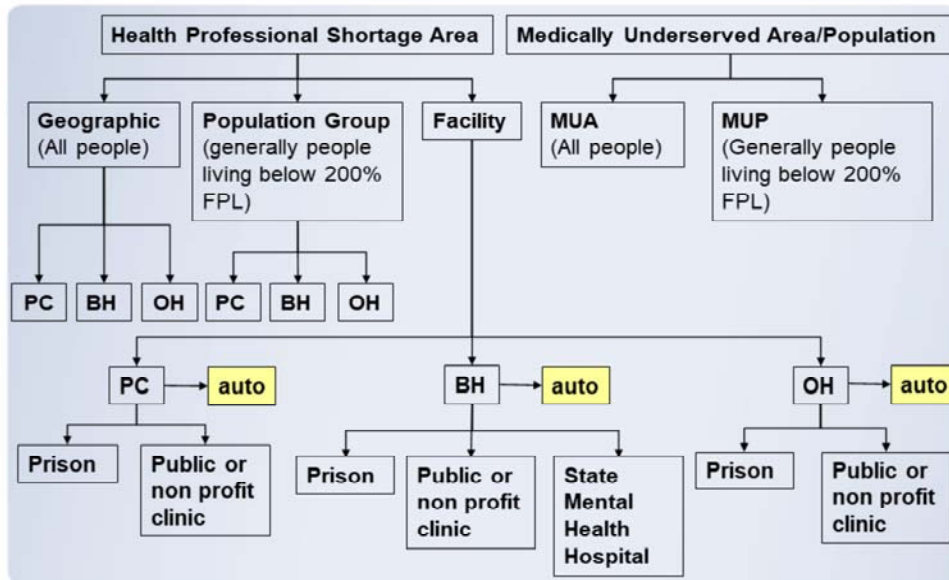
For this reason in 2002 Congress passed legislation that gave all Health Centers, Indian Health Services Facilities, and certain CMS certified Rural Health Clinics automatic Health Professional Shortage Area Designation.
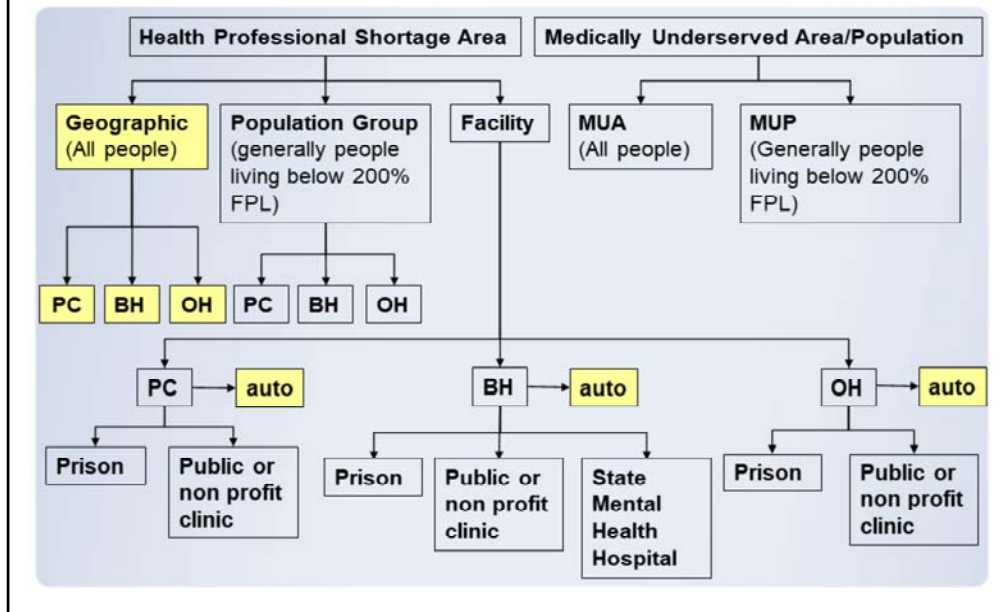
Note a Health Center can be in Both a Geographic and an Auto HPSA. The reason this is important is that a provider working at a health center can use either the auto HPSA score or the Geographic HPSA score when applying for NHSC.

