



HRSA's Changes to How Automatic Facility HPSA Scores are Calculated

As of August 17, 2016

Issue: In late July 2016, HRSA's Bureau of Health Workforce (BHW) announced changes to the data it will use to calculate one element of a Health Center's Automatic Facility HPSA score – the percentage of the population with incomes below 100% FPL. Starting with scores to be published in July 2017:

- BHW will no longer permit Health Centers to use UDS (or other data sources that are specific to their Health Center) to determine their poverty score, arguing that UDS overstates poverty and that doing so is unfair to other auto-facility HPSA providers who do not report UDS.
- Instead, the poverty score for all auto-facility HPSAs will be based on Census data for all Census tracts that are located – in whole or in part – within a 30-minute travel radius of a facility site.
- Each delivery site will receive a separate auto-facility HPSA score, instead of each Health Center organization receiving one aggregate entity score.

BHW does not expect to share an impact analysis for these changes until January 2017 and NACHC has concerns about the validity of this analysis.

Background on Auto-Facility HPSA Scoring:

- Three types of providers are eligible for auto-facility HPSAs: Health Centers; AI/AN outpatient providers; and Rural Health Clinics that accept all patients regardless of ability to pay, charge on a sliding fee scale, and participate in Medicaid. Health Centers represent over 85% of all eligible delivery sites.
- The poverty score – which reflects the percentage of the population with incomes below 100% FPL -- accounts for up to 5 points out of a maximum score of 25 for a primary care HPSA.
- At present, there are no standards regarding what data source must be used to calculate this element, or how often the score must be updated. Auto-facility HPSAs were created in 2002, and when the original scores were established, Health Centers were allowed to choose what data source to use, with many –but not all – using UDS.
- Some auto-facility scores have not been updated since 2003, despite evidence suggesting they now overstate need.
- At present, a health center organization (aka entity) receives a single, aggregated auto-HPSA score for primary care.

NACHC Position:

- NACHC feels strongly that Health Centers should be able to use UDS data to measure poverty among their patient populations. Since Health Centers often serve “pockets” of high need mixed among lower-need areas, calculating the poverty measure based on the general population will often lower a Health Center's auto-facility HPSA score, decreasing the likelihood that it will receive a NHSC provider.

- NACHC disagrees that UDS data overstates poverty, or that Health Centers should be prohibited from using it because other auto-facility HPSA provider types are not required to report it.
- For both statutory and logistical reasons, NACHC contends that auto-facility HPSA scores should continue to be assigned at the entity (aka organizational) level.

NACHC Actions:

- NACHC has had extensive communications with HRSA staff to express these concerns and demonstrate the appropriateness of using UDS data to determine poverty scores for auto-facility HPSAs. This has included a face-to-face meeting with Jim Macrae, Acting HRSA Administrator, and Dr. Luis Padilla, Associate Administrator for BHW, in early August.
- NACHC has sent a detailed memo outlining our concerns to Mr. Macrae and Dr. Padilla. A summary of this memo is attached; for the full letter, email regulatoryaffairs@nachc.org

Context for Changes to HPSA Scoring: Changing the data used for the poverty measure is one part of BHW's larger effort to redesign the way that HPSA scores are calculated. The stated goals of the new system include: "a single automated system for all processing and scoring"; "standardized, defensible data sources"; and "more transparent, consistent, and accurate HPSA scores." One of the most challenging aspects of implementing the new system has been the changes to provider data. Previously, each state's PCO submitted its own provider data to BHW. Under the new system, there will be a single national provider database, based on national NPI data. However, the NPI files have a high level of errors (e.g., duplicate listings, wrong addresses, providers no longer practicing) and do not contain information that is critical to calculating some HPSA scores (e.g., whether providers accept Medicaid or offer a sliding fee scale). PCOs have been charged with correcting and supplementing the NPI data for all providers in their state, which has created a massive workload. BHW has already extended their deadline once, and the new deadline is October 1, 2016. However, there is significant concern that much of this work will still not be completed by October.

