

DRAFT SUMMARY MEETING MINUTES

June 22-24, 2011

The Negotiated Rulemaking Committee (hereafter the “Committee”) was convened for its ninth meeting at 9:35 a.m. on June 22, 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:

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 Owens
Robert Phillips
Alice Rarig
Patrick Rock
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

REMEMBRANCE OF RON NELSON

Mr. Salsberg opened the meeting with a moment of silence in honor of Committee member Ron Nelson (of the National Association of Rural Health Clinics) who has passed away. Mr. Salsberg also thanked Committee members for their commitment to the process and noted that the Committee has spent 25 days meeting in person.

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 May's meeting and submitted edits to Nicole Patterson, HRSA. The Committee suggested additional edits and approved the minutes as edited.

EXPECTED OUTCOMES AND HRSA/HHS PERSPECTIVE

Mr. Salsberg explained that this June meeting is a critical decision point. The goal during the meeting is to reach tentative conclusions on the geographic MUA and HPSA models to be tested in order for JSI to begin full impact testing. There might be a bit more leeway with some of the populations and facilities decisions since John Snow, Inc. (JSI) is less likely to be able to complete that modeling before the July meeting. Mr. Salsberg distributed a document listing steps to completion of the proposed methodology (Attachment). The document summarizes each element that will go into the methodology. The checked items indicate where tentative agreement has already been reached. The big issues for this meeting involve the weighting and combining of the model elements. HRSA's perspective is that the population-to-provider component has to be a dominant factor in HPSA designation. It is a health professional shortage area so the provider shortage component has to be a significant factor. HRSA is very committed to this process. He also noted that there is a need to make sure the geographic, population, and facility approaches are comparable in terms of relative need and ranking; one approach should not be much more liberal than the other. The issue is how to address this in options where there are little or no data to evaluate.

There has been some discussion on the need for a communication strategy. We will definitely need it next November when we are done, but we will also need some strategy sooner so that, when Committee members go back to their constituents, they can explain the decisions made. As of now, this is not easy to do, so HRSA is looking at what resources are available to help simplify the

message and better explain the methodology. HRSA is also going to provide necessary resources to help make the Committee's process easier.

Ms. Sylvester observed that the group has managed to step up to the plate, even though the Committee is large and dealing with complex subject matter. The subcommittee process has served the Committee very well, and the group as a whole has started taking ownership. Because the deadline is approaching, Ms. Sylvester explained that the facilitators will probably be pushing the Committee harder, utilizing more of their mediator role.

REMARKS FROM BUREAU OF HEALTH PROFESSIONS

Jan Heinrich, Director of the Bureau of Health Professions (BHP), thanked the Committee for their hard work. She explained that Mr. Salsberg and other staff keep her informed of the Committee's progress and have been optimistic after each meeting. She stressed the importance of putting the Committee's decisions in writing, because what is on paper will be what is put forward once this process is complete. Dr. Heinrich assured the Committee of BHP's commitment to meeting the deadline, and asked the Committee to push to meet the deadline. She noted that BHP has brought on extra staff to help the Committee and is willing to provide other resources to assist the Committee. She also mentioned that BHP is communicating with other bureaus at HRSA and agencies within HHS (for example, CMS) about the work of the Committee, because it will have significant implications on their programs.

SUBCOMMITTEE/WORKGROUP MEETINGS

Mr. Salsberg surveyed the Subcommittees and Workgroups on whether they need to meet during the meeting and what decisions they still need to make. Based on the responses, it was decided to have the Barriers Workgroup and RSA Workgroup meet for the first hour (10:30-11:30); and the Weighting Subcommittee and Populations Subcommittee meet for the second hour (11:30-12:30). The Workforce, Implementation and Facilities Workgroups will meet at other times later in the meeting.

GENERAL ANNOUNCEMENTS

Christina Hosenfeld, HRSA, introduced John Gill who is serving as the alternate for Gail Nickerson (the officially designated alternate for Ron Nelson). Gail will now be nominated to replace Ron on the committee. Christina also introduced two summer interns now working with BHP, Margaret Bykowski and Brooke Buchanan. In addition, she mentioned that Nicole Patterson of HRSA will be going on a six-month detail in July and will not be at the Committee's subsequent meetings to take notes. Emily Cumberland will take her place in the interim.