Designation Types

Health Professional Shortage Area			Medically Underserved Area/Population	
Geographic (All people)	Population Group (generally people living below 200% FPL)	Facility	MUA (All people)	MUP (Generally people living below 200% FPL)

Geographic: PC, BH, OH
Population Group: PC, BH, OH

PC → auto
- Prison
- Public or non profit clinic

BH → auto
- Prison
- Public or non profit clinic
- State Mental Health Hospital

OH → auto
- Prison
- Public or non profit clinic

Or a Health Center can be in both a Population Group HPSA and an Auto HPSA. Again, this is important because a provider applying for NHSC can use either score.

So, what's going on with Auto HPSAs? In August 2016 HRSA announced changes to the data that would be used for scoring auto-HPSA facility designations. These changes had the potential to lower the auto HPSA score of many Health Centers. After pushback from stakeholders, HRSA retracted the announced changes and instead formed a stakeholder working group with representation from Health Centers, Primary Care Offices, Indian Health Services, and Rural Health Clinics to decide on the data sources to be used for auto HPSA designations. The working group was not able to reach consensus, instead sending multiple proposals to HRSA leadership for a final decision. We do not have a timeline on when HRSA leadership will make their decision.

Please note, that Auto-HPSAs are scored based on the same factors as geographic and low income HPSAS and ***The working group only had the latitude to propose data sources for the factors, and did not have the latitude to suggest new or different factors.***

Scoring

Highest Possible Score by Factor			
Factors	Primary	Mental	Dental
Population to Provider Ratio	10	7	10
% Pop at 100% FPL	5	5	10
Distance/Time to nearest source of care	5	5	5
Infant Mortality Rate or Low Birth Weight	5		
No fluoridated water			1
Youth Ratio		3	
Elderly Ratio		3	
Substance Abuse Prevalence		1	
Alcohol Abuse Prevalence		1	
Total Score	**25**	**25**	**26**

For primary care and mental health the highest HPSA score that is possible is a 25. For Dental HPSAs the highest score possible is a 26. The factor with the most weight is the population to provider ratio which is worth up to 10 points for primary care and dental HPSAs. Because the population to provider ratio is worth so many points it was particularly important to me that we get our recommendation for this factor as close to perfect as possible. We also wanted to get right the# of the population living below 100% of the federal poverty level and the distance to nearest source of care both of which are relatively high scoring factors and applicable to all three disciplines.

Note, each of these factors is there because the original authors of the HPSA methodology believed they helped paint a picture of the degree to which an area is in need of health care professionals. As we developed our proposal we tried to find data that get's at the heart of what each factor is intended to measure for an auto-HPSA.

Population to Provider Ratio

Three Approaches

➢ Population served
  ▪ 20,616,149 medical patients *divided by* 11,482.49 primary care physician FTE *equals* 1,795:1 *equals* **0 points**

➢ Service Area Survey

➢ Claims

Primary Care Points for Pop:Prov Ratio (R)	
R > 10,000:1	10
10,000:1 > R ≥ 5,000:1	8
5,000:1 > R ≥ 4,000:1	6
4,000:1 > R ≥ 3,500:1	4
3,500:1 > R ≥ 3,000:1	2

I think, the population to provider ratio is a reasonable way to determine if an area is a health professional shortage area. The more people there are for every physician the higher the shortage of health professionals there are in an area.

We looked at three ways to measure the population to provider ratio. The first is a population served approach. In this approach we take the number of medical patients in a health center and divide it by the number of primary care physician FTE at that health center. We quickly discovered that this approach does not seem to accurately measure the shortage of health professionals in the area. Instead, this approach measures the patient panel size that the health center has decided is appropriate. For example, using this approach on the national UDS data yielded a ratio of 1,795 patients for every 1 primary care FTE. If we used this ratio to measure the shortage of primary care physicians nationwide we would conclude that there is no shortage of primary care physicians. In fact, based on the HPSA scoring for this factor a ratio of 1,759:1 would score 0 points. The Health Center recommendation explicitly recommended against using a population served approach. CLICK. Instead, we recommended using a service area approach, which would be more likely to show if the area the health center is serving is suffering from a lack of primary care providers. To determine the FTE side of the equation we recommended using a survey of the primary care clinics in the health center's service area or by using Medicaid claims data whereby a set number of Medicaid claims would equal 1 FTE.

