

SUMMARY MEETING MINUTES

March 8-10, 2011

The Negotiated Rulemaking Committee (hereafter the “Committee”) was convened for its sixth meeting at 11:04 A.M. on March 8, 2011 at the Radisson Hotel, Arlington, Virginia. The meeting was facilitated by Lynn Sylvester and Dan LeClair of the Federal Mediation and Conciliation Service.

Committee members present:

Marc Babitz
Andrea Brassard
Roy Brooks
Jose Camacho*
Kathleen Clanon
Beth Giesting
David Goodman*†
Daniel Hawkins
Sherry Hirota
Steve Holloway
Barbara Kornblau
Tess Kuenning
Alice Larson
Tim McBride†
Alan Morgan
Ron Nelson*†
Charles Owen†
Robert Phillips
Alice Rarig
Edward Salsberg
William Scanlon†
John Supplitt
Don Taylor
Elisabeth Wilson

* Represented by a designated alternate for all or parts of the meeting

† Participation via teleconference for all or parts of the meeting

GENERAL ADMINISTRATIVE MATTERS

Ms. Sylvester reminded every Committee member to sign in each day. In addition, there was a reminder for members of the public to sign in and identify any request to address the Committee.

APPROVAL OF SUMMARY MINUTES

Prior to this meeting, the Committee reviewed the draft minutes from February's meeting. The Committee approved a couple of changes to the minutes before deciding to review the remaining changes electronically and approve them the following day.

PROGRESS REPORT TO SECRETARY AND ROADMAP

Mr. Salsberg discussed the Committee's April report to the Secretary. The Committee is required to provide the HHS Secretary with a progress report regarding whether the Committee believes they will be able to finish their assignment by the statutory deadline. The Committee's final report is due June 1, 2011 and the interim final rule is due for publication on July 1, 2011. Mr. Salsberg explained that the Committee can request, in the progress report, an extension of the deadline in order to finish their assignment. HRSA has drafted a progress report requesting to extend the deadline to October 31, 2011. The Committee must decide (1) whether they would recommend continuing based on their current progress, and (2) whether they need additional time to complete their assignment.

Mr. Salsberg then discussed the Committee's roadmap which outlined the work to be done for each month up to October 2011 (Attachment 1). Mr. Salsberg emphasized that the Committee could submit the report earlier than October if the Committee was comfortable doing so. A Committee member asked whether the Secretary is likely to accept the request for more time. Mr. Salsberg said that he would think so but does not have any information that suggests an expected response. Questions arose regarding OMB's role in this process. Mr. Salsberg explained that the Committee's final report would still go through a clearance process involving HHS and OMB. In addition, the statutory authority and funding for the Committee was discussed in the event of the authority being repealed. The Committee asked if the draft report would be available for their review before the next day. Mr. Salsberg indicated that he would try to get the draft report to the Committee before the end of the day.

REVIEW OF AGENDA

Ms. Sylvester reviewed the agenda for the remainder of the day with the Committee. Dr. Wilson requested to have time during the first day to present the Subpopulations Subcommittee streamlined report. Dr. Clanon indicated that the Facilities Workgroup might be ready to discuss the community portion of the facilities topic but would like to have more time together before discussing with the entire Committee. Dr. Rarig noted that the Data Technical Subcommittee did not meet during the two weeks between meetings because of other Workgroup tasks but that the Subcommittee should convene at some point during this

meeting. Committee members asked whether there would be any small group discussions. Ms. Sylvester suggested, and the Committee agreed, that when the Committee reaches a discussion point on the agenda, the Committee can decide then if they want to break into small groups or continue as a full Committee. The Committee also requested that all three day meetings end at 3 p.m. on the final day.

SUBPOPULATIONS SUBCOMMITTEE REPORT

Dr. Wilson reported on the work of the Subpopulations Subcommittee. She discussed the streamlined process for MUPs and the regular (non-streamlined) process for MUPs (Attachment 2). She also noted that the Subcommittee is still discussing the relationship between MUPs and special population HPSAs, as well as facilities designation as it relates to special populations.

