Auto-HPSA Designation Modernization Project

Rural Health Clinic Technical Assistance Series Webinar

April 10, 2018

2:00 – 3:00 pm ET

Coordinator: Thank you for standing by. At this time, all participants are on listen-only mode. During the question-and-answer session, you may press star 1 from your touchtone phone if you would like to ask a question. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now, I would like to turn the meeting over to Mr. (Nathan Baugh). You may begin.

(Nathan Baugh): Thank you, operator. I want to welcome all of our participants. My name is Nathan Baugh. I am the government relations director of the National Association of Rural Health Clinics and the moderator for today's call. Today's topic is automatic facility health professional shortage area or Auto-HPSA. This series is sponsored by HRSA's Federal Office of Rural Health Policy and is done in conjunction with the National Association of Rural Health Clinics.

 We're supported by a cooperative agreement which you can see on your screen right now through the Federal Office of Rural Health Policy, and this allows us to bring you these calls free of charge. The purpose of the series is to provide RHC staff with valuable technical assistance and RHC-specific information. Today's call is the 81st in a series which began in late 2004. During that time, we're proud to say that we have had over 22,000 combined participants on our calls that are now being done as webinars. As you know, there's no charge to participate.

 We like to emphasize that, and we encourage you to refer others who might benefit from this information to sign up and receive announcements regarding dates, topics and speakers and hrsa.gov/ruralhealth/policy/confcall, C-O-N-F-C-A-L-L. Just google hrsa.gov. That's probably easier. During the Q&A period, we request that callers please provide their name and city and state and location before asking their question, and now, we also have the ability to type in a question in the chat box which we'll pull up during the Q&A period.

 In the future, you can e-mail questions to bf@narhc.org and put RHCTA question in the subject line. All questions and answers will be posted on the ORHP Conference Call series website and the NARHC website which is narhc.org, but now, we also have these webinars posted on RHI hub which stands for the Rural Health Information hub, so that's another place you can get that. With all of that said, the formalities out of the way, I'd like to introduce our speakers today. From HRSA's Bureau of Health Workforce, (Melissa Ryan) and (Elisa Gladstone). (Melissa)?

(Melissa Ryan): Thank you, (Nathan), and thank you, all, for joining us today. We are excited to have the opportunity to talk to you about our national shortage designation modernization project and particularly how it relates to the automatic HPSA designations that some rural health clinics are eligible for. So, one of the things, just to take the step back that we want to kind of go over, this list here or chart here shows you that there are many, many different types of health professional shortage area designations, as well as medically underserved areas and medically underserved populations designations.

 There are many different programs that use them. So, all of them are basically designed to help us target limited resources, federal resources, to the highest-need areas, and you know, they're very important for the National Health Service Corps. They're actually part of the National Health Service Corps statute, but we also have the Health Center Program NURSE Corps CMS bonus payments, the Rural Health Clinic Program and the J1 Visa Waiver Programs that also use them, among other programs.

 So, there are several different types of HPSA's, and really overall, you can think of the HPSA as being a shortage of primary care, dental or mental health providers in either a geographic area, serving a population group within a geographic area or a facility. So, just to sort of drill down a little bit more deeply into the geographic population or facility type of designation, a geographic designation is really looking primarily at an area and the population of that area and all of the providers in that area and just looking at are there enough providers in that area to serve that population in the geographic area.

 A population designation is still tied to geography, but it is not looking at the entire population in that geographic area. It's looking at a subset of the population and the subset of providers that serve that population and determining if there's enough providers serving that subset of the population. So, for example, you can have a Medicaid-eligible population designation where you're only looking at the Medicaid-eligible population in a geography and only the providers who actually are serving patients on Medicaid. Then, you can also have a facility designation.

 So, those geographic and population designations and a few of the facility designations have to be applied for, and typically, a state primary care office does that in conjunction with a cooperative agreement through HRSA, but we actually have several different types of facilities that are automatically designated either by statute or regulation, and so using our statute and regulations, HRSA deems the following facility types as eligible for those automatic HPSA designations, and so it's FQHCs and FQHC lookalikes, tribally-run clinics, urban Indian organizations, the dual funded tribal health centers, IHS clinics and then rural health clinics so CMS-certified rural health clinics that actually meet the NHSC site requirements.

 So, it's not just any rural health clinic that's CMS certified, but it's those that meet those requirements which include taking Medicare, Medicaid, CHP and providing services on a sliding-fee scale for those at or below 200% of the federal poverty level. So, some of the things that are the same and different about those other HPSAs that actually have to be applied for versus automatic facility HPSAs, so as I mentioned, those other HPSAs, they actually have to meet some regulatory criteria and most particularly a population to provider ratio threshold in order to be designated, and so in order to do that application, we have a system right now with application and, like, designation and their scoring that is all done online.

 So, they have to sort of, you know, meet the criteria to be designated, and then the application includes a lot of the data that we use to actually do scoring of the HPSAs once they're designated. Scores range for all HPSAs from zero to 25 for primary care and mental health and zero to 26 for dental, and you know, we have a requirement that actually applies to all HPSAs but hasn't necessarily been evenly applied, but designations are required to be reviewed and updated as necessary at least annually.

 Then, there's also the fact that a score of zero is a possibility, but it's extremely rare for those HPSAs that have to be applied for because since they have to meet a population to provider ratio threshold, it's pretty rare that they actually get that score of zero. So, for automatic facilities, there is currently no automated system that actually assesses with this. It is done manually. I have a team of about a dozen public health analysts here at HRSA who use spreadsheets and go looking for a lot of different data in order to try to score automatic facility HPSAs, and this is because, you know, there's no actual application process for this.