POPULATION-TO-PROVIDER RATIO COMPONENT DISCUSSION

JSI presentation. Eric Turer, JSI, began the discussion with a presentation entitled, "Population: Provider Statistics" (Attachment). He first noted that the P2P discussion would be the same for both types of designation (HPSA and MUA/P). JSI performed some data runs on provider backouts. Using provider addresses and geocoding, they were able to match providers to different types of placement sites around the country, including FQHCs, Look-A-Likes, RHCs and NHSC. They could not include all delivery sites, such as those that might be affiliated with hospitals. In addition, current data on physicians with J-1 visa waivers is not available in national databases, so they were not included. The results were displayed on a graph, and they show that the vertical lines or "hair" (which represents each county's total number of providers before any backouts) grows longer to the right side of the graph and grows much longer in proportion to the horizontal line or "scalp" (which represents the number of providers after those in federal programs were backed out). Thus, where the horizontal line is at zero, those areas would have no providers without assistance from federal programs. This indicates that for those areas of greatest shortage, the federally supported providers represent all or nearly all of the providers in the areas.

The next two graphs presented show the distribution of population-to-primary-care-provider ratio into deciles (1) with all primary care providers counted and (2) with primary care physicians only counted, further separated between (a) all providers/MDs counted and (b) those in federal programs for designated areas backed out. Mr. Turer then displayed two graphs which demonstrate the percent MD and percent program capacity by P2P and by population size. The second graph demonstrates that, as the population size of counties increases, the proportion of care provided by MDs increases and the proportion of care provided by federal programs decreases. Thus, in rural areas, the proportion of services provided by non-MDs would increase. Mr. Turer also displayed a graph of the average percent program and percent MD capacity by rural class. The final graph presented by Mr. Turer demonstrated the average population-to-provider ratio by rural class and type.

Mr. Turer also showed a map of provider locations with all federal resources backed out. The areas in red (meaning less providers) were prominent in the central-US. It was noted that IHS providers were tagged but not backed out. There was caution raised about interpreting the map too specifically; there should be state maps and urban/rural/frontier analyses as well. There was also a question of how to assess the results of the analyses: what are the P2P ratios being compared to?

Workforce Workgroup. Ms. Kuenning spent a few minutes discussing the Workforce Workgroup's progress in relation to the document Mr. Salsberg distributed (outlining steps to completion). Ms. Kuenning first noted that the Workgroup has four documents they are using in their discussion, which will be given to the Committee the next day. She reiterated the Workgroup and

Committee's previous decision to test incorporating Ob/Gyns at a .25 weight. In relation to Foreign Medical Graduates, the Workgroup would exclude any physician with a J-1 visa or national interest waiver (NIW). Basically, if physicians have a service obligation, they would be excluded; but if they do not have a service obligation, they would be included. The Workgroup would also exclude limited license providers. The Workgroup is also recommending using Co-location Analysis when counting providers for the designation process. [NPs and PAs co-located with primary care physicians or practicing without physicians on-site will be counted as primary care providers; those co-located with physician specialists will be considered non-primary care.] There was a question about why IHS providers are included, not backed out. Mr. Turer explained that IHS PCPs would not be providing care to the general population of the area they are in; in general they serve only Indians/Native Americans. The issue, as framed by Mr. Turer, is whether a provider's presence is contingent upon maintaining the designation. His understanding is that IHS sites [as opposed to Tribal sites] do not go through the normal HPSA designation process, so their IHS site status is not dependent on a HPSA designation or backing out the IHS provider. Thus, including IHS providers would not be unreasonable. [There are tribal sites that do not use the IHS; these can apply for a HPSA designation and may be assigned NHSC personnel; if so, their NHSC personnel will be backed out.]