Streamlined Process

Dr. Wilson indicated that the Subcommittee is looking for thumbs up from the Committee in order to move forward with these proposals. Both processes are based on the current four criteria for MUPs: (1) health status, (2) ability to pay, (3) accessibility, and (4) availability. The streamlined process would assume that the included groups meet criteria #1-3 and would need to prove criterion #4, although there was some disagreement about whether these groups should have to meet #4. The groups recommended to be included by the Subcommittee are:

- Groups named in the current designation rules
- Groups identified in Section 330 of the Public Health Service Act and named in current designation
- Groups named as underserved in health care legislation that specifically identify populations in need of health care access, coverage or service delivery; disability groups as defined in the Developmental Disabilities Act criteria or as defined by Medicare/Medicaid were some other examples.

The Committee had comments on the process in general and the groups recommended by the Subcommittee, though it seemed that the Committee liked the concept of streamlined MUPs.

Non-Streamlined Process

Dr. Wilson indicated that the non-streamlined process is for everyone not covered in the streamlined process. A population group would have to document that they meet all four criteria. The group would have to prove each criterion with national data, nationally accepted documentation (Healthy People 2020) or state/local data. While there are many enumerated advantages to this process, the challenges include impact testing, validity of locally collected data and the possibility of Healthy People 2020 not being updated/accepted in the future. The

Committee had comments on the definition of disparity provided by Healthy People 2020 and how to actually improve access to care once these groups have been identified. It was suggested that the issues presented be referred back to the Subcommittee. With the outstanding issues noted, the Committee gave approval to the Subcommittee to move forward with their proposals.

WORKGROUP REPORTS

Workforce Workgroup

Ms. Kuenning reported on the progress of the Workforce Workgroup (Attachment 3). She thanked and recognized the other members of the Workgroup for their time and hard work. She noted that they had two conference calls since February's meeting.

The first issue discussed by the Workgroup was how to count primary care provider FTE. The Workgroup recommended continuing using 40 hours for one FTE. Hours spent in non-clinical activities would be excluded from the count. The Workgroup also recommended excluding clinical teaching from the count, as well as rounds admitting, and discharge calls. The Workgroup recommended continuing the current practice on excluding time spent in particular practice sites, such as government and military facilities. The Committee had questions on the rationale for excluding rounds in the count. After clarification, the Committee reached consensus on the recommendations on how to count primary care provider FTE. In addition, the Committee agreed to count time spent mentoring resident physicians, but not non-physicians, in clinic settings.

The second issue discussed by the Workgroups was how to count providers serving the underserved. The issue is related to both geographic and population specific designations. The Workgroup discussed the sub-issue of the survey of individual provider practice. The Committee recommended continuing the current practice of excluding a percentage of primary care patient FTE based on questions about percentage of practice dedicated to populations facing specific barriers. The Workgroup recommended certain populations, including low income, Medicaid, linguistically isolated and special populations. They also discussed CME, vacation time, etc. The Committee reached consensus on the Workgroup's recommendations for individual provider practice.

The Workgroup discussed the sub-issue of claims-based counting of FTE. The current practice permits Medicaid FTE to be counted by treating every 5000 Medicaid claims for primary care visits as 1.0 FTE. The Workgroup recommends treating 3800 Medicaid claims for primary care visits as 1.0 FTE, though noting that they need to follow up on their recommendation. It was suggested to check with Dr. Goodman, who was not at the meeting. The Committee reached consensus on using 3800 going forward.

The third issue the Workgroup discussed was how to handle backout of designation linked provider capacity. The Workgroup recommends continuing to exclude NHSC and J-1/Conrad 30/ARC Visa Waiver. They also recommend excluding all State Loan Repayment Program providers. The Committee reached consensus on these three recommendations. The Workgroup recommended excluding medical providers at FQHCs/CHCs, FQHC Look-Alikes and RHCs. The Committee reached consensus on these three recommendations. In addition, the Workgroup recommended not excluding providers receiving Medicare incentive payments. The Workgroup still needs to discuss prioritization, implementation and threshold.