 You're automatically designated by statute for the rural health clinics that meet NHSC site requirements, so since there's no application, there's no collection of data that we have, it's not automated, so it's a very labor-intensive process. But we do use the same criteria to determine the HPSA scores as with the other HPSAs, so the same scoring range is used. Because of sort of the onerous nature of seeking out the data, we haven't historically required the updates to the Auto-HPSA scores, and they really, at this point in time, are being done by request, the request of the facility.

 So, in addition to that, because of the fact that Auto-HPSAs are again automatically designated, and they don't have to demonstrate that they meet a certain population to provider ratio, it's much more frequent that we end up with scores of zero for these sites although largely that usually means that we've never actually received data or been able to find data to help us score it. So, that's part of what our modernization project is looking to address.

 So, some of the scoring criteria, this actually just shows you how the scoring criteria works, what they are for each of the different types of disciplines. You will notice that there are three that are common across all three disciplines, so there is that population to provider ratio which is we look at the population to provider ratio. We also look at the percentage of the population that's at or below 100% of the federal poverty level, and then the other one that's common to all of them is what we call the travel time to the nearest source of care, and the nearest source of care is defined as basically looks to sort of indicate if an individual couldn't receive care within the HPSA that we're designating, how far would they have to travel to find someone who could see them that, you know, usually accepts the type of reimbursement that they are looking for or that they meet.

 Then, we have some other criteria that are dependent on the actual discipline. So, for primary care, we look at what we call the infant health index where we look at either infant mortality or low birth weight, and we actually look at both and award points to whichever one gives them a higher score. For mental health, we look at alcohol misuse prevalence and substance misuse prevalence, as well as the ratio of adults 65 and older to adults 18 to 64 and the ratio of children under 18 to adults 18 to 64, as well.

 Then, for dental health, we look at water fluoridation. I won't belabor the point too much, but this just gives you an understanding of how many maximum points can be awarded and how they break down across the different disciplines. So, how do we actually use HPSA scores? So, primarily, the programs that use HPSA scores are the National Health Service Corps and the NURSE Corps Program.

 For the National Health Service Corps, we have essentially, you know, a priority and award, so for the NHSC Scholar Placement, in particular, after we fund those that have a preference, so people from a disadvantaged background or who have successfully completed a scholarship, we basically take all of the new applicants who are eligible for an award and start funding them in descending order of their HPSA score because in theory, the higher the HPSA score, the higher the need, and we have a statutory requirement with National Health Service Corps to send our resources to the highest need areas.

 It's been a long time since we had funds available to fund down to sites with a score of below 14, and when we do have the funding to do that, we actually pay a larger lump sum to those individuals who are applying to serve at a site that has a HPSA that is over a score of 14 because again, we're trying to, you know, drive people towards those highest need areas. Then, with scholar placement, each year, we actually have a class of scholars who comes into service.

 Either they've just finished a residency or they're just coming out of school for those health professions that don't commonly do residencies, and they're ready to start service, and we actually have a statutory requirement again in the National Health Service Corps legislation that says that we basically have to, you know, determine that there are at least one and no more than two jobs available for every one of those scholars coming into service, and so we actually look at the available jobs on our workforce connector or NHSC Job Center, and we actually do the math to figure out what the minimum HPSA score that we have enough sites to offer at least that one job and no more than two jobs.

 We try to get as close to the two jobs as possible to get it down to the lowest HPSA score we can, but that's how we use that for the National Health Service Corps. For the NURSE Corps, again, there's also a funding preference. The NURSE Corps is actually statutorily required to award people with the highest debt to salary ratio, but they also typically are awarding that to the people with the highest debt to salary ratio at sites with HPSAs of 14 or above. Then, they also similarly use it for scholar placement.

 So, our shortage designation modernization project started in 2013, and basically, you know, we're authorized by Congress at HRSA to actually conduct the shortage designation activities, but this is really a responsibility that we share with a number of different partners, both in and outside of HHS, and really, we, you know, have a cooperative agreement with our 54-state and territorial primary care offices who actually do a lot of the legwork on shortage designation in terms of doing means assessment in other states and collecting data and really then determining what areas of their states they want designated and what types of designations they want for them.

 So, in 2013, we really embarked on a project to try to make the system that we were using, as well as our processes, you know, significantly more modern, standardized and transparent and consistent. So, part of that what I like to call actually the first phase of that modernization project was the creation of the shortage designation management system or SDMS which is basically an online tool that our state primary care offices and HRSA use to manage the designation process, so it uses standardized data sets from CMS, from census and ACS and CDC as the baseline for the data to calculate, you know, eligibility, as well as scores for designations.

 It's based on our regulations that govern the shortage designation process. So, I said that there was, you know, data that was baseline. Really, we are doing our best to standardize the data system so that our PCOs don't have to go out and find all this information for each individual application, and really, we're trying to reduce it so they don't have to do individual applications as much anymore, as well. But as I said, we use CMS data, so we use the National Provider Identifier as a baseline for our provider data, and there's more that the PCOs do related to that data that I'll get to in a minute.

 But then we use also data from CDC for infant mortality and low birth weight. We use the census and the Census Bureau data so either the decennial census or the ACS, the American Community Survey data for all of sort of our demographic data, so poverty data, all residents civilian populations, ethnic populations, as well as, you know, the age of our populations when we're looking at shortage designations and scoring. We use (ESRI) data for travel which is basically the sort of geospatial mapping that powers things like your Google maps, and so that's what we're using for our travel data.