Low Income (LI) FTE

1 FTE x (25% Medicaid + 10% SFS) = .35FTE

To get a better measure of the shortage of physicians for the patients health centers serve, we recommended that both sides of the equation focus on people below 200% of the federal poverty level. For the population side, that means the number of people below 200% of poverty in the service area. For the FTE side of the equation, a good proxy is looking only at the FTE devoted to serving Medicaid and or sliding fee scale patients. Thus, a provider who works a full FTE and spends 25% of their time serving patients on Medicaid and 10% of their time serving patients on a sliding fee scale would be considered .35FTE.

Serving Patients Outside Your Service Area

Health Center A

- 10 Low Income (LI) FTE

- 80% of patients come from service area

- 10 x 80% = 8 LI FTE available to service area

To accurately determine the degree to which an area has a shortage of primary care physicians serving the low income we need the population and the FTE side of the equation to both originate from the same service area. So what happens if someone travels to the clinic from outside the service area and sees a physician at the clinic? In that case the 15 minutes the physician spent with that patient are not actually available to the low income population of the service area. To adjust for this discrepancy we recommend multiplying the health center's FTE by the % of patients that actually come from the service area.

Designating Health Center A

Health Center A

- 12.5 FTE

- 80% of patients use MA or a SFS

- 12.5 x 80% = 10 Low Income (LI) FTE

- 80% of patients come from service area

- 10 x 80% = 8 LI FTE available to service area

Let's look at an example that combines both the low income adjustment and the non-service area patient adjustment. Imagine, we are working on an auto-HPSA for Health Center A. This health center has 12.5 primary care physicians and 80% of Health Center A's patients use Medicaid or a Sliding Fee Scale. Thus, the health center has 10 FTE devoted to serving the low income. Now, lets say ,80% of Health Center A's patients come from within their service area, while the other 20% of their patients come from outside their service area. Thus, only 8 FTE are available to serve the service area's low income population.

Designating Health Center A – Service Area Overlap

Health Center B

- 10 Low Income FTE

- 25% of patients come from Health Center A's service area

- 10 x 25% = 2.5 LI FTE available to service area

Health Center A's Service Area

Health Center B's Service Area
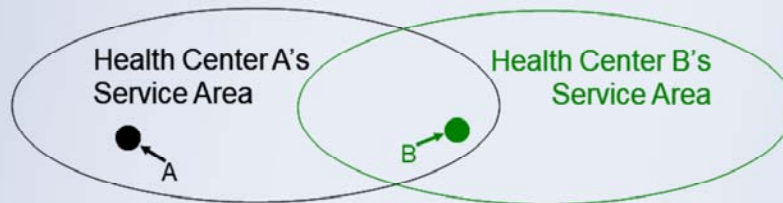
Now let's say Health Center B is located within Health Center A's service area and Health Center B has 10 low income FTE. Should we count all 10 of Health Center B's FTE? …. Without additional data we would have to, however, thanks to the 'UDS data set' we know that only 25% of Health Center B's patients come from Health Center A's service area. And because we know this, we also know that about 25% of health Center B's FTE are available to the low income population of Health Center A's service area. Thus, there are only 2.5 FTE at Health Center B available to serve the low income population of Health Center A. This example, illustrates the first method we recommended for counting the FTE side of the population to provider ratio.

Using Claims Data to Count FTE

$$FTE = (\text{\# Medicaid Claims}/X) + [\text{average hours per week in direct patient care}/40 * (\text{Sliding Fee Scale Percent})]$$

For Primary Care X = 5,000 claims = 1 FTE

For Dental and Mental Health X = 4,000 claims = 1 FTE

Health Centers collect a lot of data and that data is often readily available to them, some of it is even publicly reported. Thus, if there were only health centers in a service area it would be rather easy and fairly accurate to determine the population to provider ratio using the methodology we described earlier. However, sometimes there are other providers in a health center's service area that see patients who are insured by Medicaid and or offer a sliding fee scale to patients with no insurance. In this case, we often have to rely on a survey of these clinics to determine the % of time their physicians spend with Medicaid or Sliding fee scale patients. Sometimes the survey respondent may be using billing data to answer this question, while other times the survey responder may take their best guess as to what percent of their patients fall into this category. With the latter methodology we fear that there may be an unconscious or conscious bias to exaggerate. For this reason we recommended a second method for calculating low income FTE in the service area. This methodology relies on Medicaid claims data for the Medicaid FTE part of the equation and continues to rely on survey data for the sliding fee scale part of the methodology.

