

SUMMARY MEETING MINUTES

April 13-15, 2011

The Negotiated Rulemaking Committee (hereafter the “Committee”) was convened for its seventh meeting at 9:16 AM on April 13, 2011 at the Legacy Hotel, Rockville, Maryland. 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
Lolita McDavid
Alan Morgan
Ron Nelson
Charles Owens
Robert Phillips*
Alice Rarig
Edward Salsberg
William Scanlon
Sally Smith
John Supplitt
Don Taylor
Elizabeth Wilson

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

† Participation via teleconference for all or parts of the meeting

WELCOME REMARKS FROM HRSA

Dr. Marcia Brand, Deputy Administrator of HRSA, thanked the Committee on behalf of Dr. Mary Wakefield and HRSA. She expressed appreciation to the Committee for the time they have contributed to this process through meetings and conference calls.

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 March's meeting and submitted edits to Nicole Patterson, HRSA. The Committee approved all proposed edits from Committee members except an edit to attach the results of the straw poll on weighting and combining to the minutes.

STATUS OF REPORT TO SECRETARY

Mr. Salsberg discussed the status of the Committee's Report to the Secretary. He indicated that the Secretary has received the report but must also receive a transmittal letter from the Committee before she can respond. The transmittal letter was passed around the table for each Committee member to sign.

Mr. Salsberg also explained that once the work of the Committee is complete – a final report is produced – there will be a clearance process in HHS and a 90-120 day period of review in OMB. Mr. Salsberg estimated that the actual date for publishing the new regulations might be April, 2012.

The Committee also had an in-depth discussion on the potential change in number of designated areas. Some Committee members explained that the process should be targeting high need areas and be as data driven as possible. An assumption is that the needs are great but resources are limited, although recent legislation has increased resources considerably. Others noted that the program managers had regularly targeted resources to need, in accordance with the variable resources available, over many years, and suggested that designations should identify all areas and populations with a need, not just the greatest need.. There was discussion about whether the decisions should all be made within the program or if there would be less decision making at that level. It was also stressed that the Committee's intent is to alleviate relative need. Some members stressed that the job of the Committee is to set designation regulations, and that the the Committee has no say on programmatic decisions

or resource allocation. There was also discussion about the prioritization process and the use of designations by CMS.

SUBCOMMITTEE/WORKGROUP MEETINGS

Four subcommittees and workgroups met for 90 minute sessions: Facilities, Barriers, Populations, and Ability to Pay.

REVIEW OF ROADMAP

Mr. Salsberg provided a brief overview of the roadmap. The Committee has come far and determined a number of elements from the different components. The Committee now needs to think through what works best at committee and subcommittee levels. Mr. Salsberg explained that the months of July, August and September have been reserved to have a dialogue about test results and assure all the pieces fit together. Whether this dialogue will be face-to-face or by conference call has not been decided yet.

SUBCOMMITTEE/WORKGROUP REPORT OUTS

Workforce Workgroup

Mr. Hawkins reported on the progress of the Workforce Workgroup. He said there are two issues they need to clarify and that he can report on them at a later point during the meeting. He explained in detail the issues discussed by the Workforce Workgroup (Attachment 1). The issues included how to count primary care provider FTE, how to count providers serving the underserved and how to handle backout of designation linked provider capacity. Some of the decisions made by the Workforce Workgroup include (1) continuing to count one FTE as 40 hours; (2) continuing to exclude non-clinical activities in the count of hours; (3) continuing to exclude NHSC, J-1/Conrad 30/ARC Visa Waivers; (4) excluding State Loan Repayment Program, Federally Qualified Health Center, and Rural Health Clinic providers; and (5) not excluding Medicare 10% beneficiaries.

The Committee raised questions about whether the Workgroup thought to consider bilingual providers when they discussed providers offering interpretation services to linguistically isolated populations. There were also concerns about the Workgroup's discussion on claims-based counting of FTE, particularly the ratio and whether JSI is going to use claims-based counting in their test runs. In addition, there was a discussion about the weighting of certified nurse midwives. The earlier agreement by the Committee was to weight certified nurse midwives at 0.25; however, the Workforce Workgroup is going to discuss the issue again, weigh the pros and cons and decide if they want to change their recommendation.

Access Subcommittee

Dr. Taylor reported on the work of the Barriers/Access Subcommittee. He explained that the group looked at a number of measures including discussion of whether to create an index. They discussed the differences between area measures and individual data.

