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Tom Engels
Administrator
Health Resources and Services Administration
5600 Fishers Lane
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Dear Administrator Engels:

As the leading authority on oral health in the United States, the American Dental Association (ADA), representing more than 159,000 dentists nationwide, writes to you regarding the opportunity to comment on the **Information Collection Request related to the Shortage Designation Management System (SDMS)**.

A geographically well-distributed dental workforce is essential to the ADA's goal of expanding access to care. We support the efforts to ensure as much of the U.S. population as possible is utilizing dental care, which is based, in part, on a sufficient and adequately geographically distributed workforce. The ADA commends the work done by HRSA to improve the health of underserved communities and recognizes this as an integral piece of this strategy.

A drawback of the existing HRSA health care professional shortage area (HPSA) designation methodology is that dental health HPSA score calculation prioritizes population to provider ratio. We believe that HPSA designations should equally prioritize the patient's ability to access a provider. The ADA would like to propose a change in methodology which leverages already-available data. This could improve the accuracy of the HPSA designation and reduce the burden of information collection.

Furthermore, the ADA **urges adoption of a new Dental Care Geographic Accessibility Dashboard in lieu of the current methodology used to calculate dental health professional shortage areas**, which will ultimately strengthen SDMS processes, ease burdens on state primacy care offices (PCOs), and more accurately assess national provider needs.

Necessity and Utility of Information Collection

The ADA believes that designating HPSAs is essential for improving health in underserved regions. However, the current data collection process used by the Shortage Designation Management System (SDMS) may be unnecessary if a more efficient solution can reduce administrative burden, eliminate redundant efforts, and more accurately identify areas with provider shortages.

States and counties do not have homogenous health care needs throughout; any methodology that tries to calculate those needs in aggregate would provide limited insight into true access to care at any single location within that area. Additionally, to achieve this aggregate result, the SDMS's estimated burden of data collection for each of the nation's 54

state PCOs is upwards of 600 hours annually. However, this burden of data collection on PCOs is still not providing clarity on whether patients have access to dental care and should be revisited with an improved and more streamlined approach.

Enhancing the Quality, Utility, and Clarity of Information

HPSA designations should reflect not only the availability of providers but also patients' ability to access care. There are other categories of data that would provide a clearer picture of dental service usage and provider availability, thereby increasing the accuracy and clarity of a HPSA designation. While HPSAs are traditionally used for loan repayment, National Health Service Corps placement, and the establishment of federally qualified health centers, their usefulness can be extended further in determining network adequacy exceptions for dental services. Multiple regulations such as 42 CFR § 422.116(d) related to Medicare Advantage, 42 CFR § 438.68(e) related to Medicaid Managed Care, and 45 CFR § 156.235(b) related to Qualified Health Plans specifically mention exceptions being determined by provider ratios, whether time/distance/geographic standards can be met, or availability of providers.

However, data suggests that the primary reason adults do not seek dental care is not the availability of a provider, but barriers affiliated with type of insurance coverage each dentists accepts.[1] HPSA scores for dental provider shortage areas in their current form fall short in clarifying availability of providers based on coverage types, which is why a refined methodology for HPSA would be best in determining availability of dental care in an area. An assessment of geographic travel time/distance to provider would better indicate whether a provider shortage is the cause of any access to care issue in a given area,[2] or whether insurance network adequacy may play a role in dental care usage. If the latter, an influx of providers to an underserved area would not necessarily improve access to care, but an increase in enrolled providers in dental insurance or Medicaid networks would prove to be a more impactful strategy for improving access to care.