Facilities Designation Workgroup

Dr. Clanon reported on the progress of the Facilities Designation Workgroup (Attachment 4). The Workgroup was chartered at the last meeting. The general synopsis for facilities, discussed by the Workgroup, was that there are community facilities and correctional facilities. The Workgroup has only discussed community facilities. Dr. Clanon described three areas where the current designation is lacking: (1) safety-net, (2) magnet facilities, and (3) smaller state prisons/jails. She noted that the statutes are broad and lack any facility designation language on the MUA/P side. The proposal from the Workgroup is to preserve the elements of the current rule while adding the three new categories listed above. The Committee expressed concern about there being no mention of insufficient capacity in the workgroup report. There was discussion about keeping the notion of insufficient capacity but recognition that it needed to be defined. In addition, the Committee sought clarification on the Workgroup's proposals for safety-net and magnet facilities. It was mentioned that safety-net facilities were proposed in NPRM-2. The magnet facilities were described as having more than half of their members from a special populations group.

Barriers/Access Workgroup

Dr. Taylor reported on the progress of the Barriers/Access Workgroup. The Workgroup tried to focus on accessibility. They liked the four buckets of access barriers. JSI ran some tests for them but they have not seen the results yet. They will review them in their next breakout. They also had some discussion on ability to pay but further discussion is needed. To summarize their progress, health status is relatively set but they need to figure out how to set accessibility and ability to pay. There was a comment on the issue of double counting and a comment expressing agreement on the need to sort what goes into the status bucket and what goes into the determinants bucket or the access bucket.

WORKGROUP BREAKOUTS AND REPORTS

The Workforce Workgroup, Facilities Designation Workgroup, and Access/Barriers Workgroup met.

Dr. Clanon indicated that the Facilities Designation Workgroup had a good discussion but did not have anything to report to the full Committee because there was not enough time to make any recommendations.

Ms. Kuenning reported on the progress of the Workforce Workgroup. She explained that for purposes of prioritization, the Workgroup decided to include all providers, at least to do a strawman for the potential impact. The Workgroup wants to see what the inclusion of the providers would mean. The Committee agreed to move forward with testing this recommendation. They also discussed comparing the results of the P2P to Dr. Phillips' Quadrants to see how they fit. The Workgroup had quite a bit of discussion on thresholds. They are not sure whether the threshold topic belongs exclusively to their Workgroup. In some ways, they understand it to part of the final decision making after impact testing. In order to decide thresholds, more information is needed on the diagram. They discussed potentially using one diagram from HPSAs and another (of the same) diagram from MUPs. Then with regard to threshold, HPSA and MUA/P can be weighted differently. The Workgroup did not have any recommendations to make as of yet.

Dr. Taylor reported on the progress of the Access/Barriers Workgroup. He noted that JSI did the data runs/testing that they had asked. The Workgroup felt confident about JSI's mapping abilities. When looking at the test results, it appeared that the measures are picking up different things. They realized that they picked the four variables for JSI to run. So now they need to decide whether to run all the variables, which would be really complicated, and how to include the notion of community input.

*****Day Two*****

WORKGROUP BREAKOUTS AND REPORTS (2)

The full Committee regrouped earlier than planned to sort out what the existing workgroups have discussed. Some of the groups needed more time to discuss key issues; others needed to discuss issues with the full group before discussing further. The Committee decided to let the Facilities Designation Workgroup and Health Status Workgroup meet for a block of time before returning to the full group to discuss.

Health Status Workgroup

Dr. Taylor reported on the progress of the Health Status Workgroup (Attachment 5). He explained that the Workgroup's discussions weighted health status in two equal parts: the four variable SDI and direct measures of poor health. The four

variable SDI includes poverty (% below 100%), percent of household that are single parent households, percent of persons with less than a high school diploma and unemployment rate. The direct measures recommended by the Workgroup were (1) standardized mortality ratio, (2) diabetes prevalence (BRFSS), (3) low birth weight and (4) disability (BRFSS vs. ACS measurements). Dr. Taylor noted that the workgroup discussed two issues – prevention measures and ambulatory care sensitive conditions – that were important but thought to be part of access (rather than direct measures of health). Following Dr. Taylor's presentation, the Committee addressed some questions and concerns relating to pap smears vs. colonoscopies, using LBW in place of IMR, and the availability of BRFSS data compared to ACS data. The consensus from the Workgroup was that correlations and reports would be run by JSI to address some of these issues. They can look at the effects of changing the weights, factors, etc.