Defining the Service Area

ZIP Code	# of Patients	% of patients	Aggregate % of Patients	
ZIP Code 1	2,000	20%	20%	Service Area Threshold
ZIP Code 2	1,800	18%	38%	is met when ZCTA's 1-6
ZIP Code 3	1,500	15%	53%	are included in the
ZIP Code 4	1,000	10%	63%	service area.
ZIP Code 5	800	8%	71%	
ZIP Code 6	**900**	**9%**	**80%**	
ZIP Code 7	700	7%	87%	ZCTA's 7-10 are not
ZIP Code 8	500	5%	92%	included in the service
ZIP Code 9	500	5%	97%	area.
ZIP Code 10	300	3%	100%	
Total	10,000	100%		

The two methodologies we put forward for calculating the population to provider ratio require that a service area be defined. We recommended that the service area be defined as the ZIP codes from which 75% of patients come from when the ZIP Codes are ordered from the ZIP code with the most patients to the least. See the table in this slide for an example. In this example, the zip codes were ordered from the zip code with the most health center patients to the zip code with the least health center patients. The 75% threshold was met when zip codes 1 through 6 were combined. Note, that although the threshold is 75% it is possible that the % of patients that originate from the service area is larger than 75% as is illustrated in this example.

Scoring

Highest Possible Score by Factor			
Factors	Primary	Mental	Dental
Population to Provider Ratio	10	7	10
% Pop at 100% FPL	5	5	10
Distance/Time to nearest source of care	5	5	5
Infant Mortality Rate or Low Birth Weight	5		
No fluoridated water			1
Youth Ratio		3	
Elderly Ratio		3	
Substance Abuse Prevalence		1	
Alcohol Abuse Prevalence		1	
Total Score	**25**	**25**	**26**

We talked about pop to provider ratio now lets talk about % pop at 100% FPL.

% Pop below 100% FPL

National Poverty Rate

- General population = 15.5%

- Health Center Patients = 70.9%

We recommend using UDS data.

Primary Care Points for % Pop < 100% FPL	
P ≥ 50%	5
50% > P ≥ 40%	4
40% > P ≥ 30%	3
30% > P ≥ 20%	2
20% > P ≥ 15%	1
P < 15%	0

We just talked about how the population to provider ratio is calculated which is the first factor in an auto HPSA. Now we are going to take a look at the second factor in an auto HPSA which is the % of the population living below 100% of the federal poverty line. The idea behind this factor is that the poorer people are the more barriers they have to health care resources. Nationally 15.5% of the general population is below 100% of the federal poverty level, but 70.9% of health center patients nationally are below 100% of the federal poverty level. Since the goal of auto HPSA scoring is to determine the facilities with the highest need for additional health professional resources we felt that it is important to use the poverty rate of the health center patients rather than the general population for this measure. Thus we recommended using UDS data for this measure.

Scoring

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Factors	Primary	Mental	Dental
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% Pop at 100% FPL	5	5	10
Distance/Time to nearest source of care	5	5	5
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Distance/Time to nearest source of care

- Serves patients using Medicaid AND a Sliding Fee Scale

- Not located in any type of HPSA

- OR % of patients travelling 'long distance' to get to CHC

Primary Care Points for Travel Time or Distance to NSC	
Time ≥ 60 minutes or Distance ≥ 50 miles	5
60 min > Time ≥ 50 min or 50 mi > Distance ≥ 40 mi	4
50 min > Time ≥ 40 min or 40 mi > Distance ≥ 30 mi	3
40 min > Time ≥ 30 min or 30 mi > Distance ≥ 20 mi	2
30 min > Time ≥ 20 min or 20 mi > Distance ≥ 10 mi	1
Time < 20 min or Distance < 10 mi	0

The next factor in auto-HPSA scoring is the distance or time to the nearest source of accessible care. We recommended using HRSA's current shortage designation management software to find the nearest provider that serves patients using Medicaid AND a Sliding Fee Scale. We also recommended that the nearest source of care should not be located in any type of HPSA including another auto-HPSA facility. HPSA and auto-HPSA facilities by definition have a shortage of health professionals and thus can not be expected to be the nearest source of care for another area with a shortage of physicians. Different thresholds need to be used for urban vs. rural health centers. One way to achieve this is to use bus routes for times in urban areas.