The ADA has been researching novel methodologies to determine provider availability and network adequacy. The Association would like to propose a methodology that is empirically stronger and accounts for the needs of individual communities with more accuracy. The Dental Care Geographic Accessibility Dashboard is a collaboration between the American Dental Association Health Policy Institute (HPI) and Virginia Tech University.[3] To assess geographic accessibility, the dashboard uses 30- and 60-minute driving times to estimate how far individuals can realistically travel to reach dental services based on type of insurance coverage (privately insured/Medicaid). A 30-minute threshold reflects access to nearby, local care, while 60 minutes captures more regional availability. By analyzing

[1] Serban N, Ma S, Yu J, Anderson A, Pospichel K, Solipuram SR, Tomar SL. Dental care access for children in the United States. J Public Health Dent. 2024 Dec;84(4):351-361. doi: 10.1111/jphd.12635. Epub 2024 Jul 16. PMID: 39011783; PMCID: PMC11619532.
[2] Kim J, Karki S, Brickhouse T, Vujicic M, Nasseh K, Wang C, Zhang M. Navigating Disparities in Dental Health-A Transit-Based Investigation of Access to Dental Care in Virginia. Community Dent Oral Epidemiol. 2025 Feb;53(1):117-124. doi: 10.1111/cdoe.13015. Epub 2024 Oct 30. PMID: 39474834; PMCID: PMC11754141.
[3] https://virginiatech.maps.arcgis.com/sharing/rest/content/items/3a7039b2492b40cc95f3b7e71ed077a7/data [NOTE: Clicking this link will automatically download a pdf document with the methodology]

access within these intervals, the dashboard helps identify underserved areas and supports equitable planning for dental care delivery. At both the county and block group level, the dashboard rates each area as one of five levels of access to dental care, from Very Low to Very High, or as a “No Access” area.

To showcase this new methodology’s accuracy, ADA would like to highlight the example of Walworth County, Wisconsin which highlights the differences in methodology between HRSA’s dental HPSA designations and ADA HPI’s dental care accessibility dashboard. According to the dental HPSA classification, Walworth County is not designated as a dental HPSA shortage county (Figure 1). ADA HPI’s calculation designates Walworth County as a low dental care accessibility county when focusing on 30 minutes travel time by county (Figure 2). The calculation allows for a breakdown of access to dental care for the whole population, children on Medicaid, and adults on Medicaid. If we focus on access to dental care for the whole population, the calculation shows that in this county, 2.2% of the population have no access to dental care, 40.9% have very low access, 44.7% have low access, and 12.2% have moderate access.