 From our state primary care offices, we still have to ask them to do a little bit of legwork particularly around the provider data, so adding attributes that we need for shortage designation to providers in the NPI, so NPI only has one address. So, we have our PCOs add in actual additional practice addresses if a provider is serving in two different locations and providing services in two different locations. We have them add in the number of hours they're working at any particular site.

 We have them add in the types of populations they're serving, so are they actually taking Medicaid, so how many equivalent FTEs are they? We also look to the states to provide, you know, other sort of population data, particularly the Medicaid population data that they may have for their state's Medicaid office, as well as other populations that they might be looking to designate—homeless data, the migrant farm worker data.

 We also look to them for our fluoridation data because we realize especially in some of the larger states out west that, you know, the data that's available through CDC is only available at the county level, and there can be vast differences across counties as to, you know, what is and isn't fluoridated. Then, also, our alcohol and substance misuse rates, we are looking to them because we are able to award points if something is in the highest quartile not just for the nation but also for the state or for a region, and so we look to our colleagues for that. So, at this point, I'm going to turn it over to my colleague, (Elisa Gladstone), to talk a little bit further about this project.

(Elisa Gladstone): Thanks, (Melissa). So, as (Melissa) said, the shortage designation modernization project started in 2013, and you may be saying, oh, wow, it's been a while and why are you just now getting to Auto-HPSAs. So, just to give you a sense of where we've been, the first national shortage designation update took place in November of 2017, and we focused on geographic and population and some other facility HPSAs mainly because as you heard (Melissa) say earlier, those are the HPSAs that applications are required, and we were using the shortage designation management system to update those designations.

 So, we're now turning our sights to Auto-HPSAs learning from our mistakes, frankly, and what we did the first time around, and now, we're really perfecting our approach. I'll also highlight for you that there are significantly more Auto-HPSAs than there are geographic population or other facilities. So, we started with a small group that required applications to really make sure that the system was working the way that it was intended to work, and now we're focusing on Auto-HPSAs.

 So, as (Melissa) said, the purpose of this project is to create greater transparency, accountability and parity among Auto-HPSAs, and the rationale for that is, as you heard—next slide, actually, if you don't mind, here we go—as you heard from (Melissa), the Auto-HPSAs are currently processed manually by shortage designation staff. They're incredibly labor intensive, and due to that workload intensity, HRSA has not historically required Auto-HPSA scores to be updated regularly.

 So, what that means is that someone who was scored in, say, 2014 is competing with someone who was scored in 2016 or someone who was scored in 2003 or 2004 is competing with somebody using data from 2014, so there's this lack of parity that exists that we're trying to address with this modernization project, and I'll also flag for you that something a lot of people don't know is that if a facility comes in for a rescore currently(—our current process is an organization e-mails HRSA, asks for a rescore, we rescore the organization), and the score is lower. Right now, they are not required to keep that score.

 So again, we have this—they're can choose to pick their previous score. So again, we have an inequity here that we're trying to address with our shortage designation modernization project, and we have had broad agreements that this needs to be addressed. Next slide, please. Thank you.

 So, we convened the Auto-HPSA working group of stakeholders to help us identify the data sources to use to update all Auto-HPSAs, and we were pleased to have (Nathan) on the working group, as well as a representative from the Rural Health Association and our colleagues from the Federal Office of Rural Health Policy representing the rural health clinic perspective.

 We also have stakeholders representing the other facility types that you see on this slide. So, you'll note at the bottom of each slide, we have italicized text that says the shortage designation modernization project utilizes the existing HPSA scoring criteria. No changes to the criteria have been made, and I want to underscore that not only so everyone understands what this project is but also to provide context for the working group.

 So, the working group provided us with a number of proposals for data sources that we should use—five proposals to be exact—but they were required to use the existing HPSA scoring criteria so just keep that in mind as I review the data with you over the next following slides not to be angry with your representatives from the working group, but they were required for this project not to make any changes to the criteria.

 So again, we are going to review the data sources in a minute, but it's important to have a sense of a timeline for the Auto-HPSA update. So, we are tentatively planning for the updated Auto-HPSA to take place in April of 2019, and what you see on the slide are the milestones for 2018 leading up to that update. So, you'll see we have a number of impact analyses planned for this year, and they'll continue into 2019.

 Each impact analysis will reflect a test run of the national shortage designation update of Auto-HPSAs, and we'll be using the data captured at a single point in time. The impact analyses are meant as a planning and information tool designed for you to prepare for any changes that may occur with the update, and I'll just highlight that the results will not be used to make any federal program decision, so they're just meant again simply as planning and information tools.

 So, the results of the first impact analysis are expected to be available in August, and the rest of this presentation will focus on the data sources that we're going to be using for those impact analyses. We wanted to create standalone or self-explanatory slides that you could use as a reference or share with others, so these are extremely text heavy so bear with us. To orient you, at the top of each slide, you'll find the individual HPSA scoring criteria, the HPSA disciplines to which the criteria applies, the maximum points awarded and total possible points for each discipline, and this is what (Melissa) had on a previous slide, but for each slide, we'll have that criteria for you.

 In the body of each data slide, the Auto-HPSA facility types are listed separately, and the scoring criteria's definition and the data sources related to the facility type are listed below. Of course, for this presentation, we're going to focus on the middle RHC column, but in certain cases, we'll also look at the information for the community health centers, and you'll understand why in a moment. That's why these slides have all of the facility types listed for you.