Dr. Taylor suggested that the efficiency of subcommittees might have ended and that decisions need to be made within the full Committee. The Committee discussed this further and was in disagreement about whether subcommittees are as useful now.

The Committee also discussed the helpfulness of having an outline for HPSAs that list all the components. The task was delegated to a new subcommittee. The outline will be prepared to present at the May meeting. Dr. Goodman will chair the Outliners Subcommittee.

Facilities Workgroup

Dr. Clanon reported on the progress of the Facilities Workgroup. She reminded the Committee that there is no MUA/P version of a facility – there is only a facility designation under HPSA. In the current rule, the facility designation has two functions: (1) not meeting other criteria for designation and (2) being a facility not located in a HPSA but serving people that come from HPSAs. The workgroup proposes keeping (2) as presently defined and Dr. Clanon presented the updated proposal for the facility designations (Attachment 2). For the HPSA designation, the facility must be ineligible for a geographic or population HPSA, demonstrate insufficient capacity, and meet three qualifying characteristics. The qualifying characteristics include:

1. Being a public/nonprofit private facility or a rural health clinic
2. Being open to everyone, regardless of coverage or ability to pay, and
3. EITHER
 - More than 50% of primary care services are provided to a special population of individuals with HIV, developmental disabilities, LGBT, LEP, Native Americans, Native Hawaiians or Alaska Natives, OR
 - Of the population served, low-income individuals (<200% FPL) or a combined total of individuals who are uninsured, those covered by Medicaid or state Children's Health Insurance Program or individuals receiving services through the Indian Health Services' tribal health programs, must constitute at least:
 - 40% metropolitan
 - 30% rural
 - 20% frontier

MUA/P designations do not include a facility option so the Workgroup explored the idea of designating the population served by a location if it obtained an HPSA Facility designation. For such an MUP designation based on the user population served by a Facility HPSA, the facility must be ineligible for a geographic or service area based population HPSA, meet one of two qualifying characteristics and demonstrate continued service to underserved populations. The qualifying characteristics are (1) being a federally qualified health center, or (2) demonstrate compliance with all other FQHC requirements in Medicaid (Section 1905(l)(2)9B)). Facilities can demonstrate their service to underserved populations by meeting the third qualifying characteristic for HPSA facility designations, described above.

A Committee member noted that the term “American Indians” also includes Alaska Natives and is often shorthanded as AI/AN.

The Committee discussed whether to have “magnet clinics” for population designations and whether a facility can include more than one population to reach the 50% threshold. Both issues will be discussed further in the Workgroup. There was also discussion on insufficient capacity. The Workgroup agreed on a menu of criteria for demonstrating insufficient capacity with the thresholds to be determined. The criteria includes (a) schedule hours per provider, (b) P2P ratios defined as patient panel size (based on the number of patients seen in the last year), and (c) long wait time for first appointment or closed to new patients.

Dr. Clanon briefly discussed the Workgroup’s areas of consensus and then delved into the outstanding issues for the Workgroup related to correctional facilities. The outstanding issues include (1) county jails are not included on the list, (2) the current regulations specifically reference medium and high security facilities, (3) the threshold of 250 prisoners or more, and (4) in some jurisdictions, correctional facilities have intentional clusters of ill inmates. The Workgroup had two experts speak to them during their break out session including representatives from the Bureau of Prisons and the National Institute of Corrections. In addition, the Director of Corrections in Montgomery County, Maryland spoke with the group. The Workgroup has a list of questions and will have a subgroup working with the experts to answer their questions and gain more information.

Populations Subcommittee

Dr. Wilson reported on the work of the Populations Subcommittee (Attachment 3). She reviewed the revised streamlined process for MUPs. The Subcommittee revised its recommendations on which groups would benefit from the streamlined process. They removed Medicaid recipients, low income and linguistically isolated from the list. They settled on criteria stating that to be named to the streamlined MUP list, a special population had to be associated with current HRSA legislation which could verify two of the four MUA/P/ criteria: health status

issues and barriers to care. This placed six groups, at the present time, on the tentative list and establishes a system for adding or removing special population groups in the future. John Snow, Inc. (JSI) has been tasked with looking at poverty levels for each of these groups as a way to speak to the criteria on ability to pay and to help the group determine a reasonable threshold rule in relation to poverty status for any streamlined group. Some groups may fall out based on JSI's analysis. On the other hand, re-evaluation of LEP populations and a further search for associated HRSA-related legislation might put that group back into the streamlined process.

