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September 18, 2020

Health Resources & Services Administration
5600 Fishers Lane
Rockville, MD 20857

Re: Health Professional Shortage Area Scoring Criteria Request for Information

To Whom It May Concern:

The Academy of General Dentistry (AGD) appreciates the opportunity to respond to the Request for Information regarding the Health Professional Shortage Area (HSPA) scoring criteria. The AGD represents 39,000 general dentists who provide the full range of dental care to patients across the country.

The AGD recognizes that this RFI requests feedback on the scoring HPSA scoring criteria, as published in the Federal Register, 68 Fed. Reg. 32531 (May 30, 2003). AGD hopes this is the first step in a process for a comprehensive review of the adequacy and relevance of the designation of HPSAs. The AGD firmly agrees that there is an ongoing need to address the oral health needs of the underserved, but also believes that the HPSA process and methodology has outlived its relevance.

New scoring and designation criteria are necessary to designate underserved populations with unmet clinical needs accurately. There needs to be a shift from supply-based indicators of shortage – mainly population-to-provider ratios – to maldistribution and indicators of unmet treatment needs. Many have criticized the HPSA designation methodology. The Government Accountability Office concluded that HPSAs do not reflect realistic boundaries.[1]

AGD's comments in response to this RFI

The scoring criteria specific to dental include:

(1) population-to-provider ratio;
(2) poverty rate;
(3) travel time or distance to the nearest accessible source of care.; and,
(4) fluoridated water.

1(A) – Population-to-Provider Ratio

Dental shortages have been largely defined by reference to the dentist-to-population ratio. Unfortunately, this is not sensitive to either variation in the clinical needs of different populations or utilization of dental care within the geographical region.

The AGD offers the following recommendations

[1] U.S. Government Accountability Office. Health Professional Shortage Areas: Problems Remain with Primary Care Shortage Area Designation System. October 24, 2006 (https://www.gao.gov/assets/260/252841.pdf)

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- The utility of the current ratio and point system needs to be reviewed and evaluated. There is no basis for the scoring threshold to be a population-to-dentist ratio of 5,000 to one. This metric has not been revisited since prior to 2003. A GAO report concluded that the current criteria are "based on flawed methodologies that have not been effective at specifically identifying which parts of the population are underserved and why."[2]

  A supply-based model predicts the number of required dentists without reference to need or demand. The AGD urges HRSA to address the ratio and underlying methodology by issuing notice and comment of a proposed rule change. We note that such a proposal was mentioned in the Federal Register, 68 FR 32531 (May 30, 2003), but our understanding is that the Agency never put forth the proposal. We urge the Agency to do so.

- Whatever source of data is utilized by the State Primary Care Office (PCO) to identify the number of dental providers should include the subcategorization of general dentists. General and pediatric dentists serve on the front line of diagnostic and preventative procedures for the public. The supply of general dentists in an area may not relate to the supply of specialists.

- AGD recommends that all practicing dentists be included in data sources used by the PCOs. According to HRSA's website, all eligible providers "that accept payments via Sliding Fee Scale and/or Medicaid"[3] are included in the population-to-provider ratio. Does this suggest that providers who provide pro bono or charitable care might not be included? In our view, all practicing dentists should be included in whatever data sources are utilized by the PCO.

- The provider data set used in SDMS originates from the National Provider Identifier (NPI) file maintained by the Centers for Medicaid and Medicare Services (CMS). This data set should provide a comprehensive file with all providers covered by HIPAA actively billing insurance in the United States. Our understanding is that the PCO "validates" the provider data and supplements the NPI data by adding provider-level data points, including clinical practice activity; provider practice locations; hours worked at each location; populations served; and the amount of time a provider spends serving specific locations.

  If the population-to-provider ratio continues to be a key metric, the AGD recommends that the process used by PCOs to supplement and validate the NPI data be transparent and consistent across the country.

1(B) – Poverty rate

The AGD recommends that the current criteria of poverty rate be amended to include the portion of the population in the "rational service area" eligible for and utilizing Medicaid for oral health services. In our opinion, Medicaid eligibility is a more accurate indicator for identifying the

[2] U.S. Government Accountability Office. Health care shortage areas: designations not a useful tool for directing resources to the underserved. September 8, 1995. (https://www.gao.gov/assets/160/155178.pdf)
[3] Health Resources & Services Administration. Shortage Designation Application and Review Process. (https://bhw.hrsa.gov/shortage-designation/application-review-process)

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underserved population than percent of population alone with incomes below the Federal Poverty Level.

1(C) – Travel distance/time to the Nearest Accessible Source of Care.

Our population has become more mobile, making the existing criteria for distance and time to be hopelessly outdated. The AGD recommends that this criterion either not be maintained or be substantially revised. A study by the American Dental Association's Health Policy Institute analyzed the geographic proximity of publicly insured children to dental providers participating in public programs.[4] The work of the Health Policy Institute should be considered by HRSA when revising the HPSA methodology. We agree with the Health Policy Institute that now is the time to reexamine the way in which policymakers measure access to dentists, especially for the publicly insured.

3(A) – Fluoridated Water

Fluoride in water is the most efficient way to prevent one of the most common childhood diseases – tooth decay. An estimated 51 million school hours and 164 million work hours are lost each year due to dental-related illness. The benefits of fluoride's effectiveness extend throughout life, resulting in fewer and less severe cavities. Each generation born since the implementation of water fluoridation 75 years ago has enjoyed better dental health than the generation that preceded it.[5] Community water fluoridation is so effective at preventing tooth decay that the Centers for Disease Control and Prevention named it one of 10 great public health achievements of the 20th century.

The AGD strongly recommends that this factor should be maintained.

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Please feel free to reach me or Mr. Pat O'Connor, the Academy of General Dentistry, Washington Representative, who can be reached at 703/351-6222 or patoconnor@kentoconnor.com.

Sincerely,

Connie White, D.D.S., FAGD
President
Academy of General Dentistry

[4] Nasseh K, Eisenberg Y, Vujicic M. Geographic access to dental care varies in Missouri and Wisconsin. J Public Health Dent. January 11, 2017. (https://onlinelibrary.wiley.com/doi/pdf/10.1111/jphd.12197)
[5] Centers for Disease Control and Prevention. 75 Years of Community Water Fluoridation. January 15, 2020. (https://www.cdc.gov/fluoridation/basics/anniversary.htm)

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