 Okay. So, without further ado, for the population to provider ratio, for RHCs, we plan to create a service area which will be compromised of the census tracks intersecting with a 30 or 40-minute travel polygon which we will draw in the shortage designation management system. The population will be defined as the total population in the service area based on census data. Providers are the eligible FTEs in that service area, and as (Melissa) said, the provider data is in the SDMS or shortage designation management system comes from CMS' national provider data, and the state primary care offices review and revise those provider attributes as part of their cooperative agreement with us and the shortage designation management system.

 So, you'll notice that there are two stars next to the rural health clinics' header, and if you sort of look down towards the bottom of the slide, it reads following the national update, RHCs may provide facility level data to their state primary care office to be rescored, and you may be wondering what does that mean. If you look to the left under community health centers, you will see that we are handling the service area for community health centers a bit differently. As you may know, the community health centers are required to report data to HRSA through the uniform data system.

 So, we're actually going to be using the data that they provide to HRSA to create their service area, specifically in the zip codes in which 75% of their patients reside and use that to create a zip code tabulation area-based service area, and then we use the data underneath that. So, recognizing that RHCs may have these same data available, the percent of, you know, sort of the zip codes in which your patients are coming from, we want to make sure that you're not negatively impacted by the fact that there isn't a central repository for reporting these things so basically again trying to provide equal opportunity for folks to be able to provide data.

 So, basically, what we're going to be doing is after the update, RHCs may submit data through their primary care office to trigger a rescore, so we will have a form that RHCs may complete with all of the necessary data, such as the zip codes in which your patients reside, and then it will be uploaded by the primary care office into our system and will trigger a rescore just to highlight that the PCOs will not be keying the data themselves.

 So, this is a way to ensure that we're getting the information directly from the rural health clinics but recognizing that PCOs are the only ones who have access to our SDMS or shortage designation management system. We are working through the PCOs for that rescore. We would ideally be able to have that functionality prior to the update, but it's a matter of capacity and resources, so we're going to be doing that after the update occurs, but with the impact analysis results that we're providing, we will also be providing specifics on the data that we will be receptive to receiving.

 So, if folks don't have data currently and wanted to collect it, we'd be giving you information with the impact analyses of what you may wish to collect to trigger a rescore. Hopefully, that made sense. We'll move onto to the next slide. For the percent of population below the federal poverty level, for RHCs, we'll continue to use that service area approach, and the definition here is out of the population in the service area, the count of individuals at or below 100% FPL divided by the total population for whom poverty is determined, and we will be using census data for the percent of population below FPL.

 Again, you'll see that star next to RHCs, and following the national update, RHCs may provide facility-level data to their state primary care office. Again, if you look to the left, you'll be able to see what we would be seeking to achieve which is the total patient population from the facility, so we would accept facility-level data related to your patient. For travel distance and time to the nearest source of care, for both rural health clinics and community health centers, we'll be using the same information—the nearest provider that serves Medicaid patients and provides service on a sliding-fee scale who is not in an over utilized area.

 Hopefully, you're able to see the definition that is at the bottom of the slide which defines what overutilization is. I'll also flag here that in the impact analysis that we provide, we'll be providing every single data point that is used for the impact analysis, as well as the provider that has been identified as the nearest source of care. After the update takes place, if for some reason someone thinks that that nearest source of care is not the correct one, they're able to work with their state primary care office to move that nearest source of care with the appropriate documentation.

 For infant mortality rate or low birth weight for all Auto-HPSA facility types, the data sources and the definitions are the same, and the data will be coming from CDC. The definitions are as follows: For infant mortality rate, it is out of the total population the count of infant deaths divided by the total number of infant births for the county in which the Auto-HPSA site is located scaled by 1,000.

 For low birth weight, it's out of the total population the count of low birth weight births divided by the total number of infant births for the county in which the Auto-HPSA site is located scaled by 100, and again, that data is coming from the CDC. For water fluoridation, all Auto-HPSA facility types will receive a default score of zero, and after the national update, all Auto- HPSA facilities may provide supplemental data through their primary care office to be rescored and receive a single point if appropriate.

 For the ratio of children under 18 to adults 18 to 64 and the ratio of adults 65 and older to adults—did I read that right, yes, it's small, it's very small on the slide, clearly I need better glasses—for RHCs, we will be using census data. This is one of those examples you'll see the little star next to rural health clinics. For community health centers, we're actually looking at out of the total patient population, so again, this is one of those situations where RHCs would be able to provide their facility level patient population information to be rescored.

 For substance abuse prevalence and alcohol abuse prevalence, again, we're going to default to a score of zero, and once again, working through your state primary care office, you would be able to submit supplemental data to receive a point, if warranted. So, this is a quick summary of the data sources that are being used. You'll see on the left-hand side, UDS is sort of highlighted because that's where we are drawing the majority of the data for the community health centers, and for RHCs on the right, you see that the census is the piece that is highlighted there again recognizing that following the updates, RHCs, as well as ITUs will have the same ability to use the facility level data creating that parity with the community health centers.

 So, our next steps are to communicate, communicate, communicate. We have an Auto-HPSA communication working group that is again stakeholders. We have (Nathan) again joining us, as well as the Rural Health Association and a rural health clinic represented, as well working on the messages and materials that will best help us get the messages out to the individual facilities, states, any stakeholder who may be impacted by our update in tentatively April of 2019.

 So, we recognize that not everyone comes to HPSAs in general with the same understanding. Some folks really understand what HPSAs are. Others know they have a score but don't know how they got it, don't know what it's used for. So, we recognize that we are trying to cover a whole lot of ground without people all being on the same level. So, we're going to be doing lots of different webinars, such as this one, just to sort of level set and help people understand what Auto-HPSAs are in context of all HPSAs, how they're scored, how we plan to score them, and then as we get closer to the impact analysis results doing more webinars on what you can expect to see with the impact analysis and then finally, once we have the impact analysis results what they mean, what you're seeing, what the data you have represents and what you can do about it.