There was a recommendation from a Committee member to test weighting Nurse Practitioners and Physician Assistants at both 0.75 and 1.00 in the impact testing. This would allow the Committee to examine both data runs and determine what the best weight is for NPs and PAs going forward.

There was discussion about the data sources and how much detail could be provided to the committee; the data are governed by data use agreements that may restrict access to names, etc. There are some state data that may help refine the provider data. Additionally, there are data from the ASAPS system and Oregon has NP/PA data that might be useful to use in testing at some point.

There were concerns expressed by members of the committee that the backout process could result in resources going to less needy areas; how temporary are these resources? The option of having the resource allocation decisions by the various programs take these federal resources into account when they make program decisions was offered as the mechanism to address that concern; whether this has been effective in the past was not clear (although the data presented by Eric Turer/JSI, as noted on page 2, affirmed the strong connection between an area's degree of shortage and the presence of federal resources there). Historically, backouts were limited to those resources specifically linked to the designations: NHSC providers excluded from HPSAs for example. An option of partial backouts was also raised.

HEALTH STATUS/SDI COMPONENT DISCUSSION

Dr. Phillips and Dr. Taylor began the discussion on Health Status/SDI. They presented their recommendation for the component based on previous Committee discussions and dialogue. The recommendation separates SDI (Social Deprivation Index) variables (representing risk for bad health outcomes) from direct measures of health outcomes, with each group being weighted at 50%. The recommended SDI variables (and their recommended internal weights within the overall SDI) are poverty (50%), unemployment (30%), percent persons with less than high school diploma (10%) and percent households with single parents (10%). These weights for the SDI variables are based on the factor analysis that was presented to the Committee (by the Graham Center) in February. The recommended direct health measures (and their recommended weights) are standardized mortality ratio (75%) and diabetes prevalence (25%).

The Committee had a number of questions on why SMR and diabetes prevalence are the recommended direct measures of health. There were concerns about diabetes data coming from the county level, resulting in poor quality estimates in small areas. There were also concerns that infant mortality rate (IMR) and/or rate of low birth-weight (LBW) births were not at all addressed in the recommendation. There was much discussion on the relative benefits and disadvantages of including LBW, IMR, diabetes and/or SMR. Additional suggestions were made, including the use of a local option that could substitute local direct measures of health. The option of a menu approach was raised. Concerns were also raised that if every applicant can select a local option, everyone will have a problem and the process will not differentiate between areas of need very well; it might in fact have the unintended result of reducing the role of barriers in the process if everyone has one.

There was also discussion about the recommended SDI variables. There was a question about whether poverty would get “overweighted” since it is also part of the ATP component of the models. Dr. Phillips and Dr. Taylor discussed other SDI variables that were considered. Based on a discussion of the unemployment vs. non-employed variables, led by Dr. McBride, and the Committee’s resulting recommendations, the unemployment rate variable would be replaced by one minus the employment rate. After a lengthy discussion and multiple votes, the Committee reached consensus to test the following SDI variables and direct measures of health:

HEALTH STATUS

SDI Variables

(50% of Health Status)

- Poverty (50%)
- One minus the employment rate (30%)
- Percent of persons with less than high school diploma (10%)
- Percent of households with single parents (10%)

Direct Measures

(50% of Health Status)

- Standardized Mortality Ratio (70%)
- Low Birth Weight OR Diabetes Prevalence (30%)

POPULATION-TO-PROVIDER THRESHOLD FOR IMPACT TESTING

Mr. Turer noted that there would be no population-to-provider threshold involved if an indexing approach to HPSA designation were adopted, but that the Committee has already discussed consideration of an alternate concept that looks more like the current HPSA, with one or two thresholds. The discussion centered on whether to have a single or double threshold or somehow make the threshold continuous. There were questions about using an “ideal” or “normative” value: is the intent of the statute to “drive towards the ideal” or identify those areas that are the worst off? There were suggestions on both sides of the debate. The suggestion was made to table the discussion until the next day. The Committee agreed and also asked the Workforce Workgroup to meet in the morning and begin the threshold discussion.