A second methodology we recommended, which would require more work to fully define should HRSA choose to go this route, is measuring the percent of patients that travel a long distance to get care at the Health Center.

Scoring

Highest Possible Score by Factor			
Factors	Primary	Mental	Dental
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% Pop at 100% FPL	5	5	10
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Infant Mortality Rate or Low Birth Weight

➢ CDC or State Equivalent Data

➢ Weighted by CHC patient's racial composition OR if available by patient's income

Primary Care Points for Infant Health Index	
IMR ≥ 20 or LBW ≥ 13	5
20 > IMR ≥ 18 or 13 > LBW ≥ 11	4
18 > IMR ≥ 15 or 11 > LBW ≥ 10	3
15 > IMR ≥ 12 or 10 > LBW ≥ 9	2
12 > IMR ≥ 10 or 9 > LBW ≥ 7	1
IMR < 10 or LBW < 7	0

For the Infant Mortality Rate or Low Birth Weight we recommended using CDC or equivalent state data and weight that based on the Health Centers racial composition. Ideally, we would like to weight this data by the health center's poverty data, however, we could not find a source for Infant Mortality Rate or Low Birth Weight that broke the data up by poverty.

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No Fluoridated Water

➢ CDC or State Equivalent Data

➢ If ≤50% of the population has fluoridated water the HPSA is awarded a point.

For fluoridated water we recommended using CDC or state equivalent data. This factor adds 1 point to a dental HPSA that where 50% or less of the population has access to fluoridated water.

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Youth and Elderly Ratios

$$Elderly\ Ratio = \frac{Population\ Age\ 65\ and\ over}{Population\ Age\ 18-64}$$

$$Youth\ Ratio = \frac{Population\ Age\ under\ 18}{Population\ Age\ 18-64}$$

➤ UDS data
➤ OR American Community Survey data
  ▪ Universe = pop. <200% FPL

Mental Health Points for Elderly Ratio	
R ≥ 0.25:1	3
0.25:1 > R ≥ 0.15:1	2
0.15:1 > R ≥ 0.10:1	1

Mental Health Points for Youth Ratio	
R ≥ 0.6:1	3
0.6:1 > R ≥ 0.4:1	2
0.4:1 > R ≥ 0.2:1	1

For the mental health factors of Youth and Elderly Ratios we recommended using either UDS data or the American Community Survey. If the American Community Survey is used we recommended using a universe of people living below 200% of the federal poverty level. Each of these factors is worth up to 3 points for mental health HPSAs.

Scoring

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Alcohol and Substance Abuse

➢ HRSA defines this factor as "Area's rate is in worst quartile for nation, region, or state"

➢ Alcohol and substance abuse are each worth 1 point

➢ Recommended SAMSHA data tables that look at binge drinking, alcohol dependence, marijuana, illicit drugs, cocaine, opioids, etc.

For the alcohol and substance abuse rate, which are factors used for mental health HPSAs, we recommended using a number of SAMHSA data tables that look at alcohol and substance abuse from different lenses. For example, binge drinking, alcohol dependence, marijuana, illicit drugs, cocaine, opioids, etc. If at least one of the alcohol related tables shows that the area is in the worst quartile nationally then the area would be awarded one point for that factor and the same for the substance abuse factor.

Organizational vs. Site Level Scoring

➢ Recommended organizational level scoring.

- Consistent with regulation

- Flexibility in provider placement

- Matches UDS data

The NACHC HPSA working group reviewed organizational vs. site level scoring. Our conclusion was that the benefits of organizational site level scoring by far outweigh any benefits from site level scoring. There are three main benefits with organizational level scoring. First it is consistent with the federal regulation which states "facilities will be scored as an entity." Second it gives health centers flexibility in placing providers recruited through the national health service corps in the site where they are needed most. Third, organizational scoring allows us to use UDS data for certain factors and allows us to create a service area. In addition, we analyzed data for one state that was concerned about this decision and found that the difference between organizational vs. site level scoring was minimal. Health centers with a site in an area with an extremely high population to provider ratio may also choose to use their geographic or population group HPSA for national health service corps if that HPSA has a higher score than their automatic facility HPSA.