 So, that's what we'll be working on in terms of next steps. We're actively gearing up also to be able to distribute the results of the first impact analysis again which we anticipate in August of 2018. I don't have this on the slide. I meant to add a slide related to common questions that we've already received, and I have two that I wanted to highlight for you. One is that all Auto-HPSAs will be included in the national update of Auto-HPSAs regardless of when that facility has last been scored.

 So, please don't rush to HRSA or your state primary office and say I need a rescore before this update occurs because while you're certainly welcome to do that, it will not get anyone out of this national update. Secondly, with the national update, every facility will be required to keep that score. Of course, triggering rescores, we're happy to rescore following the updates, but you will not be able to keep your previous score.

 So, I want to make clear, we have two different points of communication at the moment. You'll see the SDB@hrsa.gov on the left, and that is the current process for a facility to request a score or a rescore, and that remains in place and remains in effect again highlighting that even if you are scored as early as '18 or early '19, you'll still be included in this update.

 We want to make sure that that FTB SDB e-mail box focuses on scores and rescores, so we've created a new e-mail address, S-D as in David-M as in Mary-P as in Paul which also stands for shortage designation modernization project, not our most creative acronym, but sdmp@hrsa.gov, and that is where we have a single point of contact for questions related to this project to help ensure consistency in messaging and also importantly to help give us a sense of where we may need to enhance our communication efforts, clarify specific things and making sure that we really have a handle on what we’re hearing from the community, your questions and concerns. That, I think, does it for me.

(Melissa Ryan): So, I think at this point—thank you so much, Elisa—we're open to taking any questions. I know that I've seen a couple in the chat pod. I can't read the totality of them.

(Nathan Baugh): (Melissa), why don't we let the operator give the instructions for over-the-phone questions, and then I'll read some of the chat questions so you guys can respond, as well.

(Melissa Ryan): Great.

(Nathan Baugh): Operator?

Coordinator: If you would like to ask a question, please press star 1 from your phone, unmute your line and record your name clearly when prompted. If you would like to withdraw your question, please press star 2. One moment as we wait for the first question.

(Nathan Baugh): Okay. Right before we start our Q&A period, we're going to put up a poll that we ask attendees to please fill out quickly, and with that said, we'll get started on some of these chat questions. (Todd) asks will HPSAs cross state lines in the future.

(Melissa Ryan): So, HPSAs themselves are probably not going to cross state lines. I think if you're asking about the service areas that we will be using, if, for example, we're talking about a rural health clinic that might be very close to a state boundary, while we’re creating a potential service area through the automated process through a 30 to 40 minute travel polygon around a point which would be the actual rural health clinic, that service area may cross state lines, but a HPSA itself doesn't cross state lines because remember for the rural health clinic designation, it is the facility that's designated, not an area that's designated. Not sure if that helps but hopefully.

(Nathan Baugh): Sure, I think it helps. (Tawny)—I apologize if I got that name wrong—(Tawny) asks—she wants to clarify that RHCs that do not have a sliding-fee scale that they cannot apply for an Auto-HPSA score.

(Melissa Ryan): So, at this point in time, the CMS-certified rural health clinics that meet NHSC site requirements are the only ones that are automatically designated as HPSAs, and the NHSC site requirements do require a sliding-fee scale or basically that you're serving everyone regardless of their ability to pay. So, you would have to take Medicare, Medicaid, CHIP and provide services on a sliding-fee scale, yes.

(Nathan Baugh): Right, so if you don't do that, you don't have an Auto-HPSA score.

(Melissa Ryan): You are not eligible, no.

(Nathan Baugh): Right. So, (Stephanie) wants to know if a clinic was auto-designated, how does the clinic know that. If there a way to check if they're unsure? Let's say they have a sliding-fee scale, but they're not sure that they got on…

(Melissa Ryan): Sure, so they could go on to—there's actually a great site. It's called HPSA find H-P-S-A find. You can google that, and you would be able to essentially go to the, you know, state and county and search by state and county, and it will turn back all the designations that are in the state and county. So, it will give you back both the geographic and population but also the facility designation, so you would be able to see if there is a rural health clinic that has an Auto-HPSA facility in the state and county where that facility is located.

(Nathan Baugh): Okay. (Rosio) doesn't really have a question. He has a statement. (Rosio), if you want to maybe put in a question, we can ask that. The next question comes from (Melissa Catina), does withdrawing an old MUA designation and submitting a new one for a GDSA cause any harm to the existing FQHCs who are using the MUA designation?

(Melissa Ryan): I'm sorry. You'll have to run it by me. I'm not entirely—new for GDSA. I’m not...

(Nathan Baugh): (Unintelligible)…

(Melissa Ryan): …sure off the top of my head what a GDSA is, and I mean, what I will say is that all FQHCs are also Auto-HPSAs like automatically designated as HPSAs, so I can't really speak with any certitude as not being an expert on the health center program whether there's harm that would come to someone as a result of that, but, you know, FQHCs are automatically designated as HPSAs but not MUAs or MUPs. MUA and MUP designation is really used by the health center programs to determine eligibility to receive those funds, but I know that they have other factors that go into that. So, I couldn't say with any degree of certitude.

(Nathan Baugh): Okay. Operator, do we have any questions on the phone?

Coordinator: We do have a question from (John Andrew). Your line is now open.

(John Andrew): Yes, hi. I have a question about how the…

(Nathan Baugh): (John), hold on, hold on, where are you from?