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

RECAP AND PROGRESS ASSESSMENT

Ms. Sylvester thought that Day 1 went well and hopes to continue the progress through the next two days. She explained that the Subcommittee/Workgroup Chairs have agreed to put together a document (called a “Straw Person”) that will be presented to the Committee prior to the July meeting. The Workforce Workgroup distributed their completed documents (Attachments). Mr. Salsberg distributed a document with decision points to be made by the Committee (Attachment). He reviewed the decisions points with the Committee. Ms. Hirota said the Barriers decision points are mostly accurate; the Workgroup is clear about which barriers need to be solidified. Dr. McBride confirmed the decision point for Ability to Pay. Mr. Holloway said that the last two questions under Rational Service Areas had been answered; the definition of population center is still outstanding. Mr. Salsberg noted that the Weighting/Combining discussion

would occur after lunch. Ms Kuenning recommended adding to our Workforce Committee work, once special populations are defined, the question of what would be the most appropriate P2P threshold for those special populations. Dr. Clanon confirmed the decision points listed under Facilities. When asked if any groups with outstanding decisions were left off the decision points document, Dr. Wilson asked to add the following three decision points for Populations: (1) the P2P ratio for special populations; (2) outstanding issues about measure of barriers, ability to pay, health status for population groups, etc.; and (3) how to decide which population groups fit into the streamlined, simplified and regular population group categories.

BARRIERS/ACCESS COMPONENT DISCUSSION

Ms. Hirota led the discussion on barriers/access. She distributed a document outlining the Workgroup's recommendations as well as the background leading up to the recommendations (Attachment). At this point, there are three decision points for the Committee to decide on. According to Ms. Hirota, the Committee previously agreed to the following model for impact testing: applicants would choose one factor from the menu below for their total Access score within the MUA computation, and for the regular MUP process the applicant could also choose a "local option" variable.

- Race/Ethnicity
- LEP
- Ambulatory Care Sensitive Conditions
- Hispanic
- Rural/Frontier Factor
- Disabilities

The Committee's first decision point is whether to allow inclusion of a local option for regular MUP applicants, i.e., those subpopulations that face specific barriers not addressed by the default factors. The Barriers Workgroup recommends including such a local option as a seventh factor in the menu.

The Committee had a lengthy discussion on this decision point. Concerns arose about not having any set criteria for this option, including criteria that demonstrate how the local barrier chosen is relevant to the program involved and can be addressed by that program. The idea of criteria for local option factors was acknowledged and Dr. Wilson offered to work on that. The suggestion was to keep the options limited and not something so complex that only the well-resourced communities can dominate the process. There were questions about the correlation between the Race/Ethnicity and Hispanic variables, as well as between Hispanic and LEP. Ms. Hirota explained that there indeed is a high correlation between those factors. The Committee decided to table the decision on whether to have a local option.

The Committee's second decision point is what model to use. Previous discussions raised some interest in having a model that allows picking more than one factor. Ms. Hirota presented four model options, the first two of which are recommended by the Workgroup. Option 1 would give additional points if an applicant scored high in a second factor. Option 2 would allow the applicant to select two factors and weight them evenly. Option 3 would also allow the applicant to select two factors but the factors would be categorized, as either risk factors or direct measures, and the applicant would choose one from each category. Option 4 would allow the applicant to choose one factor from the menu and combine it with an additional common factor (applicable to every applicant). The Committee's discussion on what option to choose included questions about ambulatory care sensitive conditions, usual source of care, disability, scoring the individual factors and specific examples for each option. There was some discussion about whether some of the barriers get addressed in other components of the model or process; in the RSA definition, the selection of the population for a pop group designation, in SDI/HS or ATP? The Committee took a straw poll and on the four options (lumping options 1 and 2 together). There were 8 votes for Options 1 & 2; 11 votes for Option 3 and 1 vote for Option 4. Members who voted for Option 1 & 2 briefly explained their reasoning. In addition, members who did not vote explained why. The Committee took a second straw poll, with the results shifting to Options 1 & 2 (receiving 12 votes) while Option 3 had 8 votes. The Committee decided to have JSI do impact testing on both options, specifically Options 2 & 3.