Figure 1. HRSA’s Dental HPSA Designation

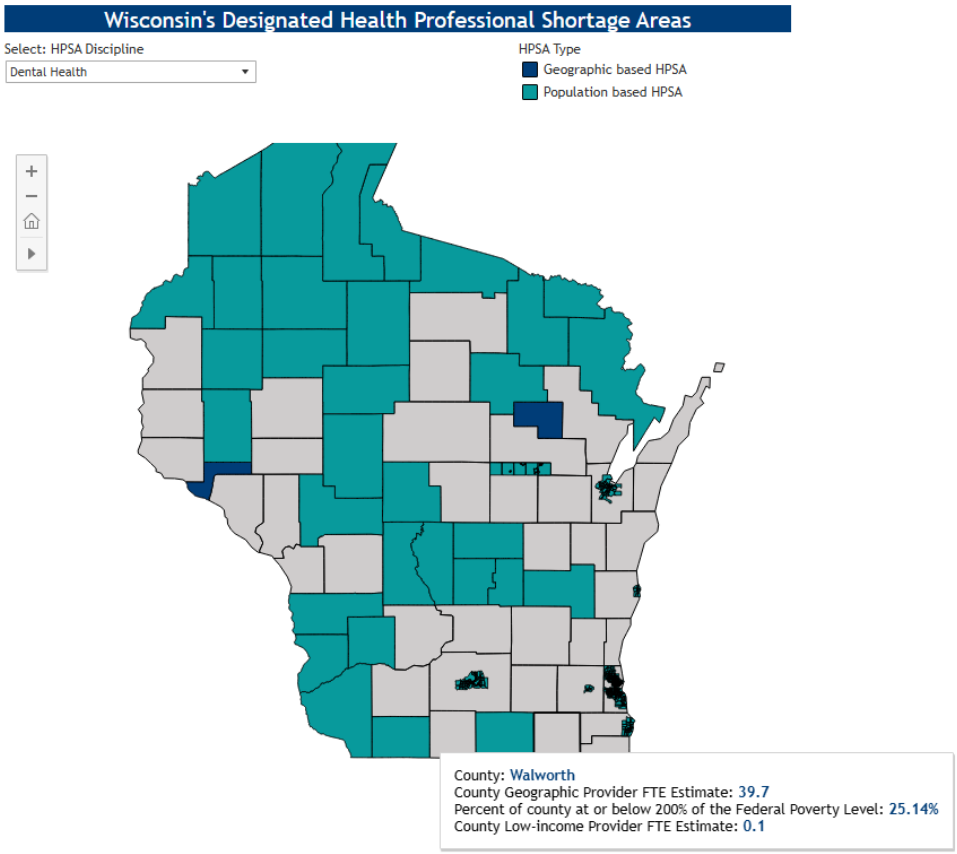
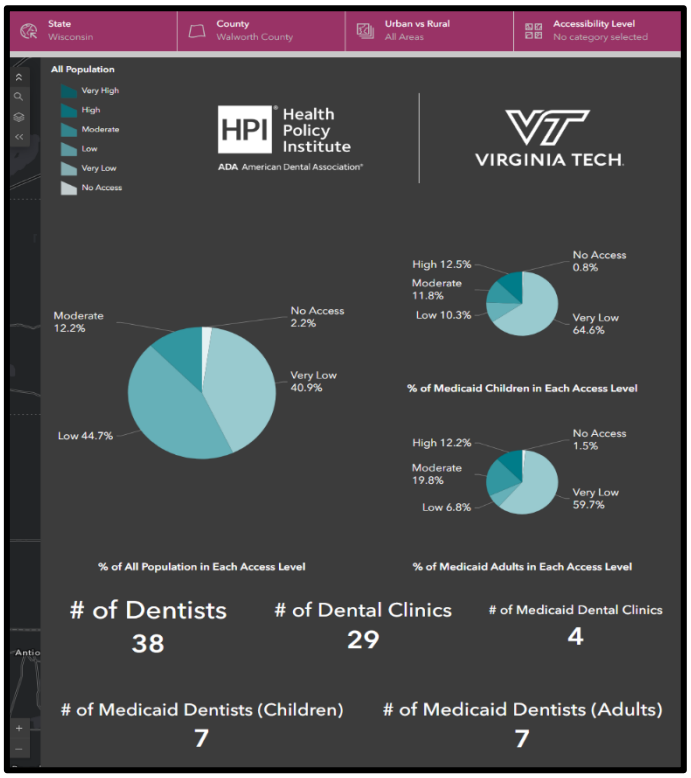


Figure 2. ADA HPI's Dental Care Accessibility of Walworth County, WI



To then further highlight the discrepancy compared to the two methodologies, the association then assessed a particular address with very low/low dental care access and whether this was classified by HRSA as a dental professional shortage area. The ADA chose a hypothetical address of W6296 Pierce Rd, Elkhorn, Wisconsin, 53121 (Walworth County). HRSA's methodology shows that this location is not in a dental HPSA area (Figure 3). However, when one views this address through ADA HPI's classification and methodology, the address clearly has no access to dental care area for 30 minutes travel time of the block group that the address is in (Figure 4). In addition, ADA HPI's map shows that there is only one dentist within that block group and zero dentists participating in Medicaid. Thus, ADA HPI's methodology shows that there is a shortage of dentists in that area. To showcase this tool's accuracy, the Health Policy Institute would be happy to host demonstrations of the dashboard's capabilities to HRSA staff.