Non FQHC Auto HPSAs

➢ Self-report where UDS is used

There are a few clinic types outside of FQHCs that receive automatic HPSA designation. For those clinics we recommended using our proposed data sources with the exception of UDS data. For the factors we recommended using UDS data for non-FQHCs we recommended having the self-report this data to the state primary care office or the bureau of health workforce.

Other Considerations

➢ Local data acceptable

➢ Increased PCO workload

Finally, we noted that whenever there is local reputable data source that uses the same definition as the recommended national source that local data can be substituted for the national data source. In addition, it is important to note that adopting our proposal may mean an increase in survey work for state Primary Care Offices. This is because there may be health centers located in areas of the state that PCOs have not historically surveyed.

Other Stakeholder Proposals

➢ Less developed

➢ Population served approach to pop:prov ratio

➢ Limiting provider FTE surveys to known safety net providers

➢ Service area definition = 30-40 min travel ring

➢ BRFSS instead of SAMHSA

➢ Distance to nearest similar clinic

There were non-FQHC stakeholders in the Bureau of Health Workforce's auto-HPSA working group and these stakeholders suggested other methodologies and data sources for auto HPSA scoring that were also sent to HRSA leadership. From my perspective these proposals were not as well developed and I had a number of concerns with them.

A representative from Primary Care Offices recommended using a population served approach especially for the population to provider ratio. This representative also recommended changing the ratio thresholds to adjust to this approach. The NACHC HPSA workgroup felt this approach would not work no matter how the thresholds are adjusted because the patient to physician ratio measures the clinic's panel size and staffing model and has no relation to the clinic's patient's and potential patient's need for additional physicians.

Another PCO representative recommended limiting the FTE side of the population to provider ratio to known safety net clinics. The idea behind this recommendation is to make more manageable the additional survey work that Primary Care Offices will need to complete. We agreed that this was a reasonable recommendation.

Another recommendation that was made was to use a 30 to 40 minute travel ring to define the clinic's service area. From our perspective this is unreasonably complicated and inaccurate when looking at health centers with multiple and scattered sites.

Another recommendation was to use the BRFSS instead of SAMHSA for the alcohol and substance abuse factors. We felt that the SAMHSA data does a better job looking at the various ways substance or alcohol abuse prevalence may present itself in a population.

Finally there was a recommendation especially for Indian health Service clinics to have the nearest source of care be a clinic with a similar patient population. For an Indian Health Services clinic this would mean the nearest source of care would be another Indian Health Services clinic. This makes sense for Indian Health Services, however, for FQHCs which sometimes have overlapping service areas this proposal would artificially lower auto-HPSA scores.

What's Next

➤ HRSA leadership decision

➤ Impact analysis

➤ Build out technical capability

➤ Negotiate workload with PCOs

➤ Scores may decrease

Now that the various proposals from the HPSA workgroup has been submitted to HRSA leadership. The next step is for HRSA leadership to decide on the data sources and methodology they want to use for auto HPSA scoring going forward. Once that decision is made HRSA will provide stakeholders with an impact analysis of the new methodology. If HRSA decides to adopt our proposal they will need to build out the technical capability to automatically pull in relevant UDS data into the shortage designation management system. In addition, if HRSA decides to adopt our proposal they will need to work with state primary care offices to make sure that areas where auto-HPSAs are located are surveyed for the FTE side of the population to provider ratio. This may be a serious workload increase for states where auto HPSA facilities are located in large urban areas that have not needed to be regularly surveyed by the state primary care office. Regardless of which method is chosen please expect that your auto HPSA score may decrease. The reason for this is that current methodology allows auto HPSA facilities to cherry pick data and once a high score is achieved to lock that score in indefinitely. The new methodology will standardize the data sources used and we expect that HRSA will plan to update automatic HPSA scores on a periodic basis.

Questions?

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At this time I would like to answer any questions you may have.

Also, if you have additional questions after this call please don't hesitate to reach out to me.