The Committee's third decision point is how to weight and allocate points within the models selected by the Committee. After confirmation by JSI that multiple weights can be tested, the Committee decided to run initial testing at 50% for each factor and let JSI adjust it accordingly to see the different impacts.

ABILITY TO PAY COMPONENT DISCUSSION

Mr. Holloway led the discussion on ability to pay. He explained that the Workgroup had decided that ability to pay should be based on income and insurance status. Specifically, the Workgroup's recommended definition of ability to pay is the proportion of the population that is both below 400% of the federal poverty level and uninsured. Mr. Turer demonstrated, on a graph, the correlation between the uninsured population and population below 200% of the federal poverty level. He noted that MEPS data were used to demonstrate this correlation and that there is a lot of variation among states. Because ACS data on uninsurance will not be available until 2013, JSI has been using uninsurance figures from the Current Population Survey (CPS). It was noted the CPS asks the question related to "insured in the last year" while the ACS, which would be used after 2013, asks "insured now."

The Committee voted to use the Workgroup's definition/model of ability to pay for impact testing.

WORKFORCE/THRESHOLD DISCUSSION

Ms. Kuenning reviewed the summary of the Workforce Workgroup's decisions that she distributed to the Committee earlier in the day (Attachment). She also distributed a matrix of the Workgroup's decisions (Attachment) and a document comparing the productivity ratios of data from UDS and MGMA (Attachment). She went page by page through the document, asking for any questions or revisions. There was a question about how the certification of disability providers would be dealt with; does that make them specialists and not therefore counted in this process? Concern over the backout issue was raised again by Mr. Scanlon; while in the aggregate it may not seem like that big an issue, but in some areas it does make a big difference. He noted that it seemed an issue of equity; some areas really have nothing and some areas look like they have nothing after the backout – but are they really equal and are they similar in terms of the likelihood of resources/providers staying. He also observed that programs have not always targeted well. The challenge is to balance the concern about losing needed federal resources and still identifying true areas of remaining need. There was agreement to see what the impact testing would show and how to present the justification as we go forward. There was one suggestion to change the language for linguistically isolated populations (under surveys of individual provider practices) to be parallel to the UDS language. Concerns about the source of data for counts of NPs and PAs practicing primary care were raised. With the single revision, the Committee reached consensus on the summary document for impact testing.

Ms. Kuenning also explained that the Workgroup began a discussion on thresholds. While they had no recommendations for the Committee, they did create a framework:

1. HPSA
2. Current/future state/document
3. Identify empirical data
4. With empirical data, identify on the continuum what's the worst and best
5. Create tiers.

Essentially, there might be three categories: automatic, qualified based on other need factors (access, ability to pay and health status), and not qualified. The threshold is where the lines that separate the three categories fall on the continuum. This is what the Committee needs to decide. It was noted that while HPSA designation establishes only eligibility for NHSC, it is automatic for a geographic area to qualify for the CMS bonus payment; that impact will be assessed in the testing, but the amount is significant in terms of annual funding. There will be calls scheduled for the Workforce Workgroup to review empirical data and other options for helping set thresholds.

WEIGHTING AND COMBINING DISCUSSION

Mr. Salsberg briefly introduced the discussion and Dr. Rarig reported on the Data Weighting Committee’s progress (Attachment). She reviewed the components of the framework, options for selecting variables, and options for combining variables. She reviewed the currently selected variables for barriers/access to care, ability to pay, SDI and direct measures of health. The approach she discussed is to maintain two distinct designations: HPSAs primarily for provider shortages/unavailability and MUAs for unmet infrastructure needs of a population. The variables used would be defined in the same way for both designations types but would be weighted differently under each. The options for combining factors include using either an index or a threshold approach; the former results in a single “score” for an area based on the formula for combining the factors; the latter may set various cutoff points based on the interaction of the various factors. The relative weighting of components can be based on the Committee’s opinion, a factor analysis or a combination of the two. Dr. Rarig presented a framework in the form of Mr. Holloway’s adjusted graphic. The graphic demonstrates the continuum of barriers and health status (on the Y-axis) and P2P (on the X-axis). The graphic portrays the relationship of provider availability to composite need measure. Because the inclusion of NPs, PAs and CNMs may strongly affect the P2P ratio (X-axis), there should be a consideration to make adjustments. The X-axis represents provider availability and the Y-axis represents other need factors. Dr. Rarig presented a few outstanding issues, including deciding on total points for each dimension/component and relative weights for the factors within each component.