Impact Analysis: HRSA/ BHW has stated that they will conduct an impact analysis using the new poverty measure one in October 2016 – after the updates to the provider data have been completed – and release it in January 2017. However, if the updates to the provider data have not been completed nationally by the time the impact analysis is conducted, NACHC contends that the results will be unreliable.

Summary of NACHC Letter to HRSA/ BHW re: Changes to Data Used to Calculate Poverty for Auto-Facility HPSA Scores

Sent August 15, 2016

1. While NACHC does not oppose BHW's general policy of ensuring that auto-facility HPSA scores reflect current data, we contend that BHW is acting a manner that is inconsistent with Congressional intent by failing to use entity-specific data to calculate entities' auto-facility HPSA scores.

Specifically:

- Congressional intent in creating auto-facility HPSAs was to reflect the needs of the specific populations these entities serve.
- BHW's proposal undermines Congressional intent. Specifically, proposal to measure the percentage of population below 100% FPL using Census data for all tracts located fully or partially within a 30-minute travel polygon around a delivery site effectively converts the poverty score from a measure of the patients served by the entity eligible for the auto-facility HPSA to a general population measure for an arbitrarily-determined geographic HPSA.
- For many Health Centers, it would be practically impossible to design a population or geographic HPSA that adequately mirrors their patient population, so this is not an adequate alternative to an appropriately-calculated auto-facility HPSA.
- NACHC is concerned that BHW may seek to calculate the other elements of auto-facility HPSA scores on a global basis, without recognizing the distinct needs of many Health Center populations. NACHC is also concerned about how a potential 30-minute travel polygon will be designed.

For these reasons:

- NACHC strongly urges BHW to reflect Congressional intent in creating auto-facility HPSAs by ensuring that their scores are calculated using data that reflects the actual patient populations served by the eligible entities.
- We request additional information on how the three other elements of an auto-facility HPSA score will be calculated.
- While we strongly opposes the use of a 30-minute travel polygon to identify the population served by an entity eligible for an auto-facility HPSA, if BHW does proceed with this approach, we request information on how this polygon will be calculated.

2. BHW's decision to prohibit the use of UDS data when calculating poverty measures for Health Centers' auto-facility HPSA scores is misguided, because:

- Requiring the use of UDS for Health Centers' auto-facility HPSA scores would ensure a consistent, transparent data source for these calculations;
- UDS data on poverty is already reported to HRSA by the vast majority of delivery sites eligible for auto-facility HPSAs;
- Of the remaining eligible delivery sites, the majority already collect similar data; and
- It is inappropriate to assume that all Health Center patients who do not report their income are above 100% FPL;

- PCOs have recommended the use of UDS data for determining auto-facility HPSAs for Health Centers; and
- UDS data has been appropriate to be reported to, and used by, the HHS Secretary, Congress, and the President for over two decades.

For these reasons, NACHC strongly recommends that BHW:

- Require the use of UDS data to measure the percentage of a Health Center's population which has incomes below 100% FPL; and
- Establish a mechanism for qualified RHCs and AI/AN entities to provide BHW with entity-specific data on poverty, using similar guidelines as UDS.

3. Assigning separate scores to individual delivery sites, rather than a single score at the entity level, is inappropriate because:

- The statute indicates that auto-facility designations apply at the entity level, not the site level;
- Site-level scores will make it difficult for Health Centers to respond flexibly to emerging needs and to maximize the impact of NHSC providers; and
- Site-level scoring is inappropriate for the 2000+ non-traditional Health Center sites.

For these reasons:

- NACHC recommends that BHW continue to assign auto-facility HPSA scores at the entity (aka organization) level; and
- In the event that BHW continues with plans to assign scores at the site level, BHW should ensure that Health Centers have appropriate flexibility to rapidly move NHSC providers to other sites in response to emerging needs, and that providers' FTCA coverage will follow them across sites.

4. Finally, no systemic changes should be made to any HPSA scores until BHW and PCOs are confident that all provider data has been appropriately updated.