(John Andrew): Oh, I'm from Porterville, California, Sequoia Family Medical Center.

(Nathan Baugh): Excellent.

(John Andrew): I have a question about how the rescoring process is going to work. I guess I'd start off by saying that, you know, I'm really happy to see that it looks like there's going to be a little bit more parity between the community health centers and the rural health clinics if we resubmit data after the initial scoring, that's great to hear.

 The first question, I guess, is on the provider ratio, you had said that we would be able to define our service area similar to how the community health centers are defining their service area, but you didn't talk about the population. It looks like the definition on the population of the community health centers is very different than the population for rural health clinics, you know, within a service area definition. Is it going to be parity also on those metrics or is it something different?

(Melissa Ryan): So, it is going to be a little bit different. What we're looking to do for the CHCs versus the rural health clinics, so what we're taking from UDS, the zip codes were 75% of their patient population comes from, you know, in order to sort of like weed out outliers and things like that, so I think we'd be welcoming zip code data from rural health centers about where, you know, sort of a similar percentage of your population comes from.

 But the rural health clinics, what we will be looking to do is actually, you know, take that service area, and then we would actually be looking at all of the population within that service area and counting all of that population, all what we call the resident civilian population so essentially anyone who isn't institutionalized in that area and counting that as the potential population for the rural health clinic.

(John Andrew): Then, what would be the provider definition?

(Melissa Ryan): We would also be looking at all the providers in that area, so you know, all the providers that are relevant, you know, that we count for shortage designation, so for primary care, our regulations only allow us to count physicians that we look at primary care physicians, such as family practice, you know, general internal medicine, OB/GYNs and pediatricians, so we'd be looking at all of those providers in that area.

(John Andrew): Okay. Is there any consideration to make it a little bit more similar to the CHCs? I mean, that puts them at a significant advantage even though they're in the same exact local area?

(Melissa Ryan): So, actually, it doesn't give you an advantage to do that, and we thought about that. The health centers, what we're doing is we're actually looking at just what we call the low income population so anyone at or below 200% of the federal poverty level, and we're doing that because we understand that, you know, we were trying to give a nod to the fact that, you know, health centers are often considered safety net providers for these low income populations where they are, and therefore, that makes up a large percentage of their population that they're serving.

 In the rural health clinics, you're really a safety net for a rural area, and so if we were to do it the same way we're doing it for the rural health clinics, we would only be looking at the people in that area under 200% of the federal poverty level which actually reduces your population base that we're looking at for your population to provider ratio.

 So, we didn't really want to do that to the rural health clinics because thing that, you know, you already have issues with getting lots of points on the population to provider ratios because you're in rural areas where the population and staff aren't as high as those surrounding some of the more urban community health centers. So, that was sort of our thinking on that.

(John Andrew): Okay. Thank you. One last question, the rescoring will take place sometime after April 2019. Which loan repayment year do you think the scores are going to impact, you know, people that work at our clinics?

(Melissa Ryan): So, you know, our idea is to do it after the application cycle for the National Health Service Corps loan repayment closes in 2019, so it would likely be just for potentially continuations and even new loan repayment in 2020.

(John Andrew): Thank you.

(Nathan Baugh): All right. Thanks.

Coordinator: As a reminder, if you would like to ask a question, please press star 1.

(Nathan Baugh): Operator, so, I'm assuming we don't have any on the line?

Coordinator: No additional questions at this time.

(Nathan Baugh): Okay. I'm going to go back to the chat box for a moment. (Rachel) asks is the form that the RHCs will complete and send to their PCOs collecting data on the provider and the patients, what data will be collected and uploaded to the SDMS and when does this form process go into effect? So, maybe just some general information about that form that gives us that option to report different other than the travel polygon.

(Melissa Ryan): So, sure. So, just to be clear, all the data points that we went over is sort of what we're going to be doing as a default, so you'll get a score that's generated based on all that data that will be sort of a default, and then there will be an opportunity after that for rural health clinics to provide data to the state primary care office on a form that will be what I just talked about.

 If you want to provide zip codes if you don't think that the 30 to 40-minute travel polygon that we sort of automatically draw around your site or your clinic is reflective of your actual patient population, and you have data to give us the zip codes where your actual patient population comes from. I would accept that data in order to, you know, input into the system and then use that as your service area that we were using to pull data to calculate your scores.

 We would also, you know, take information on if you have information on your patient population about poverty and what percentage of your patients are actually living at or below 100% of the poverty level, as well as data on the age of your patient population to look at those youth ratios and senior ratios for the mental health designations, as well. So, that's the kind of the idea.

 Also, we would be looking at, you know, if you are a clinic that has dental services, and you want to submit information about your fluoridation rate or again, for any mental health designations, the substance and alcohol misuse rate data, as well as if you don't think that the nearest source of care that we've identified is an accurate reflection of who the nearest source of care is. You can come in and say, you know, here's the nearest source of care.

 One thing I will say about that that I think will probably come into play for a lot of the rural health clinics is there is a point threshold after which we don't award any more points, and so the system will kind of only search out to a certain area, and once it sort of hits that threshold where you get the maximum number of points, it may not actually identify a nearest source of care.

 So, if you've gotten the maximum of five points for that, you know, you don't necessarily have to come back in and tell us, oh, well, here's our nearest source of care unless, of course, it's something that would get you under five points in which case, sure, tell us. You know, let us know who that is if our system missed it.

(Elisa Gladstone): This is (Elisa). Thanks, (Melissa). I would just add that we always encourage people to work with their state primary care office related to provider data, so while it may not be related to provider data for the auto HPSA scoring, our primary care offices are required to have information about the providers in their state, and so working closely with your PCO about the provider, it's always an important thing to do.