Figure 3. HRSA's Dental HPSA Designation of W6296 Pierce Rd, Elkhorn, Wisconsin, 53121

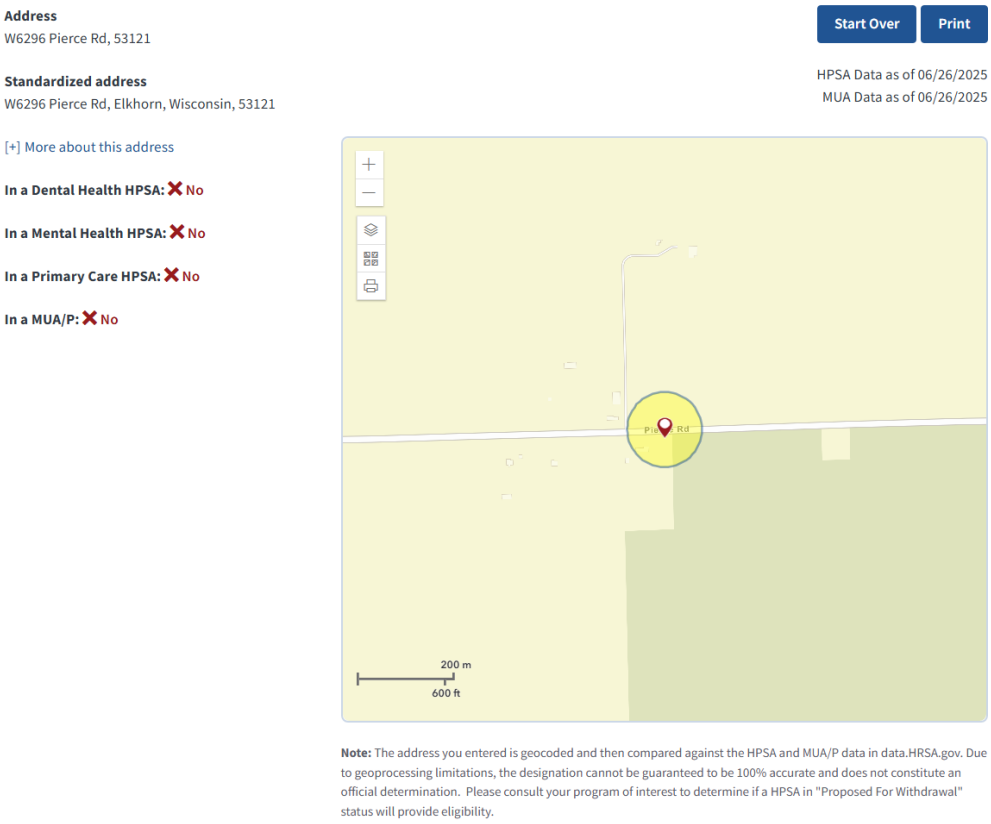
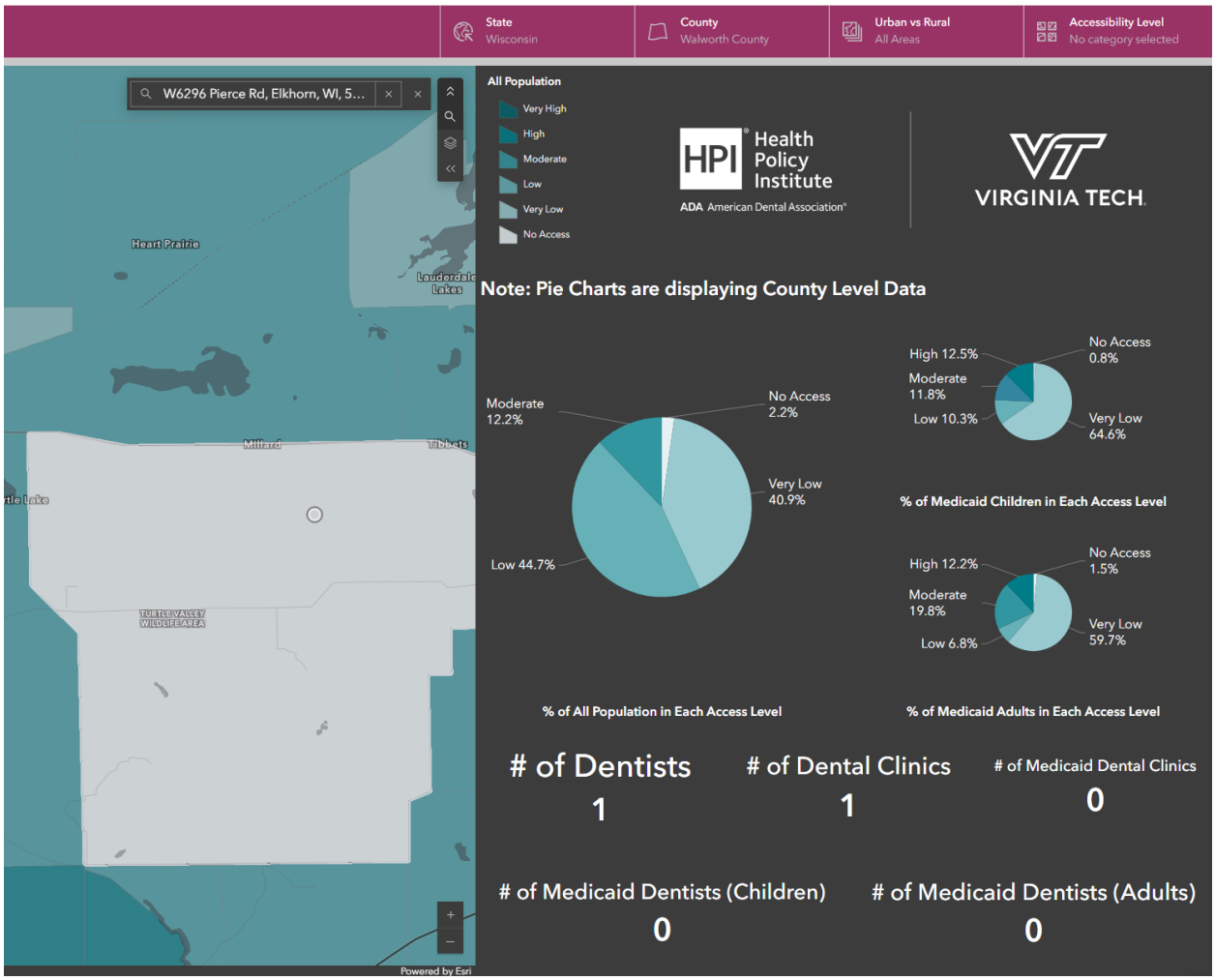