The Subcommittee decided that Section 330 groups (migrant/seasonal farmworkers, homeless individuals, and residents of public housing) would be assumed to meet all four criteria: health status issues, access barriers, inability to pay for services, and lack of provider capacity. They would only need to prove that a sufficient number of the relevant 330 population exists within a RSA. All of the other streamlined groups would need to demonstrate similar number presence plus lack of (or inadequate) provider capacity. The recommendations for the non-streamlined process for special populations not pre-identified as meeting the criteria for streamlining were revised slightly. It is expected these special population groups will meet the criteria for MUA designation utilizing data to that special population. Criteria could be proved through national, state or local data. Additionally the Subcommittee suggests an opportunity for applicants to use proxy data when no local figures are available. Finally, the Subcommittee assumes the Facility Workgroup is dealing with that designation category and has been told that the Governor's exception for MUA/Ps is set in legislation. Therefore, the Subcommittee will do no further work in this area.

The Committee's discussion following Dr. Wilson's report included whether the Subcommittee considered the possibility of three categories and the tests that JSI is going to run for the Subcommittee.

DISCUSSION ON IMPLEMENTATION

The Committee discussed the implementation of the new criteria. There was some discussion about whether to have both old and new regulations exist for a period of time, creating an overlap and phase out implementation process. The Committee also discussed the update cycle and whether it should coincide with the ACS estimates, which occur every 5 years. Setting the update cycle at the appropriate interval would spread out the implementation process. There was also a suggestion to have pilot states that would implement the new criteria as a test run (a few Committee members volunteered their states) or deal with the expected flood of designations on a regional basis taking the oldest first. The Committee discussed what sort of timeframe would be appropriate for the renewal process of MUA/Ps. The Committee decided to form a subcommittee to further discuss these issues.

WEIGHTING AND COMBINING

Fred Decker, HRSA, gave a presentation entitled, “Examples of Different Models for Scoring Components in HPSA and MUA Designation: Discussion Paper for the Negotiated Rulemaking Committee” (Attachment 4). Mr. Decker noted that the presentation was a condensed version of the document that was given to the Committee (Attachment). In developing a model, there are three steps: (1) group indicators into components, (2) develop a scoring method for each component, and (3) develop a method for combining the component scores. Mr. Decker discussed the options and issues for component scoring methods. He also described three models for combining individual component scores for determining designation as HPSA and/or MUA. The first model was a generic index model and the other two models were sequential models. There was Committee discussion about the benefits and disadvantages of each model. In addition, there was a suggestion to add a fourth model.

Mr. Holloway presented his model to the Committee (Attachment 5). The model, which charts three categories of designations, is based on the relationship of provider capacity to health status (in deciles). The Committee discussed the pros and cons of Mr. Holloway’s model, as well.

The Committee proposed that the Data Subcommittee look at the various models and bring back recommendations to the group. Their charge is to explore alternative methodological approaches for scoring and combining the measures and factors that people are interested in, keeping the statute in mind.

PRELIMINARY P2P RATIO ANALYSES

Mr. Turer gave a presentation entitled, “Preliminary Population to Provider Ratio Analyses” (Attachment 6). He discussed the three objectives of the analyses: (1) demonstrate the impact of adding non-physician providers, (2) assess the impact of age-gender adjustment on population, and (3) show the preliminary numerical and geographic distribution of Population-to-Provider ratios. He described the methods used by JSI to perform the analyses. They included using, to the degree possible, Committee decisions on the counting of provider FTE with current data. The adjusted base provider counts totaled 275,463. Mr. Turer presented the results of the analyses using graphs. In addition, he discussed the findings by plotting them on maps. Some Committee members expressed concern that the results show the effect of offering health services only through non-physician providers in some rural areas. Questions were raised on whether this adequately met need for capacity and the effect this might have on continued designation of many rural areas. Mr. Turer explained that the databases they had to use for non-physician providers did not show discounts for work in specialty care, less than full-time practice or time spent in other than primary care

and so may inflate the effect of adding these provider types to the counts. Members indicated they would try to gather information to more accurately discount NPs and PAs for time not spent in primary care, and Mr. Turer indicated he would pursue receipt of more detailed databases as promised by NP and PA Associations. He also said he would provide the Committee with detailed tables identifying the counts in rural versus urban and suburban areas.