Mr. Scanlon presented what he saw as four options:

1. Index of all four components (P2P, HS/SDI, Barriers/Access, and ATP) combined or linear model
2. Varied Threshold levels per Mr. Holloway’s graph
3. And for either, two ways to weight factors: judgment and statistical analysis. This would include weighting for factors within each component and the weights between the components.

	LINEAR/INDEX	STEPWISE
JUDGMENT		
STATISTICAL		

There was some discussion about what factor analysis is and what it shows; it is similar to a regression/correlation analysis but without knowing the dependent variable. It essentially assumes an underlying reality (in this case, that there is a true measure of underservice or shortage) that is not easy to identify, and it shows the extent to which each variable included in the analysis relates to or affects that underlying, unknown measure. Here it would be used to identify the degree to which the various factors explain or affect the variations in underservice among the counties. There was further discussion of weighting options but no final decisions.

JSI Presentation on Impact Testing Mr. Turer gave a presentation on the preliminary impact analysis performed by JSI (Attachment). He explained the impact testing design (county-level analysis and variable standardization). The individual variables combine to form components or factors that, in turn, combine to produce final county scores. JSI used the factor weights discussed at the May meeting which Mr. Turer noted had already been changed in discussion at this June meeting. The various models considered utilized expert or statistical approaches, or both, for grouping and weighting. Model 1 was expert grouping and weighting. Model 2 was expert grouping and statistical weighting. Model 3 was statistical grouping and weighting. Mr. Turer explained that Models 1 and 3 produced viable scoring procedures but Model 2 could not produce statistical weights. He then presented the preliminary results for each model. For the next impact analysis, he explained that there will be an option to test alternate weights or exclude variables within factors. In addition, a threshold must be selected for each designation.

There was a brief discussion of the results presented. The expert weighting method appeared to result in a very high number of designations, but it seemed a low percentage of current HPSAs at the county level remained - what is behind those swings in results? The issue of displaying results using the distribution of populations or geographic areas was discussed - it was decided to do both. There was discussion about population weighting in the factor analysis at the county level, and a suggestion that the factor analysis be rerun at the PCSA level for testing of the model results for PCSAs.

JSI RESULTS

As a first step in testing the results of the initial Committee decisions related to Geographic designations, JSI developed a series of models incorporating those decisions with the available data at the community level (County at this point but more refined versions of service areas will follow). All models reflected an 'Index' approach in which all variables were combined into a single final score for each community using a series of scales and weights for the various components. The models compared 'Expert' decisions on grouping and weighting of variables based on a vote of Committee members, as well as a 'Statistical' model in which the grouping and weighting was developed using factor analysis. A 'Hybrid'

model in which committee grouping of variables was to be weighted using factor analysis was tested but found not to be statistically viable.

JSI presented a Powerpoint presentation summarizing the inputs and process by which the models were developed and run, as well as the results of the factor analysis of variables driving the statistical version of the model. The distribution of results amongst communities (Counties) was presented and a threshold reflecting the lowest 'quartile' of counties was used by JSI just for presentation purposes. For each model, JSI was able to show maps of counties that would be designated based on these assumptions, as well as tables showing the 'impact' of the decisions along several key parameters. These included the percentage of counties and overall population covered, the relative coverage of metro, non-metro, and frontier areas, the portion of currently designated populations that would remain covered, and the portion of various federal program sites (FQHC, Look-Alike, RHC, and free-standing medical NHSC placements) that would be covered. The models are designed to permit dynamic selection and reweighting of inputs and some variation of these parameters was conducted.

