

NRMC Special Populations Subcommittee Discussion Summary January, 2011

Subcommittee Objectives and Discussion Themes:

- New rule should be inclusive of more underserved groups
- Build in a process to make room for new/emerging populations
- Simplify and try to decrease work and expense for local communities and state agencies to implement
- Allow local communities latitude to make a case for local needs

Our subcommittee discussion (3 meetings/6 hrs total) is summarized below in a table that includes four columns:

1) summary of the issues, 2) status of subcommittee consensus (Y = Yes, N = No, UD = Undecided), 3) notes and/or analysis, and 4) questions for full committee.

Subcommittee Discussion			
Issue Summary	Sub-Com consensus?	Notes/Analysis	Questions for Full Committee

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<p>I. Basic framework for MUP</p> <p>Use section 330 Medically Underserved Populations criteria:</p> <ol style="list-style-type: none"> 1) factors indicative of the health status of a population group or residents of an area, 2) the ability of the residents of an area or of a population group to pay for health services, and 3) their accessibility to them 4) the availability of health professionals to residents of an area or to a population group. 	Y	<ul style="list-style-type: none"> • useful to start with well-established criteria 	<ul style="list-style-type: none"> • Does the larger group agree with using section 330 MUP criteria (thumbs up for consensus)?
<p>II. Some populations should be pre-identified and named in the rule</p> <p>Certain population groups are already recognized by HRSA and named in current designation and/or programmatic regulations because they have sufficient documentation to meet the top three criteria. There may be other population groups with sufficient recognized documentation to meet these same criteria. Pre-identified groups would therefore meet criteria #1-3 already, and would only have to prove #4 at the local level through:</p> <ol style="list-style-type: none"> a. Verification that at least a threshold number of the Special Population group exists within a Rational Service Area (RSA). b. Verification that insufficient medical providers exist within the RSA to serve this Special Population group. 	Y/UD	<ul style="list-style-type: none"> • Avoids an expensive/laborious process for local communities and state agencies if some high need groups can be identified nationally • There may be more populations that merit pre-identification. Question is how to identify/select these groups. 	<ul style="list-style-type: none"> • Consensus on having a pre-identified list of named populations? • Advice for the subcommittee on ways to identify who needs to be on this list?

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<p>III. Populations that are NOT pre-identified</p> <ul style="list-style-type: none"> • For any other group not pre-identified, it would be necessary to document that the group meets all 4 criteria, as outlined above. • Review the criteria and p2p thresholds adopted for MUA and consider adjustments as needed for MUP. • For MUP health status factors, include factors adopted for MUA but expand the list based on the Healthy People 2020. Create a menu of health status factors representative of disparities experienced by underserved communities. • Communities would make case for specific populations in their service area. • Future lists of population groups to consider would be recognized as they are updated in Healthy People 2020 or similar nationally recognized health planning documents prepared by HRSA. 	<p>Y/UD</p>	<ul style="list-style-type: none"> • MUA criteria pending, may need to revisit • Our committee reviewed Healthy People 2020 (e.g. list of populations experiencing disparities) as a potential HRSA-endorsed living source for identification of underserved populations. • Advantages of this approach: <ul style="list-style-type: none"> ○ Includes more underserved groups, depending on local conditions. ○ Addresses new and emerging groups in the future ○ Allows for local communities to make their case ○ HP 2020 is widely accepted as valid source; backed by scholarship and includes community input. • Challenges: <ul style="list-style-type: none"> ○ Impact testing ○ Standards for/validity of locally collected data? ○ HP 2020 is very inclusive and research is limited in some sections. ○ HP 2020 may not be updated and/or accepted in future. 	<ul style="list-style-type: none"> • Reactions to idea of using Healthy People 2020 and future updates of this planning document? • Other documents or reports the committee feels would be acceptable sources? • Suggestions on a mechanism/process to allow for the use of national, state and local data including validation process. • Are there other health status measures related to underservice that the group should review?
<p>IV. Relationship of MUP to HPSA population</p> <p>The question is whether or not MUP designation would equal an automatic Special Population HPSA designation. There was disagreement on this point, based on purpose of HPSA and p2p</p>	<p>N</p>	<ul style="list-style-type: none"> • Both designations address pop to provider ratio and barriers to care. • If MUP granted, data are verified for three criteria: health status, access and ability to pay. Not necessary to reinvent these data for Spec Pops HPSA designation. 	<ul style="list-style-type: none"> • Need to revisit this issue when the broader group adopts p2p thresholds for the geographic designations, namely the MUA and geographic

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thresholds.		<ul style="list-style-type: none"> • MUP and HPSA are addressing different issues related to different needs. HPSA is more focused on provider availability. • MUP and HPSA currently have different p2p ratios, therefore gaining MUP status would not prove out HPSA need. 	HPSA.
<p>V. Special Population HPSA</p> <p>Two criteria noted in statute and current regulations should remain:</p> <ol style="list-style-type: none"> 1) provider to population ratio 2) Access barriers that prevent use 	UD	<ul style="list-style-type: none"> • Need more information on how the second factor, “access barriers” is analyzed under the current HPSA designation process. • Our committee has not fully addressed this issue. 	
<p>VI. Governor's Exception for MUP, Special Pop HPSA</p> <p>There should be such a process for exceptions for both designation types.</p>	Y	<ul style="list-style-type: none"> • Allows for local needs and input where data may not support designation through regular means. 	<ul style="list-style-type: none"> • Agreement?
<p>VII. Facility Designation for MUP, Special Pop HPSA</p> <p>There should be a process using established criteria:</p> <ol style="list-style-type: none"> 1) Nonprofit or public facility 2) Serving threshold number of underserved population 3) <i>Percent of underserved or spec pop assisted also meet specified poverty level OR document health status indicators for that population</i> 	UD	<ul style="list-style-type: none"> • Our committee has not fully addressed this issue. 	

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<p>VIII. Still Under Discussion</p> <ul style="list-style-type: none"> • Process for selecting groups (pre-identified and non-pre-identified) • Mechanism for setting /reviewing population thresholds • Mechanism for setting/reviewing provider to patient ratios • How can Impact testing be done, given the “menu” approach? • Setting standards for local data validity • Special Population HPSA designation criteria • Facility designations 			<ul style="list-style-type: none"> • Ideas or suggestions for approaching these questions?