(Melissa Ryan): Yes, thank you. Good point.

(Nathan Baugh): But can you guys clarify when you anticipate releasing the form that would convey all this information?

(Elisa Gladstone): Sure, so we're hoping to have the form the same time that we have the impact analysis results in August. If that's…

(Nathan Baugh): Okay.

(Elisa Gladstone): …not the case -- sometimes technology is outside of our control -- it will be shortly thereafter, and so, ideally, we would want you to have as much time as you need to able to pull that data and have it available so after the update occurs, you could send it to your PCO or you could send it to your PCO in advance, and they could have it to upload it after that update occurs, so we want there to be lots of flexibility for you related to data collection, and there wouldn't be a set date by which you had to submit something, if that helps.

(Nathan Baugh): It sure does. I know that (Elisa) has to go at 3:00 Eastern on the dot, but (Melissa) can stay around a little bit longer to answer questions. We're going to try to get through as many questions as we can. There are a few more on the chat, and then we'll go to the phones.

 (Rosio) reposted his question. This is not necessarily about an Auto-HPSA, but he's asking there's geographic HSPA expiring soon for his area of Ridgecrest, and it doesn't impact his rural health clinic, but he wants to know if it could impact the hospital which is located in Ridgecrest. Do you guys want to take that one?

(Melissa Ryan): You know, it depends on what type of geographic HPSA we're talking about, so I’m not sure if it's primary care, dental or mental health. If it's dental, it wouldn't have an effect on the hospital as best I could tell unless it has an outpatient dental clinic that is designated or that's an NHSC-certified site in which case then it would no longer be eligible for NHSC.

 But hospitals, specifically in-patient settings like actual hospitals and in-patient settings aren't typically NHSC-approved sites unless they are critical-access hospitals which can be eligible, and they have a whole bunch of different requirements. But generally, a geographic HPSA, if it's a primary care HPSA or a mental health HPSA, CMS pays out a 10% physician, a bonus payment for all services provided on Medicare Part B services provided, so the physician fee schedules, so any physicians that provide services would be missing out on that 10% bonus payment, but what I will say is, you know, I don't know whether it says it's expiring soon.

 I don't know whether that's because, you know, it's been withdrawn by a state primary care office and potentially replaced with something else because frequently, RHC primary care offices will withdraw HPSAs and then sort of redraw the lines of them if they think, oh, well, we have this HPSA, and we actually want to add these two additional census tracks. They will withdraw the previous one and then put another one in place in which case nothing would happen if it's still within the bounds of that new HPSA.

 But at the same time, you know, just the reality is HPSAs come and they go because it really is based on the sort of on the ground real time data of what your population is and what providers you have. So, oftentimes when HPSAs go away, it's because you're doing better relative to where you were before in terms of your population to provider ratios. So, hopefully, that's helpful.

(Nathan Baugh): So, let's clarify what she meant by GDSAs, Governor's Designated Shortage Area, but (Alyssa), let's take that question offline. I think you have my e-mail. E-mail that to me. I think I know where you're getting at, but I think that's an entirely different subject than this topic. So, I'm going to go to the next question on the chat which is (Stephanie), and (Stephanie) asks are there any financial impacts on the RHC is they are or are not designated HPSA? I think…

(Melissa Gladstone): So, there's no financial impact in terms of your enhanced reimbursement as a CMS-certified rural health clinic. You know, as I said, any physician providing certain Medicare Part B services within a primary care geographic or a mental health geographic designation does receive that 10% bonus from CMS. Excuse me. Those rural health clinics that are in a designation or have their own facility designation and meet NHSC state requirements are eligible to, you know, recruit through the National Health Service Corps or The NURSE Corps program, as well. They can also use J1 Visa waiver providers, so it really just sort of depends on how broadly you would like to define financial impact.

(Nathan Baugh): Right, it won't affect your all-inclusive rate reimbursement.

(Melissa Ryan): Right.

(Nathan Baugh): But it has financial impacts in whether you want to expand or move. You're going to - need to be in a HPSA or medically underserved or a Governor's Designated Shortage Area in order to move. So, there's financial impacts but not reimbursement impacts. Operator, do we have anyone on the line?

Coordinator: Yes, we have a question from (John Andrew) again. One moment. (John), your line is now open.

(Nathan Baugh): (John), where are you from?

(John Andrew): From Porterville, California, Sequoia Family Medical Center. One more question, I know that community health centers have an option to, like, average all of the scores of their locations into one kind of average score. Is that something that is available to rural health clinics if you're a part of multi-chain rural health clinic organization, and is that going to continue into the future?

(Melissa Ryan): So, the averaging of the community health centers is going to continue into the future. That was actually a big question because, you know, it's a double-edged sword for them because that means that their sites that have higher scores actually come down, and those that have lower scores kind of come up a little bit, so they will be able to do that. We have talked about it with the rural health clinics. For us, the challenge is knowing what the networks are but also just to make sure that all of the rural health clinics, again all of the sites that are eligible have to meet all of those criteria, so all of those sites have to have a sliding-fee scale, all of those sites have to take Medicaid, all of those sites have to take CHP, so you know, it's certainly something that we can talk about if you think that that would be helpful, but you know, as I said, it is a double-edged sword because you might have an instance where you have one rural health clinic in your network that would have a score of a 20 which would be incredibly competitive for a National Health Service Corps, and then if you have another one that was 6, and it's just those two sites, that's going to average the score out to a 13 which is not especially competitive for the National Health Service Corps low repayment program at this point in time. So, it's just something to think about.