SUBCOMMITTEE/WORKGROUP REPORT OUTS (2)

Barriers Workgroup

Dr. Wilson reported on the progress of the Barriers Workgroup (Attachment 7), from the history of the Workgroup's examination of potential access barriers. This included development of a comprehensive list of barriers which were grouped into four categories. From there, the Workgroup narrowed the list down to five final risk factors and asked JSI to look at data on those five factors. JSI performed four data runs that focused on different correlations. Dr. Wilson discussed the different data runs and results. The first data run looked at the prevalence of the five factors by county and population; the results were half-expected and half-surprising. The second data run looked at the correlation between the five factors and a measure for usual source of care at the county level which only covered 68% of all counties. This showed a low correlation for most factors, but the Workgroup acknowledged that the measurement source was insufficient. The third data run created new maps that show weighting possibilities. The fourth data run looked at the correlation between the five factors and ambulatory care sensitive hospitalizations, again using a data source that only covered a small fraction of counties throughout the country. Dr. Phillips was asked to discuss the results once Dr. Wilson finished reporting. Finally, Dr. Wilson briefly described the current issues, including the "top up" idea, the index vs. menu method.

Dr. Phillips discussed the desire to have JSI perform an additional data run looking for correlations between access and these identified barriers. This process would look at risk factors by area and then by individual. The risk factors include LEP, non-white, Hispanic, travel time, uninsured, and population density. He then suggested that the four factors utilized in the SDI under health status also be correlated. These include 100% of poverty, employment, less than high school education and single parent households. Correlations would be performed by looking at data from the MEPS, the ACSC, BRFSS and other possible data sources. It was suggested that the American Community Survey could be used to examine area data, while analysis on individual data would come from the other sources. He expressed the idea that such an analysis would build confidence in using these factors. Dr. Phillips said such an analysis might show that there was no need to add other barriers as the inclusion of the SDI factors might cover the issue of access sufficiently.

Several Committee members expressed concern about drawing final conclusions from such correlations, feeling that the data sources available through which to prove access were insufficient; e.g., only covering the Medicare population or not sufficiently inclusive of particular populations. Some factors would not be included at all in these databases, such as travel time. There was also discussion about the usefulness of usual source of care and whether there is a correlation with usual source of care and the other listed factors. Last, Committee members referred to the large body of evidence that pinpointed the identified factors as barriers to care as justification for their inclusion in the designation process. The Barriers Workgroup agreed to examine the data runs developed by JSI and discuss these issues further.

Rational Service Areas Workgroup

Mr. Holloway noted that the Workgroup had nothing to report as they did not meet the previous day.

American Community Survey Workgroup

During the weeks between the March and April meetings, Dr. Larson and Dr. Rarig researched some questions which have arisen concerning utilization of data from the American Community Survey (ACS). Dr. Larson reported that they had calls with two experts: (1) Alfredo Navarro, Assistant Division Chief for ACS Statistical Design with the Census Bureau, and (2) Greg Williams, recently retired Demographer for the State of Alaska. Dr. Navarro stressed two points: (1) whenever ACS data are used to compare areas of different sizes, the same type of period estimates should be utilized, and (2) the measure of uncertainty (i.e., margin of error) should be utilized in some manner whenever ACS data are included. Dr. Larson and Dr. Rarig noted the Census Bureau will begin basing sample size and statistical analyses on 2010 Census population counts starting with the publication of 2010 ACS data in September 2011. They also mentioned that they were looking into the potential for HRSA to request special data runs that might group ACS statistics into existing state planning RSAs, existing HPSA and MUA areas and grouped Census Tracts.

Ability to Pay Workgroup

Dr. McBride reported on the progress of the Ability to Pay Workgroup (Attachment 8). The Workgroup had three areas of focus: poverty, unemployment and uninsurance. In the area of poverty, the Workgroup explored the idea of incorporating cost of living measures in some way including examining new methods being developed by the Census Bureau or computing indices in some other manner. However, no method was found to be feasible at this time. The Workgroup suggested that the subject should be left open as an option for use in the future when and if sufficient methodologies become available. In the area of unemployment, the Workgroup suggests using the

percent of population not employed as an alternative to any current measurement of the unemployment rate, which results in undercounting. In the area of uninsurance, the Workgroup sees no option available but to use ACS measures of uninsurance as these data become available.

SUBCOMMITTEE/WORKGROUP MEETINGS (2)

The Populations Subcommittee, Rational Service Areas Workgroup, Outliners Workgroup and Weighting Subcommittee met for the remainder of the day.