Facilities Designation Workgroup

Dr. Clanon reported on the progress of the Facilities Designation Workgroup. The current language for designating facilities requires that the facility prove it is undermanned. However, the rule is not clear as to how a facility can demonstrate undermanning. The Workgroup discussed factors that demonstrate insufficient provider capacity: FTE vacancy rates, encounter #s, waiting time in clinic, waiting time for appointments, P2P ratios, unmet need for population and maldistribution of providers.

REVIEW OF DRAFT PROGRESS REPORT TO SECRETARY

The Committee reviewed the draft progress report to the HHS Secretary (Attachment 6) and suggested a couple of word changes. With the minor revisions, the Committee agreed to send the report to the Secretary. With the Committee now requesting an extension to October 31, 2011, there was an agreement for the Committee to continue to work as hard as they would have been if the deadline was still July 1, 2011.

DISCUSSION ON WEIGHTING AND COMBINING COMPONENTS

Mr. Salsberg began the discussion on weighting and combining components. He discussed possible recommendations for weighting health status, barriers and population-to-provider ratio. Dr. Larson, referring to the requirements in MUA/P/ legislation suggested ability to pay be added to the three components already listed (health status, accessibility and capacity). This fourth category was added to the chart. Mr. Holloway also presented his conceptual diagram for weighting (Attachment 7). The axes of the diagram are the decile health status and provider capacity. The Committee agreed to allow a small group to further discuss this issue. That group and the Barriers Access Workgroup met for 90 minutes.

WORKGROUP BREAKOUTS AND REPORTS (3)

Barriers Access Workgroup

Dr. Taylor reported on the progress of the Barriers Access Workgroup (Attachment 8). The group recommended five measures of PCSA data to test:

- Population density
- Percent uninsured
- Linguistic Isolation/limited English proficiency
- Travel time (e.g., to nearest PCSA)
- Percent non-white (white v. non-white, with and without Hispanic)

They were interested in seeing how they correlated and how they look across the country.

The group also chose three measures to keep on the radar and consider local data collection:

- Discrimination measures (e.g., hate crimes)
- Physical/disabled
- State-based input

There were questions raised about whether there should be some boundaries on valid local input and how any of the programs linked to the designations would affect any of these issues.

Ms. Kuenning added that the selected access barriers potentially may not be representative and valid indicators of need in more rural homogeneous states. She agreed that for purposes of impact testing we could test these, but asked the Subcommittee to consider alternative indicators that she would forward on to the Subcommittee before the next meeting.

Dr. Taylor explained that relevant areas would be provided with additional points based on the bottom three measures. He noted that there is plenty of work to be done. The Committee had questions about using hate crime data and population density. There were also questions on using PCSAs instead of RUCAs and whether the measures chosen work for every state. There was a request for JSI to do a separate run just for Hispanics. In addition, travel time was clarified as measured from the population center to the nearest PCSA with a proper number of providers. After much debate, the Committee agreed for JSI to test the Workgroup's recommendations, provided that the measures chosen are revisited following testing.

Weighting and Combining Workgroup

Mr. Salsberg and Mr. Babitz reported on the discussion of the Weighting and Combining Workgroup. The Workgroup had a lively discussion but did not reach consensus on recommendations to the full Committee. More discussion is needed for the Workgroup.

During the discussion with the full Committee questions were raised about the appropriateness of Ms. Kuenning's diagram of components. A Committee member suggested that the diagram should not include barriers because it creates double counting. There was disagreement with this suggestion, especially because of all the work the Access/Barriers Workgroup has completed in the last three months and the fact that Access/Barriers is a category required in the MUA legislation. There was a comment that the population-to-provider ratio is nothing more than an assessment of access (or barrier to access). Essentially, the population-to-provider count is just another barrier. It was suggested that the Access/Barriers Workgroup include a couple of direct access measures in their testing, which they agreed to do. Ambulatory Care Sensitive Conditions (ACSC) and Usual Source of Care (USC) were suggested for consideration.

DAY TWO WRAP UP

The Facilities Designation Workgroup agreed to meet for an hour in the morning before the full meeting begins on Day Three.

Ms. Sylvester noted that Nicole Patterson, HRSA, emailed the Committee a copy of the minutes with edits and that a PDF copy was available, as well. She also requested that the Committee members email all presentations to Ms. Patterson so that she can maintain a complete record.

*****Day Three*****

APPROVAL OF SUMMARY MINUTES (2)

After reviewing the February meeting minutes with edits, the Committee voted to approve the minutes with all suggested edits.