(John Andrew): So, you will offer it on a case-by-case basis, and we would need to speak with our PCO about it if we wanted to?

(Melissa Ryan): So, it's not something that we've made a determination on. I would really recommend that you have a conversation with (Nathan) and bring, you know, your sort of proposal forward and how we would get that data, and we would be certainly happy to entertain the conversation.

(John Andrew): Okay.

(Nathan Baugh): Let's talk. (John), let's talk, you and I, and we can figure out what we want to propose.

(John Andrew): Okay. Is the averaging for community health centers just one site plus another site and then average the two or is it based…

(Melissa Ryan): Yes, it is.

(John Andrew): …on volume of patients seen at each location?

(Melissa Ryan): No, - it's one site plus another site, average of the two.

(John Andrew): Thank you.

(Nathan Baugh): All right. I think we have a chat question from (Brianna). She basically wants to know if it's worth it to create a sliding-fee scale so that her clinic can be eligible for the Auto-HPSA scoring.

(Melissa Ryan): That's entirely a decision that you have to make at your own clinic because, you know, it's not just about having a sliding-fee scale. It's about actually operationalizing it and making sure that you really are providing those services to people at or below 200% of the federal poverty level when you get down to the lower levels what's considered a nominal fee which might be, you know, five dollars.

 So, if your rural health clinic can afford to do that, then I absolutely think it's worth it, so then, you know, get the sliding-fee scale, implement it and get your Auto-HPSA so that you can compete for NHSC. That said, with NHSC, you know, you will go through a site certification sort of process as a rural health clinic, and we do come out and we look for that billing data to demonstrate that you are, in fact, implementing that sliding-fee scale.

 So, it's really also what score might you get and would that score make you competitive for resources through the National Health Service Corps and would those resources be enough to then—is that I don't want to call it a trade-off, but is it worth it is only a calculation you can do for yourself at your own site.

(Nathan Baugh): Right. Okay. We're going to do a few more questions, and then we'll probably have to call it. (Holly McDonald) asks so after the update, would you expect to see an RHC and an FQHC that are within a block of each other have a similar score? I'm not sure if you guys would—that's not really something you could speak to, but I'll open it up for you guys.

(Melissa Ryan): So, yes, I mean, as we pointed out, there will be some differences in how we’re calculating that population to provider ratio for RHCs versus CHCs, so while many of the criteria might be similar, again it also depends on how well—and not just the how we're counting population differently between the two, but also to what extent the service areas overlap because what an FQHC or a CHC might be reporting through UDS as their zip codes were 75% of their patient population comes from may not really overlap as much as you might think with your service area if you've defined it for us or with the service area that we've drawn based on a 30 to 40 minute travel polygon. So, while we can't say that definitively, we do expect that there would be some differences although not necessarily vastly so, but again, it depends on those necessary criteria.

(Nathan Baugh): Okay. We're going to make this the last chat question. (Levi) wants to know where we can find the information on the RHC 30 to 40 miles radius, as well as the federal poverty level and the population provider ratio. So, where will they be able to see the radius for their clinic?

(Melissa Ryan): So, actually, it's not going to be a 30 to 40-mile radius. It's minutes, so it's a travel time, basically, which is what we actually use the (ESRE) data for, so you could, you know, kind of think how we would get you that, but in terms of the actual impact analyses, you will be able to see the data points so what the travel time is to the nearest source of care.

 You could try to—you know, if you have someone who does a geo-mapping for you—figure out what the exact boundaries of that are, and we can also look to our technical team to see if there's some way we might be able to provide some information on that. But in terms of all those other sort of data points—the poverty level, the population to provider ratio—all of that will be part of the information that's released with the impact analyses.

(Nathan Baugh): Where will that impact analyses be posted?

(Melissa Ryan): So, I'm looking to my colleague, (Elisa). I think that's some of the information that we’re still working on with our communications plan and our communications work through.

(Nathan Baugh): So, you can…

(Elisa Gladstone): That's something…

(Nathan Baugh): …give that to me, and we can send that out over our list serve, so folks can find that when that decision has been made.

(Elisa Gladstone): Absolutely. What we’re looking at is how to get the individual impact analyses to the individual organizations, so we'd rather not post those anywhere centrally, and so we're really looking at how to do this individually, so that's what we're trying to look at resources at the moment and how best to do that.

(Melissa Ryan): It's not a small feat because we're literally talking about thousands of Auto- HPSA facilities around the country.

(Nathan Baugh): Okay. All right. So, that's to be determined how we will get the impact analyses out to folks. But we're working on that. We will communicate that through the communications group. We will use our list serve to communicate that with folks. I think that'll do it for the chat box. We'll take one more question if there is one on the phone.

Coordinator: No questions on the phone at this time.

(Nathan Baugh): All right. So, with that, I would like to thank everyone on today's call and especially our speakers, (Melissa Ryan) and I'm going to say it, is it (Elisa Gladstone)…

(Elisa Gladstone): (Elisa).

(Nathan Baugh): …(Elisa Gladstone) for their presentations today and the Federal Office of Rural Health Policy for the RHCTA series. Please encourage others who may be interested to register for the RHCTA series, and in addition, we welcome you to e-mail us with your thoughts and suggestions for future call topics at bf@narhc.org and please be sure to put RHCTA topic in the e-mail subject line. We anticipate scheduling the next RHC technical assistance call in a couple of a weeks. A notice will be sent out—with the details for the next call. Thank you for your participation, and that concludes today's call.

Coordinator: Thank you for participating in today's conference. You may all disconnect at this time.

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