The Committee put together a list of final questions that needed to be answered in order for JSI to perform additional impact testing:

1. Specific simulations?
2. Which models should JSI analyze?
3. At what geographic level should the analysis be conducted?
4. What changes/assumptions should JSI test?
5. Should JSI look at a higher P2P level for HPSAs?
6. Should JSI use pilot states at this point, or at what point?

Dr. Rarig asked to hold the discussion. She offered to create a matrix with the remaining questions to review the next day. With the note that the Committee still has a lot to cover, the Committee agreed to return to the discussion the next day.

IMPLEMENTATION DISCUSSION

Mr. Owens briefly discussed the progress of the Implementation Workgroup. He mentioned four points/questions on their radar:

1. There was a suggestion to have some type of automatic process for the implementation.
2. The issue of hiring a communications consultant or staffing it with HRSA is still outstanding.
3. There was a request to see the current work flow of a shortage designation application. The Workgroup put together a flow chart that describes the 8-step process (Attachment).

4. Medicare Incentive Payment data came up as an issue. JSI has the data but they need to refine it to ensure it includes all of the physicians.

Some of the discussion following Mr. Owens' presentation centered on the implementation timeline and the role of PCOs in the process. While the current practice seems to allow for 4-year designation periods, Dan Hawkins noted that the typical health center is given a 5-year project period until its next competitive renewal, and suggested that a similar period of designation might be logical. There was some anecdotal reports of state's filtering designation requests due to budget concerns and wanted that to be considered in the implementation planning.

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

FUTURE MEETING SCHEDULE

Andy Jordan, HRSA, reminded everyone that the next meeting is July 20-21, 2011 at the Sheraton Suites Old Town in Alexandria, Virginia. The August meeting will likely be a conference call/webinar. The dates with the best availability are August 16-19, 2011. There was a suggestion to have two half days rather than one full day. The September meeting will likely be in person. The last two weeks of September have the best availability.

WEIGHTING AND COMBINING DISCUSSION (continued)

Dr. Rarig distributed a document to the Committee that addressed the weighting/combining questions from the previous day (Attachment). She provided additional information on what model options are available for JSI to test. Specifically, there are expert judgment and all-statistical weighting models. Under each model, there are two approaches to consider: linear index and stepwise. Dr. Rarig discussed these two approaches in the context of each model. She also discussed which geographic levels to test: county and PCSA levels, and existing RSAs (at least for RSA states). She explained the assumptions to use, options for thresholds and testing of pilot states. The Committee's follow-up discussion focused on which models to test and what thresholds to use.

POPULATIONS DISCUSSION

Dr. Wilson updated the Committee on the progress of the Populations Subcommittee (Attachment). There are three processes for MUP: regular, simplified and streamlined. Each process uses a tiered approach that includes a local option. For the regular MUP process, an applicant needs to demonstrate need using the four criteria: (1) disparities in health status, (2) inability to pay/lack of affordability, (3) barriers to access, and (4) unavailability of primary care providers. The first criterion, disparities in health status, has three tiers.

Applicants start with the first tier and move to the next tier only if data are not available at the level necessary. For the second criterion, barriers to access, the Subcommittee is discussing the criteria for other/local measures. The third criterion, inability to pay, has a similar tiered approach as disparities in health status that is contingent upon the availability of data at a particular level. The fourth criterion, unavailable primary care providers, will primarily allow survey determinations to show lack of providers, unless there are other ways of collecting the data. The simplified and streamlined MUP processes did not change much since Dr. Wilson last presented them. Dr. Wilson also discussed Special Population HPSAs and the two processes: regular and streamlined. For the regular process, the threshold will be adjusted based on the threshold set for the general population. The streamlined process will include named groups, including the Section 330 Groups and NA/AI from the streamlined MUP process.