RATIONAL SERVICE AREA PRESENTATION

Mr. Holloway gave a presentation entitled, "Service Areas That Are Rational for the Delivery of Care" (Attachment 9) using his work in Colorado as an example. He described the difference between "rational service area" and "contiguous area." He explained that the Committee needs to decide what units of boundaries to use. Census tracts are the basic unit. He described acceptable constructions for rational service areas. They can be constructed of a single county, multiple counties, sub-counties and parts of adjacent counties. The areas must be contiguous, without overlap or interior portions carved out. An

area is “rational” when there is a population with similar demographic, health status or socioeconomic characteristics; when it is distinctive from contiguous areas by the same population characteristics; when it is isolated from health resources (because of poverty, racial/ethnic composition, language, etc.); and/or when there are significant physical barriers to travel to contiguous areas (such as mountain ranges, bodies of water, national parks, etc.). Mr. Holloway noted the use of the contiguous area analysis. Such an analysis distinguishes the rational service area population from the surrounding populations. The analysis also describes how contiguous areas are considered unreasonable areas to acquire care for the rational service area population. The only real debate the Committee has, according to Mr. Holloway, is which unit of geography to use: census tracts or zip codes.

The Committee discussed the use of zip codes compared to census tracts. Some members noted that zip codes do not always represent a population but can represent a thing (i.e., building, post office, etc.). Mr. Holloway was asked if it was possible to use both zip codes and census tracts, allowing the population to choose. He explained that this would cause overlap. A Committee member described how census tracts could be deconstructed and rebuilt into zip codes. Other Committee members noted how more databases appear to relate to census tracts rather than zip codes. There was also discussion on the use of PCSAs. The Committee sought clarification on whether the Committee defaults to any states with their own rational service area designation. Andy Jordan, HRSA, explained that currently only 5 or 6 states have their own rational service areas; and the last one to be updated was about eight years ago. The Committee agreed that impact testing would have to be a combination of PCSAs, counties and census tracts, as well as existing designated areas and state defined RSAs.. To further the discussion, the Committee decided to form a Rational Service Area Workgroup.

FACILITIES DESIGNATION WORKGROUP

Dr. Clanon reported on the progress of the Facilities Designation Workgroup (Attachment 10). Their proposal applies to non-correctional facilities. To meet the criteria, the facility must be (a) public or non-profit private, and (b) ineligible for a geographic or population HPSA. To qualify for the HPSA designation, the facility must meet all of the following:

1. The facility must be open to everyone, regardless of coverage or ability to pay
2. The population served by the facility is
 - a. More than 50%* comprised of a special population (expressly listed on the attachment); or
 - b. Comprised of the applicable percentage of low-income individuals (<200% poverty)
 - i. Metro – 50%

- ii. Rural – 40%
 - iii. Frontier – 30%
3. The facility must demonstrate insufficient capacity (the method of which is still under discussion)

*This percentage is still under discussion

There was a question on whether the 50% special population service requirement meant serving only one listed population or a combination of populations. Dr. Clanon said that the concept was for the facilities to be serving one particular population. The Workgroup will consider the wording of the requirement to reflect the concept. There were questions about the number of magnet clinics nationwide, wording the language to narrow down the criteria/qualifications and the relationship between MUA and MUP.

The discussion briefly turned to correctional facilities. The Committee decided to form a Correctional Facilities Workgroup.

PRESENTATION ON IMPACT TESTING

Mr. Turer gave a presentation entitled, “Overview of Impact Testing Plan” (Attachment 11). He explained that the goal of impact testing is to model the likely result of the proposed rule. This would demonstrate the implications on current and proposed populations. Impact testing would be primarily based on nationally available data. The process would include scoring potential service areas, producing statistics/maps that estimate the impact of the new rule, and running sensitivity analyses. The results would reveal the overall and relative impact of the new rule for the tested area. Mr. Turer explained that impact testing has many values but is an imperfect process: it is mostly at the geographic level; there may be a way to estimate Low Income or Medicaid population testing at least for the P2P component. There are not data for the facilities in general, and national data is never as good as local data for providers in particular.