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

SUBCOMMITTEE/WORKGROUP REPORT OUTS (3)

Outliners Workgroup

Mr. Supplitt reported on the progress of the Outliners Workgroup. The Workgroup agreed to draft an outline of what the HPSA rule would look like in its basic format. The outline will contain headings of the existing rule. Each heading will list the current language and the language the Committee has discussed as a group thus far. The thought is that by comparing the current versus proposed language, the Committee will be able to identify what areas need more progress. If the Workgroup keeps it simple, the outline will be meaningful and available for the May meeting.

Populations Subcommittee

Dr. Wilson reported on the work of the Populations Subcommittee. They met the previous day to discuss designation specifications for Special Population HPSAs. The discussion concerned: (1) which populations should be included and criteria for making such decisions, (2) whether to include P2P adjustments and how these might be determined, and (3) the relationship between Special Population HPSAs and MUPs. Mr. Salsberg asked how much progress they think they will make by the May meeting. Dr. Wilson said that they hope to bring the streamlined process to the Committee in a finalized form. They have asked JSI to run some tests for the streamlined process. The non-streamlined MUP process is on hold awaiting decisions by the full Committee on MUA designations. The Subcommittee discussion on Special Population HPSAs is ongoing.

Rational Service Areas Workgroup

Mr. Holloway reported on the progress of the Rational Service Areas Workgroup. They met the previous day and agreed to meet once a week until the May meeting. They began their discussion with what defines an RSA. They agreed that it should represent the following characteristics:

- Geography
- Continuity
- No overlaps (except a MUA/HPSA overlap)
- No interior portion should be carved out
- Interrelated with commuting patterns, acquisition of care, demographics, health status, socioeconomics, etc.
- Distinguished from nearby service areas

They also discussed the size of the population and whether there should be a practical floor or ceiling. They discussed using 1,000 as a working number for the floor but did not discuss a working number for the ceiling. They failed to create rough outlines for how to delineate a maximum and minimum geographic time. They suggested that for travel time, they could use one of the two measurements for travel radius.

The Committee discussed how individual states can use their own RSAs and how to find more information about the methods of those states that do currently use their own.

Weighting Subcommittee

Dr. Rarig reported on the progress of the Weighting Subcommittee. The Subcommittee pulled together a list of possible viable variables that could be considered for testing to determine possible weights. No final decisions were made. Their discussion was not focused on either HPSA or MUA/P and they made sure to keep the statute in reference. During Committee discussion four components were proposed: SDI, direct health measures, barriers and population-to-provider ratio. A Committee member suggested including ability to pay as a separate component making a total of five components. There was also discussion about what factors fit into the components, whether to allow communities to choose their own health indicators and the threshold for activities of daily living. There was discussion about a menu approach versus an index approach. In addition, there was a reminder about the importance of documenting the process of how the Committee reaches all its decisions.

It was requested that a draft of the results of the Weighting Subcommittee and the Outlining Group be forwarded to the entire Committee with enough time for all members to consider the suggestions prior to the next full Committee meeting.

American Community Survey (ACS) Workgroup

Dr. Larson suggested that there are two things she and Dr. Rarig can continue working on regarding utilization of ACS data. First, they can further explore the idea of special data runs with Dr. Navarro and others from the Census Bureau. The first such runs might be related to implementation testing. Dr. Rarig noted

they are trying to find the most efficient, cost effective way to develop the data which will be needed. Second, Dr. Larson and Dr. Rarig can develop proposals for ACS data given the issues with allowing applicants to use both one- year and five-year estimates, and address data reliability by incorporating utilization of the confidence interval the ACS offers with every data point. Dr Larson and Dr. Rarig indicated they would present their findings and proposals to the Committee in May for further discussion.

P2P Ratio Discussion

There was also Committee discussion on whether to use two separate population-to-provider ratios: one for only MDs and the other for MDs/NPs/PAs. The Committee noted that they have data to use both. There was also mention that the UDS standard is to use two. The Committee decided to use one ratio for testing but will revisit this decision if necessary.

DISCUSSION ON IMPACT TESTING

Mr. Turer led the discussion on impact testing by highlighting some key points from a prior presentation (Attachment 9). Andy Jordan, HRSA, suggested the conversation might concern how the Committee will know when the testing produces results that seem reasonable. Mr. Turer explained the outputs of impact testing and how a lot of people are probably concerned with the relative impact. He also explained the utility of impact testing. The Committee discussed other ways to measure the impact, including standards coined the “Gold Standard” and “Flint Standard.” Options offered were comparing to the RWJ County rankings, looking at the SDI areas with the lowest scores, the areas with the highest poverty, lowest ratios, and poorest health status and outcomes to see if they were being identified in the process. Looking at areas where free clinics now operate that are not designated was another suggestion. There was also discussion of the importance of using existing designations as a way to measure the impact.