Committee members had concerns about the regular MUP criteria being too broad and causing the door to open wide. How would the population and geography be defined for very small incidence groups? An example of the “end of life” group was offered as an example of a potential applicant group-would that be the type of group anticipated? Do the proposed population count and resource requirements provide enough limits? Should the populations be ones that have a specific program to address them to be eligible? There was a suggestion to add Medicare to Special Populations HPSA criteria, in addition to Medicaid. There was also a question about combining groups in a request-would that be appropriate? There was a discussion on where the 5% above normative 100% poverty rate came from (relating to the inability to pay criterion). There were some suggestions to use something such as 1 times the poverty rate, thus eliminating an arbitrary percentage. Dr. Wilson noted that they will reexamine the poverty rate, and look at how to tighten the criteria. With those remarks noted, the Committee gave consensus for the proposal to go forward for impact testing.

FACILITIES DISCUSSION

Dr. Clanon reported on the progress of the Facilities Workgroup (Attachment). The biggest changes to their proposal for HPSA facilities were to the insufficient capacity criterion for HPSA designations. There are seven options for demonstrating insufficient capacity, of which applicants must use at least two. There was a lot of feedback from the Committee on the choices/options for insufficient capacity, including questioning on why insufficient capacity is being used at all for facilities. Dr. Clanon took a straw poll on whether to have some criteria for insufficient capacity for HPSA facilities. The majority of the Committee voted to have some criteria. Dr. Clanon also asked the Committee if the criteria for insufficient capacity should apply to all HPSA facilities or only to those that are newly requesting a designation. There was not a clear majority on this poll. There was also a suggestion to change the language to “shortage” rather than

insufficient capacity-it would have to be defined; the intent of it would be to assess the capacity of the facility to serve the population.

Dr. Clanon discussed the proposal for facility HPSA – dependent MUP designation. The Committee had no comments or suggestions to the proposal. She also discussed changes made to the Correctional Facility HPSA proposal. The two changes noted were (1) using language that includes “all security levels” of correctional institutions; and (2) using a threshold of 200 internees as opposed to the current threshold of 250.

PUBLIC COMMENT

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

- Andrew Halpern, Child and Adult Psychiatrist
- Dave Mason, Mason Consulting, LLC
- Jamal Edwards, President & CEO, Howard Brown Health Center
- American Nurses Association

There were no public comments given during the meeting.

WRAP-UP

A Committee member asked about population density (rural, travel time and distance) and wondered if JSI could test at all three in order to allow for better judgment when reviewing the results. It was noted that density should be tested with the impact of both high and low density; are there data to support the link to health status to help develop a metric?

Dr. Wilson noted that she asked JSI about performing population impact testing, understanding that JSI has a lot of testing to run.

Dr. Larson provided a quick update on the ACS proposal, mentioning that there will be a full presentation in July. This proposal was ready to present in June, however a full agenda put discussion off until next month.

Mr. Salsberg concluded the meeting by encouraging the Committee to keep up the progress made in June. If materials are given to the Committee for review prior to the July meeting, the meeting will be more productive. He noted that HRSA and JSI are working hard to figure out how to present data in smaller, more manageable chunks. In the meantime, he asked the Committee to keep working hard and thanked them again for all the work they have done thus far.

The meeting adjourned on June 24, 2011 at 1:59 p.m.

**JUNE 22-24, 2011 SUMMARY MEETING MINUTES
ATTACHMENTS**

1. Steps to Completion of Proposed Methodology
2. Population: Provider Statistics (PowerPoint)
3. Barriers Workgroup Decision Points (June 22, 2011)
4. Summary of Workforce Workgroup Decisions (June 27, 2011) (PDF)
5. Workforce Workgroup Decisions Matrix (PDF)
6. UDS vs. MGMA Productivity Ratio (PDF)
7. Data Weighting Committee Report (PowerPoint)
8. Preliminary Impact Analysis (PowerPoint)
9. Current Shortage Designation Workflow (PowerPoint)
10. Shortage Designation Models for Testing
11. MUP Proposals: Regular, Simplified & Streamlined (June 23, 2011) (PowerPoint)
12. Facilities Workgroup Proposals (June 23, 2011)
13. Written Comment from Dr. Andrew Halpern
14. Written Comment from Dave Mason
15. Written Comment from Jamal Edwards
16. Written Comment from American Nurses Association