Figure 4. ADA HPI's Dental Care Accessibility of W6296 Pierce Rd, Elkhorn, Wisconsin, 53121



Minimizing the Information Collection Burden

One additional benefit of this methodology is that it utilizes data that is already collected and validated, thereby minimizing the need for additional data collection. The map's source for dentist practice locations is the HPI Office Database, itself a merged compilation of dentist addresses from the ADA masterfile, the CMS Insure Kids Now database, the National Provider Identifier dentist registry, and public data on dentists affiliated with Dental Service Organizations or group practices. Data for populations and Medicaid populations come from the U.S. Census Bureau's American Community Survey. Boundaries for counties and block groups are from the Census Bureau's TIGER dataset. Isochrone data for areas reachable within selected travel times come from Mapbox API.

In summary, **the ADA proposes that the SDMS adopt the Dental Care Geographic Accessibility Dashboard** as its information collection methodology, which would streamline

SDMS processes, reduce the burden on state PCOs, and determine the provider needs of the nation's population with greater accuracy.

We appreciate allowing us to comment on this information request and the efforts of HRSA in supporting a geographically well-distributed dental workforce. The ADA believes that the designation of HPSAs is vital and necessary to improve the health of the nation's underserved areas; however, the process of information collection carried out by the SDMS may itself be unnecessary if a solution can be employed that streamlines the burden, avoids duplicative work, and can be employed to greater utility to target areas of provider shortage with greater nuance and accuracy.

We welcome the opportunity to discuss our suggested changes and the methodology of a new Dental Care Geographic Accessibility Dashboard. If you have any questions or would like additional information, please contact Marko Vujicic, ADA Chief Economist and Vice President of the Health Policy Institute at vujicicm@ada.org.

Sincerely,

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