CURRENT SUBCOMMITTEES AND WORKGROUPS

Ms. Sylvester confirmed that the following subcommittees and workgroups are still being utilized:

- Barriers/Access – Ms. Hirota (chair)
- RSA – Mr. Holloway (chair)
- Outliners – Dr. Goodman (chair)
- Data/Weighting – Dr. Rarig (chair)
- Facilities – Dr. Clanon (chair)
 - Corrections – Mr. Brooks (chair)
- Implementation – Mr. Owens (chair)
- Populations – Dr. Wilson (chair)

- Workforce – Ms. Kuenning (chair)

PUBLIC COMMENT

The Committee was provided with written comments from the following:

- Annette Kowal, Chief Executive Officer and Ross Brooks, Chief Operating Officer, Colorado Community Health Network (Attachment 10)
- Jean Public (Attachment 11)
- 20 comments from concerned U.S. citizens who are graduates of foreign medical schools (Attachment 12)

David Haltiwanger, from Chase Brexton Health Services in Baltimore, Maryland, stressed the need for research on health disparities in the LGBT community. Chase Brexton was the first LGBT health center to become a FQHC and has mentored other health centers to also reach that milestone. Even though Chase Brexton considers themselves LGBT-friendly, only 2,000 patients of a total 17,000 are LGBT. Their patient mix is 1/3 uninsured, 1/3 Medicaid and 1/3 commercially insured. The Committee engaged in a rich discussion with Mr. Haltiwanger on the impact of being a FQHC and the Committee's current proposal for "magnet clinics."

Ms. Kornblau mentioned that the National Health Interview Survey had a lot of questions on disability and was wondering why she was told the survey was not good enough to use as a data source. She noted that MEPS is actually drawn from the National Health Interview Survey, and the Committee is willing to use MEPS while downplaying the data source (National Health Interview Survey) from which it is drawn. Dr. Rarig noted that data from MEPS and the National Health Interview Survey are highly appropriate when trying to figure out the national norm. She reminded the Committee to send any data sources or requests to the Data Subcommittee or JSI. There was also a question about the concept of a community profile as presented earlier and whether this was still under consideration.

The Committee wondered why they received so many comments from foreign medical graduates who cannot find residencies. It was explained that Ms. Patterson's contact information was given out at a foreign medical graduate forum (for U.S. citizens) under the false impression that the Committee is working on that issue.

Mr. Holloway asked that members representing PCOs and PCAs pay particular attention to the comment from the Colorado Community Health Network because it discusses an issue of productivity related to the Committee's proposed weighting of providers.

NEXT MEETINGS

The May meeting will be held on May 18-20, 2011 in Rockville, Maryland at the Legacy Hotel. The June meeting will be held on June 22-24, 2011 with a location to be determined later. Committee members were asked to hold off on making any travel arrangements for May and June until the logistics funding is finalized.

JSI has polled members of the Committee for their availability in July, August and September. All members have not responded so the dates will not be finalized until all responses are received.

The meeting adjourned on April 15, 2011 at 2:10 p.m.

**APRIL 13-15, 2011 SUMMARY MEETING MINUTES
ATTACHMENTS**

1. Summary of Workforce Workgroup Conference Call on Outstanding Decisions
2. Notes from Facilities Designations Conference Call (April 8, 2011)
3. Medically Underserved Populations – Streamlined and Non-Streamlined Processes
4. Examples of Different Models for Scoring Components in HPSA and MUA Designation: Discussion Paper for the Negotiated Rulemaking Committee (PowerPoint)
5. Weighting and Combining Model (S. Holloway) (Excel)
6. Preliminary Population to Provider Ratio Analyses (PowerPoint)
7. Barriers Workgroup – Risk Factors for Access Problems (April 14, 2011)
8. Ability to Pay Workgroup Report (PowerPoint)
9. Overview of Impact Testing Plan (PowerPoint)
10. Written Comment from Annette Kowal, Chief Executive Officer and Ross Brooks, Chief Operating Officer, Colorado Community Health Network
11. Written Comment from Jean Public
12. Written Comments from U.S. citizens that are graduates of foreign medical schools