PUBLIC COMMENT

The Committee was provided with written comments from the following individuals:

- Mary Clark (Attachment 12)
- Jean Public (Attachment 13)
- Diane Turner (Attachment 14)
- Mary Looker, Chief Executive Officer, Washington Association of Community & Migrant Health Centers (Attachment 15)

Mary Jo Goolsby from the American Academy of Nurse Practitioners expressed that the Committee’s discussion and dialogue on nurse practitioners is critical

(Attachment 16). She noted that 89% of nurse practitioners are prepared in primary care. She reminded the Committee that as they perform impact testing there are states with very rural areas, which are excellent practice environments for nurse practitioners.

UDS MAPPER DEMONSTRATION

Dr. Phillips demonstrated the issue of Rational Service Areas in the UDS Mapper. He took FQHC patient data by zip code and constructed service areas, determined by centers with 10 or more patients in that area. He then contrasted the UDS mapper with PCSAs in the service areas. He noted that there were more PCSAs on the map than the areas with zip codes.

DEVELOP AGENDA FOR APRIL MEETING AND WRAP UP

Mr. Salsberg facilitated the discussion on the agenda for the meeting in April. The Committee decided that there are six small groups that need to meet before April's meeting:

1. Subpopulations Subcommittee
2. Facilities Designation Workgroup
3. Rational Service Area Workgroup
4. Ability to Pay Workgroup
5. Correctional Facilities Workgroup
6. Weighting/Combining/Thresholds Workgroup
7. Data Workgroup to further investigate utilization of American Community Survey data

Mr. Salsberg ran through the roadmap (Attachment 1) and noted that the items on the list for March were completed. The items on the list for April would comprise the agenda for April's meeting with the addition of consensus on rational service areas, barriers and ability to pay. Mr. Salsberg noted that not all meetings in further months (from June forward) have to be face-to-face; however, some Committee members expressed concern about productivity without face-to-face meetings.

Committee members expressed their interest in serving on the newly formed workgroups:

- Correctional Facilities Workgroup
 - Ms. Kornblau (Chair)
 - Mr. Brooks
- Rational Service Area Workgroup
 - Mr. Holloway (Chair)
 - Dr. Phillips
 - Dr. Babitz

Health Resources and Services Administration
Negotiated Rulemaking
Designation of Medically Underserved Areas/Populations & Health Professional Shortage Areas

- Mr. Supplitt
- Dr. Goodman
- Mr. Taylor
- Ability to Pay Workgroup
 - Dr. McBride (Chair)
 - Mr. Camacho
 - Dr. Rarig
 - Mr. Scanlon
 - Dr. Larson
- Data Workgroup on ACS
 - Dr. Larson
 - Dr. Rarig

Because most Committee members expressed an interest in being part of the Combining/Weighting/Threshold Workgroup, Mr. Salsberg volunteered to chair further discussion of this topic during the period between face-to-face Committee meetings.

The June meeting will be held on June 22-24, 2011. Meeting locations are currently being researched, including alternative Crystal City, Virginia locations.

JSI will canvas the Committee's availability to meet in the months of July, August, September and October.

The meeting adjourned on March 10, 2011 at 2:28 p.m.

**MARCH 8-10, 2011 SUMMARY MEETING MINUTES
ATTACHMENTS**

1. HPSA and MUA/P Negotiated Rulemaking Revised Draft Road Map (PowerPoint)
2. Medically Underserved Populations – Streamlined and Non-Streamlined Processes
3. Summary of Workforce Workgroup Conference Call on Outstanding Decisions
4. Facilities Designation Workgroup – Proposal Summary (3/8/11)
5. Proposal for Health Status Portions of the New MUA Process to be Tested
6. Draft Progress Report to HHS Secretary
7. Weighting and Combining Components – Conceptual Diagram (Excel)
8. Health Status Workgroup – Access/Barriers Decision Points (3/9/11)
9. Service Areas that are Rational for the Delivery of Care (PowerPoint)
10. Proposal for HPSA Facility Designation (3/10/11)
11. Overview of Impact Testing Plan (PowerPoint)
12. Written Comment from Mary Clark
13. Written Comment from Jean Public
14. Written Comment from Diane Turner
15. Written Comment from Mary Looker, Chief Executive Officer, Washington Association of Community & Migrant Health Centers
16. Written Comment from Mary Jo Goolsby, Director of Research and Education, American Academy of Nurse Practitioners